Multi-state survival analysis in Stata

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Michael J. Crowther and Paul C. Lambert

Department of Health Sciences
University of Leicester
and
Department of Medical Epidemiology and Biostatistics
Karolinska Institutet
michael.crowther@le.ac.uk

Plan

- Background
- Primary breast cancer example
- Multi-state survival models
  - Common approaches
  - Some extensions
  - Clinically useful measures of absolute risk
- New Stata `multistate` package
- Future research

Background

- In survival analysis, we often concentrate on the time to a single event of interest
- In practice, there are many clinical examples of where a patient may experience a variety of intermediate events
  - Cancer
  - Cardiovascular disease
- This can create complex disease pathways

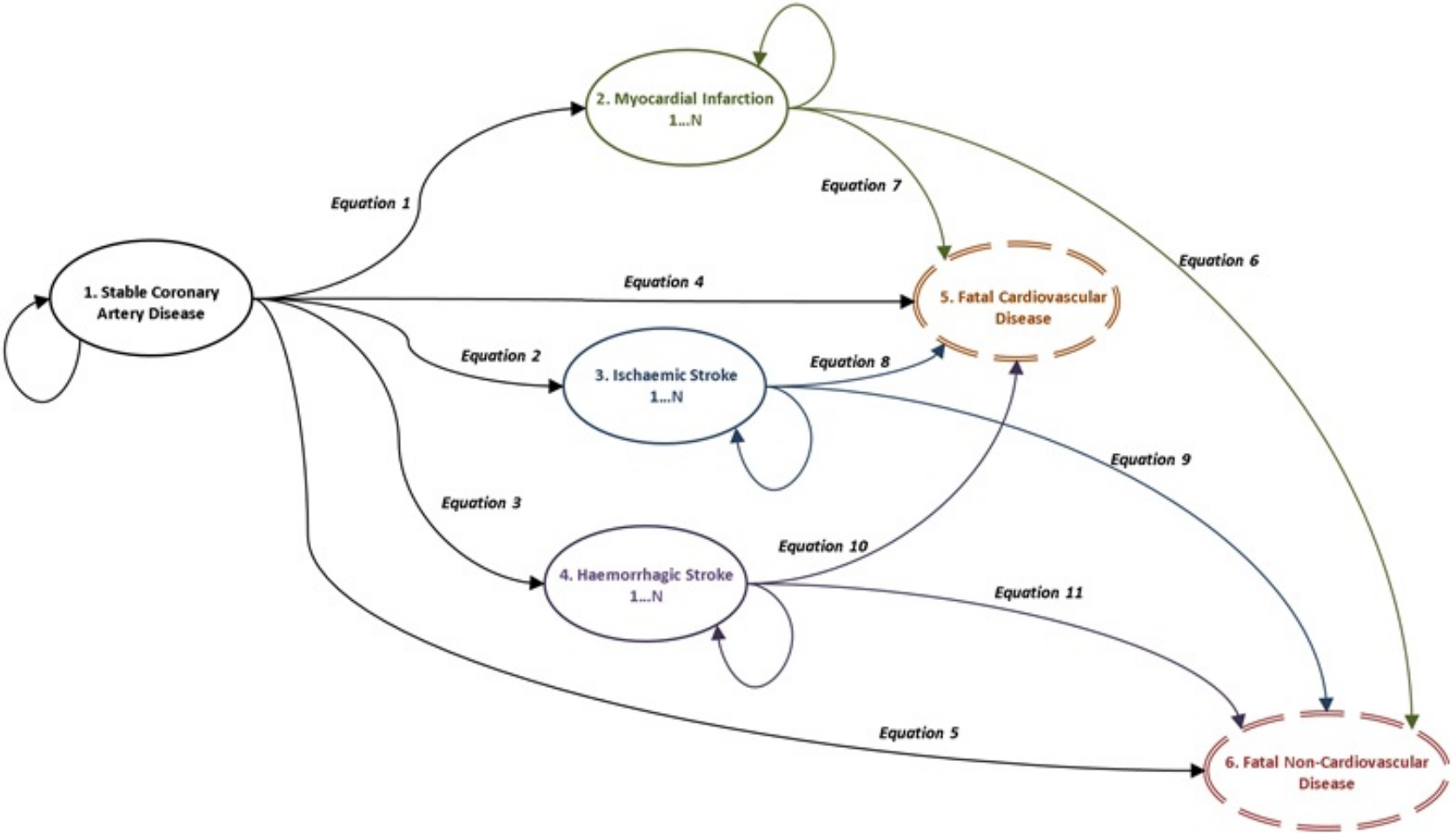

Figure: An example from stable coronary disease (Asaria et al., 2016)

- We want to investigate covariate effects for each specific transition between two states
- With the drive towards personalised medicine, and expanded availability of registry-based data sources, including data-linkage, there are substantial opportunities to gain greater understanding of disease processes, and how they change over time

Primary breast cancer (Sauerbrei et al., 2007)

- To illustrate, I use data from 2,982 patients with primary breast cancer, where we have information on the time to relapse and the time to death.
- All patients begin in the initial 'healthy' state, which is defined as the time of primary surgery, and can then move to a relapse state, or a dead state, and can also die after relapse.
- Covariates of interest include; age at primary surgery, tumour size (three classes; $\leq$ 20mm, 20-50mm, $>$ 50mm), number of positive nodes, progesterone level (fmol/l), and whether patients were on hormonal therapy (binary, yes/no). In all analyses we use a transformation of progesterone level ($\log(pgr + 1)$).

