**Modelling of prostate cancer within the Thanzi La Onse Model**

**Background: The Thanzi La Onse Model**

As part of the Thanzi La Onse program a model is being developed which aims to capture the health experiences of the population of Malawi and the consequent interactions with the health care system. The intent is that this model will help to inform future delivery of health care in Malawi. The model is an individual based model – which means we explcitly simulate the individual life and health experiences of a representative proportion of the population of Malawi. The simulation initiates on 1 Jan 2010 and we attempt to simulate the attributes of the population at that point. We can run the model forward to any specified future time point. Each potential intervention and its associated diseases are being modelled. This is being divided into separate disease/intervention modules. AIDS associated cancers of non-Hodgkin’s lymphoma and Kaposi’s sarcoma are modelled as part of AIDS. Leading adult non-AIDS-defining cancers of oesophageal cancer, breast cancer, prostate cancer and bladder cancer are modelled separately. Cervical cancer is also modelled separately. This document describes the module on other adult cancers.

**Background: General approach to decisions on modelling causal influences and effects of interventions**

This module was designed in the context of an overall approach to modelling causal effects in general and causal effects of interventions in particular. The overal intent is to adopt as simple a structure as can be conceived, whilst still capturing the essential elements of a disease and the interventions used to prevent or treatment. We include a causal link between a “variable” (by which we mean a characteristic or property of an individual, whether that be demographic, social or biologic), and risk of disease or another variable if there is strong evidence from an overall body of studies that such a causal link exists and is at least moderately strong. In informing such decisions we place particular value on RCTs or studies with a quasi-experimental design such as analyses based on an instrumental variable There is no expectation that such studies will be from Malawi or even from Africa. If there are such local studies and in the unlikely event that they provide strong evidence to suggest that the causal link is substantively different in Malawi then the intent is that this is taken into account and the Malawi-specific link included.

In the special case of a potential causal variable which relates to whether an individual has experienced or is experiencing an intervention the intent is to only include interventions if there is substantial RCT evidence of their beneficial effect, based on trials with objectively ascertained clinical endpoints with low risk of serious bias. Whilst DCP-3 (and to some extent the Malawi EHP) provides an initial list of such interventions and the evidence to support them, where possible our intent has been to form our own opinion on intervention efficacy based on the source trials.

Unless there is evidence to the contrary, the intent is to summarize and incorporate intervention effects into the model as relative risks or rates rather than absolute differences due to the fact that such measures are less likely to differ substantively by context. Interactions between characterstics (on the multiplicative scale) are only to be be incorporated if there is strong evidence. Again, we have not intended to rely on data from Malawi or Africa for such evidence but if local evidence exists which strongly suggests a different effect than elsewhere then the intent is that this modified effect is incorporated in the model.

**Background: Demographic and social characteristics modelled**

Based on data on the distribution of the population in Malawi according to geographic location we assign individuals a geographic location, which maps onto whether they are classified as living in a rural or urban area. Informed largely by data from the Malawi DHS, variables are also created indicating the person’s wealth level (based on 5 quintiles), whether the person has access to improved sanitation, clean drinking water, hand washing facilities, and whether they experience indoor air pollution (wood burning stove). We assign individuals a current education status (none, primary, secondary) which is updated 3 monthly from age 5 to 20. From age 15 we assign BMI in 5 categories, tobacco use status, drinking excess alcohol, having low exercise, high sugar intake, high salt intake, and marital status (never, currently, widowed/divorced). The status with regard to such variables for individuals can change over time. The influences between these variables are described in detail in a separate document.

**Model structure**

**Variables modelled**

The model updates information on each individual with regard to prostate cancer status every 3 months. The model structure is described in Figure 1. Variables that we create for each man aged over 35 in relation to prostate cancer (Table 1) are as follows: prostate cancer status (pc\_status; none, prostate\_confined, local\_ln, metastatic), date of any diagnosis of prostate cancer (pc\_date\_diagnosis), date of any attempted curative treatment (pc\_date\_treatment) and at what stage (pc\_stage\_at\_which\_treatment\_given; no, yes prostate\_confined, yes local\_ln).

**Incidence of prostate\_confined prostate cancer**

Table 2 describes the parameters and their values. Jointly, the chosen parameter values produce the model outputs shown in Table 3. Informed by incidence rates of prostate cancer from Malawi cancer registry and other studies (Chasimpha et al, 2017), incidence of prostate cancer is assumed to be dependent on age. Other causes are unknown.

**Progression between cancer states**

Informed by data on progression of prostate cancer in the absence of treatment (Popiolek et al; 2013) we assume an annual rate of progression from prostate\_confined prostate cancer to local\_ln of 0.5 per year, and from local\_ln to metastatic cancer of 0.5 per year. The rate of progression from untreated metastatic cancer to death is 0.7 per year.

**Incidence of urinary symptoms and pelvic pain**

Presentation at late stages of cancer is common in the region (Kingham et al; 2013). In the initial report from the registry for very few cancer cases was their a cancer stage at diagnosis recorded (Msyamboza et al, 2012). We model two main symptoms that lead to the possibility of presentation: urinary symptoms (pain when urinating and other associated urinary symptoms) and pelvic pain. The rate of appearance of urinary symptoms is assumed to be 0.05 per 3 months at prostate-confined stage, and this rate increases by 1.5 times at higher stages, similarly for pelvic pain.

**Treatment for prostate cancer**

We consider potential medical treatment aimed at cure amongst people who are diagnosed. Depending on stage this might include surgery,chemotherapy and adjuvant treatments. We recognise that availability of treatment is currently extremely limited in Malawi. There were reported in 2015 to be five Malawian oncologists and haematologists involved in full-time cancer care in the whole country (Masamba et al, 2015). There is generally low access to treatments (Kingham et al; 2013).

**Effect of treatment**

The rate ratio for local\_ln prostate cancer for people treated with prostate\_confined is estimated as 0.2, likewise the rate ratio for metastatic prostate cancer in people treated at local\_ln stage is 0.2 based on the high survival rates in high income settings (<https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/prostate-cancer/survival#heading-Zero>).

**Rate of death from prostate cancer**

The death rate from bladder cancer in people with metastatic cancer is assumed to be 0.70 per year (Inferred from Popiolek et al 2013).

**Disability weights**

* For persons with any stage of cancer prior to metastatic stage and have never had any treatment, a disability-weight of 0.288 is applied, corresponding to "Diagnosis and primary therapy phase of prostate cancer: Cancer, diagnosis and primary therapy, has pain, nausea, fatigue, weight loss and high anxiety”.
* For persons with any stage of cancer prior to metastatic stage and have ever had any treatment, a disability-weight of 0.049 is applied, corresponding to "Controlled phase of prostate cancer, Generic uncomplicated disease: worry and daily medication, has a chronic disease that requires medication every day and causes some worry but minimal interference with daily activities”
* For persons with a cancer in metastatic stage and with no palliative care, a disability-weight of 0.451 is applied, corresponding to “Metastatic phase of prostate cancer: Cancer, metastatic: has severe pain, extreme fatigue, weight loss and high anxiety."
* For persons with a cancer in metastatic stage and with no palliative care, a disability-weight of 0.451 is applied, corresponding to “Metastatic phase of prostate cancer: Cancer, metastatic: has severe pain, extreme fatigue, weight loss and high anxiety."
* For persons with a cancer in metastatic stage and with palliative care, a disability-weight that is applied that is equal to those with earlier stage cancers without treatment.

**Health System Interactions**

*Care Seeking & Diagnosis*

Urinary symptoms or pelvic pain are assumed to trigger healthcare seeking to a Non-Emergency Generic Appointment at Facility Level 1, whereupon referral to further health system interaction is indicated. In that appointment, a prostate-specific antigen (PSA) test is undertaken. If the level is raised then the patient undergoes a second Non-Emergency Generic Appointment at Facility Level 1 for a biopsy. If that investigation confirms Prostate Cancer and if the stage of cancer is not stage 4 then the patient is referred to initiate treatment. If the cancer is confirmed and is in stage 4, the patient is referred to Palliative Care.

We aim for these rates to eventually be informed by data on stage of oesophageal cancer at diagnosis from the cancer registry, although in the initial report from the registry for very few cancer cases was there a cancer stage at diagnosis recorded (Msyamboza et al, 2012).