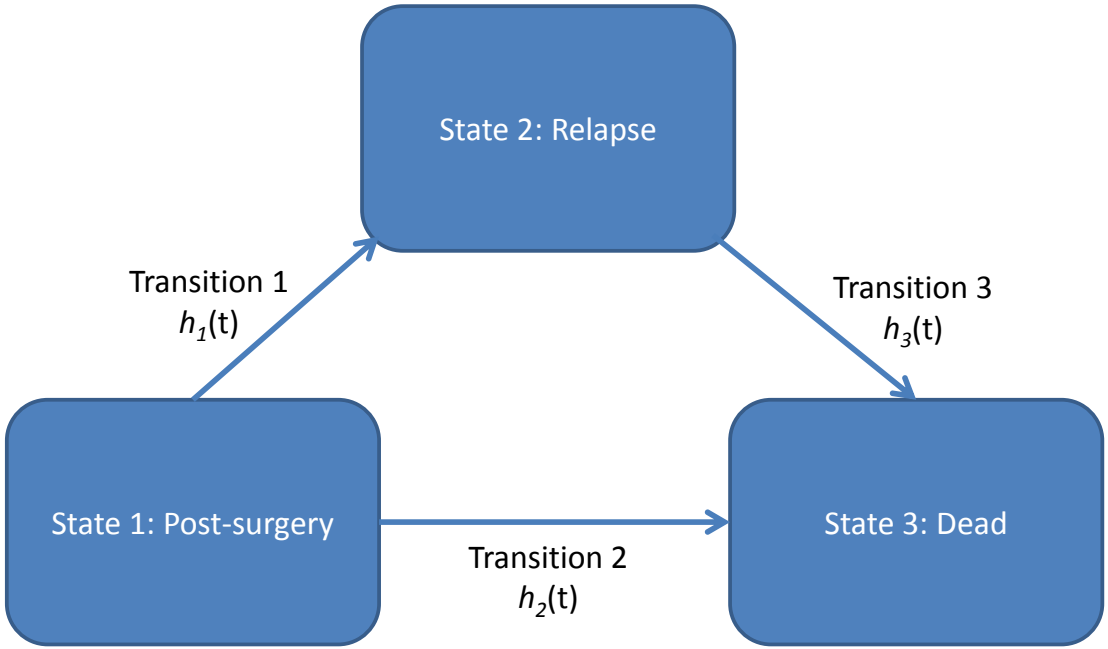

Figure: Illness-death model for primary breast cancer example.

Markov multi-state models

Consider a random process $\{Y(t), t \geq 0\}$ which takes the values in the finite state space $\mathcal{S} = \{1, \ldots, S\}$. We define the history of the process until time s, to be $\mathcal{H}_s = \{Y(u); 0 \leq u \leq s\}$. The transition probability can then be defined as,

$$P(Y(t) = b | Y(s) = a, \mathcal{H}_{s-})$$

where $a, b \in \mathcal{S}$. This is the probability of being in state b at time t, given that it was in state a at time s and conditional on the past trajectory until time s.

Markov multi-state models

A Markov multi-state model makes the following assumption,

$$P(Y(t) = b | Y(s) = a, \mathcal{H}_{s-}) = P(Y(t) = b | Y(s) = a)$$

which implies that the future behaviour of the process is only dependent on the present.

Markov multi-state models

The transition intensity is then defined as,

$$h_{ab}(t) = \lim_{\delta t \to 0} \frac{P(Y(t+\delta t) = b | Y(t) = a)}{\delta t}$$

Or, for the kth transition from state a_k to state b_k, we have

$$h_k(t) = \lim_{\delta t \to 0} \frac{P(Y(t+\delta t) = b_k | Y(t) = a_k)}{\delta t}$$

which represents the instantaneous risk of moving from state a_k to state b_k. Our collection of transitions intensities governs the multi-state model.