*Treatment Initiation & Monitoring*

Treatment is implemented for the patient in a separate single appointment, following diagnosis of any form of stage prior to stage 4 (low/high grade dysplasia and stages 1-3). The patient is monitored every year thereafter, and if the patients has progressed to stage 4, the patient is initiated on Palliative Care.

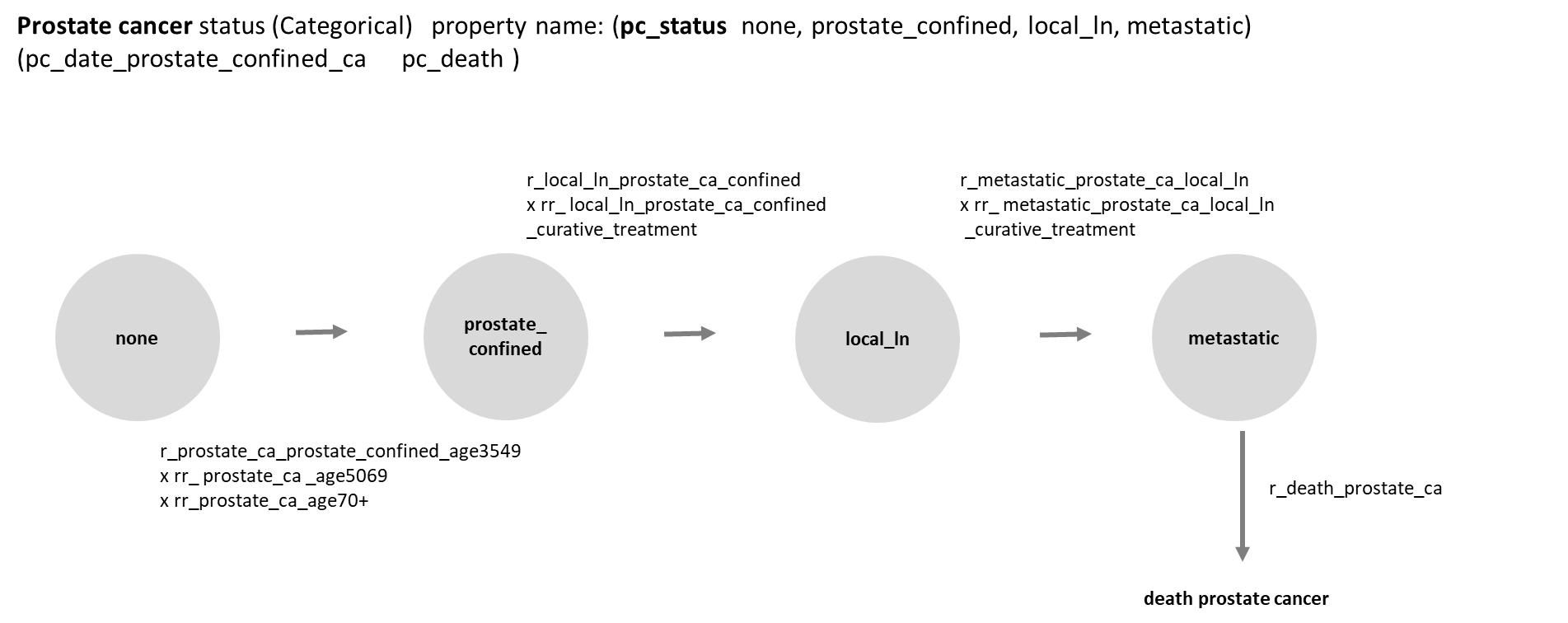
*Palliative Care*

Patients initiated on palliative care remain on palliative care and received a monitoring appointment each month. No benefit for the patient is in effect.

**Main Limitations**

The main limitations are the relative lack of data to directly inform many of the parameter values. Underlying progression of the condition is assumed to follow a similar course as in studies in other parts of the world. For incidence of prostate cancer and rates of diagnosis and availability of curative treatment it is necessary to consider data from Malawi itself given that these are likely to depend on the setting. As it becomes possible to perform more analyses in collaboration with the cancer registry we expect to be able to further inform our parameter values. In future iterations we will consider breaking down attempted curative treatment into surgery, chemotherapy, radiotherapy, and endocrine therapy etc. There is also uncertainty over disability weights.

**Figure 1. Prostate cancer status**



**Table 1. Properties modelled.**

|  |  |
| --- | --- |
| **Variable** | **Description** |
| pc\_status | none, prostate\_confined, metastatic |
| pc\_date\_diagnosis | date diagnosis |
| pc\_stage\_at\_which\_treatment\_given | received attempted curative treatment (never, yes prostate\_confined, yes local\_ln) |
| pc\_date\_treatment | date attempted curative treatment for prostate cancer |
| pc\_date\_palliative\_care | date start palliative care (note this is not prostate cancer-specific) |

|  |  |  |  |
| --- | --- | --- | --- |
| **Table 2. Description of parameters and proposed values** | | | |
| **Parameter** | **Proposed value** | **Description** | **Notes** |
| r\_prostate\_ca\_prostate\_confined\_age3549 | **0.000002** | annual rate of incident prostate cancer for 35-49 year old men | Indirectly informed by Chasimpha et al 2017 |
| x rr\_prostate\_ca \_age5069 | **2** | rate ratio for incident prostate cancer for people age 50-69 | Adeloye et al 2016 |
| x rr\_prostate\_ca\_age70+ | **4** | rate ratio for incident prostate cancer for people age 70+ | Adeloye et al 2016 |
| r\_local\_ln\_prostate\_ca\_confined | **0.15** | rate of progression to local lymph node from prostate confined | Inferred from Popiolek et al 2013 |
| rr\_ local\_ln\_prostate\_ca\_confined \_curative\_treatment | **0.1** | rate ratio for progression to local\_ln prostate cancer if had attempted curative treatment at prostate\_confined | Inferred from high survival in high income settings in people with access to treatment https://www.cancerresearchuk.org |
| r\_metastatic\_prostate\_ca\_local\_ln | **0.15** | annual rate of progression to metastatic prostate cancer if local\_ln | Inferred from Popiolek et al 2013 |
| rr\_ metastatic\_prostate\_ca\_local\_ln  \_curative\_treatment | **0.2** | rate ratio for progression to metastatic prostate cancer if had attempted curative treatment at local\_ln | Inferred from high survival in high income settings in people with access to treatment https://www.cancerresearchuk.org |
| r\_death\_prostate\_ca | **0.2** | annual rate of death in people with metastatic prostate cancer | Inferred from Popiolek et al 2013 |

**Table 3. Model outputs and observed data from Malawi**

(note this is with treatment given in 100% of diagnosed people pre-metastatic)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Model Output** | **Observed Data** | **Notes** |
| Number of incident diagnoses of prostate cancer per year | ~350 | 525 | Globocan\* |
| Rate of diagnosed prostate cancer cases (/100,000 men aged > 35 per year) | ~25  (but note comparison above) | age 40-49: 12.9;  age 50-59:16.3;  age 60-69 25.0;  age 70+ 39.0 | During 2008 – 2010, Blantyre. Chasimpha et al. 2017.  Adeloye 2016 (sub-Saharan Africa) |
| Number of people living with prostate cancer (any stage) in 2020, whether diagnosed or not | ~1200 | Not available by definition |  |
| Number of people living with **diagnosed** prostate cancer (any stage) in 2020. | ~490 | 752 | 752 (5 year prevalence) Globocan\* |
| Percentage of prostate-confined cancer cases diagnosed | ~30% | No data identified data so far to inform. |  |
| Number of people given attempted curative treatment for prostate cancer per year | ~310 | Low but have not identified data so far. | 5 Malawian Oncologists in full time care; Masamba et al 2015 |
| Number of deaths from prostate cancer per year (modelled output includes people never diagnosed) | ~470 | 355 | Globocan\* |

\* Globocan Methods: Incidence Country-specific data source: National Cancer Registry of Malawi Method: Most recent rates from a single registry applied to 2018 population Mortality Country-specific data source: No data Method: Estimated from national incidence estimates by modelling, using incidence:mortality ratios derived from cancer registry data in neighbouring countries Prevalence Computed using sex-; site- and age-specific incidence to 1-;3- and 5-year prevalence ratios from Nordic countries for the period (2000-2009), and scaled using Human Development Index (HDI) ratios

**References**

Riffenburgh et al. Survival Patterns of Cancer Patients. Cancer 2001; 91:2469–75.

https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/

Msyamboza et al. BMC Research Notes 2012, 5:149 http://www.biomedcentral.com/1756-0500/5/149

Moses et al. Risk factors for common cancers among patients at Kamuzu Central Hospital in Lilongwe, Malawi: A retrospective cohort study. Malawi Medical Journal 29 (2): June 2017

Chasimpha et al. Three-year cancer incidence in Blantyre, Malawi (2008–2010). Int. J. Cancer: 141, 694–700 (2017).

Masamba et al. The state of oncology in Malawi in 2015. Malawi Medical Journal; 27(3): 77-78 September 2015.

Msyamboza et al. Burden of cancer in Malawi; common types, incidence and trends: National population-based cancer registry. BMC Research Notes 2012, 5:149

Mukhula et al. Characterising cancer burden and quality of care at two palliative care clinics in Malawi. Malawi Medical Journal 29 (2): June 2017

Gowshall et al. The increasing prevalence of non-communicable diseases in low-middle income countries: the view from Malawi. International Journal of General Medicine 2018:11 255–264

Malawi DHS 2010, 2015/16 <https://dhsprogram.com/>

Salomon et al. Common values in assessing health outcomes from disease and injury: disability weights measurement study for the Global Burden of Disease Study 2010. Lancet 2012; 380: 2129–43. <http://www.biomedcentral.com/1756-0500/5/149>

Malawi Cancer Consortium <http://malawicancerconsortium.web.unc.edu/>

Stefan et al. Cancer Care in Africa: An Overview of Resources Volume 1, Issue 1, October 2015.. J Glob Oncol 1:30-36. © 2015 by American Society of Clinical Oncology.

Globocan <http://gco.iarc.fr/today/data/factsheets/populations/454-malawi-fact-sheets.pdf>

Parkin M, Hämmer L, Ferlay J, Kantelhardt EJ. Cancer in Africa 2018: The role of infections. Int. J. Cancer 2019

Parkin M et al. Part I: Cancer in Indigenous Africans—burden, distribution, and trends. Lancet Oncol 2008; 9: 683–92

Carla Carrilho et al. Cancer incidence in Mozambique in 2015–2016: data from the Maputo Central Hospital Cancer Registry. European Journal of Cancer Prevention 2019, 28:373–376

P Mtonga et al . Biopsy case mix and diagnostic yield at a Malawian central hospital. Malawi Medical Journal; 23(3): 62-64 September 2013

Popiolek et al. Natural History of Early, Localized Prostate Cancer: A Final Report from Three Decades of Follow-up. EUROPEAN UROLOGY 6 3 (2 01 3 ) 4 2 8 – 4 3 5

Roman Gulati et al. What If I Don't Treat My PSA-Detected Prostate Cancer? Answers from Three Natural History Models. Cancer Epidemiol Biomarkers Prev; 20(5); 740–50. 2011

Kingham TP et al. Treatment of cancer in sub-Saharan Africa. Lancet Oncol 2013; 14: e158–67

<https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/prostate-cancer/survival#heading-Zero>

Adeloye D, David RA, Aderemi AV, Iseolorunkanmi A, Oyedokun A, Iweala EEJ, et al. (2016) An Estimate of the Incidence of Prostate Cancer in Africa: A Systematic Review and Meta-Analysis. PLoS ONE 11(4): e0153496. doi:10.1371/journal.pone.0153496

Gopal S, Krysiak R, Liomba NG, Horner M-J, Shores CG, et al. (2013) Early Experience after Developing a Pathology Laboratory in Malawi, with Emphasis on Cancer Diagnoses. PLoS ONE 8(8): e70361. doi:10.1371/journal.pone.0070361

Cancer treatment guidelines for SSA <https://www.nccn.org/harmonized/>

Parkin DM et al. Cancer in Sub-Saharan Africa. International Agency for Research on Cancer Lyon, France 2018

<https://www.uptodate.com/contents/screening-for-prostate-cancer#:~:text=A%20PSA%20cutoff%20of%204.0,83%2C91%2D93%5D.>