Estimating a multi-state models

- There are a variety of challenges in estimating transition probabilities in multi-state models, within both non-/semi-parametric and parametric frameworks (Putter et al., 2007), which I'm not going to go into today
- Essentially, a multi-state model can be specified by a combination of transition-specific survival models
- The most convenient way to do this is through the stacked data notation, where each patient has a row of data for each transition that they are at risk for, using start and stop notation (standard delayed entry setup)

Consider the breast cancer dataset, with recurrence-free and overall survival

```
. list pid rf rfi os osi if pid==1 | pid==1371, sepby(pid) noobs
```

pid	rf	rfi	os	osi
1	59.1	0	59.1	alive
1371	16.6	1	24.3	deceased

We can restructure using `msset`

Title

msset — data preparation for multi-state and competing risks analysis

Syntax

msset [*if*] [*in*] , **id(***varname***) states(***varlist***) times(***varlist***)** [*options*]

options	Description
id(*varname***)**	identification variable
states(*varlist***)**	indicator variables for each state
times(*varlist***)**	time variables for each state
transmatrix(*matname***)**	transition matrix
covariates(*varlist***)**	variables to expand into transition specific covariates

msset creates the following variables:

_from	starting state
_to	receiving state
_trans	transition number
_start	starting time for each transition
_stop	stopping time for each transition
_status	status variable, indicating a transition (coded 1) or censoring (coded 0)
_flag	indicator variable to show observations where changes to the original data have been made

Saved results

msset returns the following in r():

Matrices:

r(Nnextstates)	number of possible next states from starting state (row number)
r(transmatrix)	transition matrix
r(freqmatrix)	frequencies of transitions

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. msset, id(pid) states(rfi osi) times(rf os) covariates(age)
  variables age_trans1 to age_trans3 created
```

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. matrix tmat = r(transmatrix)
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. matrix tmat = r(transmatrix)
. list pid _start _stop _from _to _status _trans if pid==1 | pid==1371
```

pid	_start	_stop	_from	_to	_status	_trans
1	0	59.104721	1	2	0	1
1	0	59.104721	1	3	0	2
1371	0	16.558521	1	2	1	1
1371	0	16.558521	1	3	0	2
1371	16.558521	24.344969	2	3	1	3

```
. list pid rf rfi os osi if pid==1 | pid==1371, sepby(pid) noobs
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1371	0	16.558521	1	3	0	2
1371	16.558521	24.344969	2	3	1	3

```
. stset _stop, enter(_start) failure(_status==1) scale(12)
```

- Now our data is restructured and declared as survival data, we can use any standard survival model available within Stata
  - Proportional baselines across transitions
  - Stratified baselines
  - Shared or separate covariate effects across transitions
- This is all easy to do in Stata; however, calculating transition probabilities (what we are generally most interested in!) is not so easy

Calculating transition probabilities

$$P(Y(t) = b | Y(s) = a)$$

There are a variety of approaches

- Exponential distribution is convenient (Jackson, 2011)
- Numerical integration (Hsieh et al., 2002; Hinchliffe et al., 2013)
- Ordinary differential equations (Titman, 2011)
- Simulation (Iacobelli and Carstensen, 2013; Touraine et al., 2013; Jackson, 2016)

Simulation

- Given our estimated transition intensities, we simulate n patients through the transition matrix (Crowther and Lambert, 2013)
- At specified time points, we simply count how many people are in each state, and divide by the total to get our transition probabilities
- To get confidence intervals, we draw from a multivariate normal distribution, with mean vector the estimated coefficients from the intensity models, and associated variance-covariance matrix, and repeated M times

Extending multi-state models

- What I've described so far assumes the same underlying distribution for every transition
- Consider a set of available covariates X. We therefore define, for the kth transition, the hazard function at time t is,

$$h_k(t) = h_{0k}(t)\exp(X_k\beta_k)$$

where $h_{0k}(t)$ is the baseline hazard function for the $a_k \rightarrow b_k$ transition, which can take any parametric form such that $h_{0k}(t) > 0$. To maintain flexibility, we have a vector of patient-level covariates included in the $a_k \rightarrow b_k$ transition, X_k, where $X_k \in X$.

Proportional baseline, transition specific age effect

```
. streg age_trans1 age_trans2 age_trans3 _trans2 _trans3, dist(weibull)
Weibull regression -- log relative-hazard form
No. of subjects =        7,482                 Number of obs    =        7,482
No. of failures =        2,790
Time at risk    =  38474.53852
                                               LR chi2(5)       =      3057.11
Log likelihood  =   -5547.7893                 Prob > chi2      =       0.0000
```

_t	Haz. Ratio	Std. Err.	z	P>|z|	[95% Conf.	Interval]
age_trans1	.9977633	.0020646	-1.08	0.279	.993725	1.001818
age_trans2	1.127599	.0084241	16.07	0.000	1.111208	1.144231
age_trans3	1.007975	.0023694	3.38	0.001	1.003342	1.01263
_trans2	.0000569	.000031	-17.95	0.000	.0000196	.0001653
_trans3	1.85405	.325532	3.52	0.000	1.314221	2.615619
_cons	.1236137	.0149401	-17.30	0.000	.0975415	.1566547
/ln_p	-.1156762	.0196771	-5.88	0.000	-.1542426	-.0771098
p	.8907636	.0175276			.8570641	.9257882
1/p	1.122632	.0220901			1.080161	1.166774

predictms

```
. predictms, transmat(tmat) at(age 50)
```

predictms

```
. predictms, transmat(tmat) at(age 50) graph
```

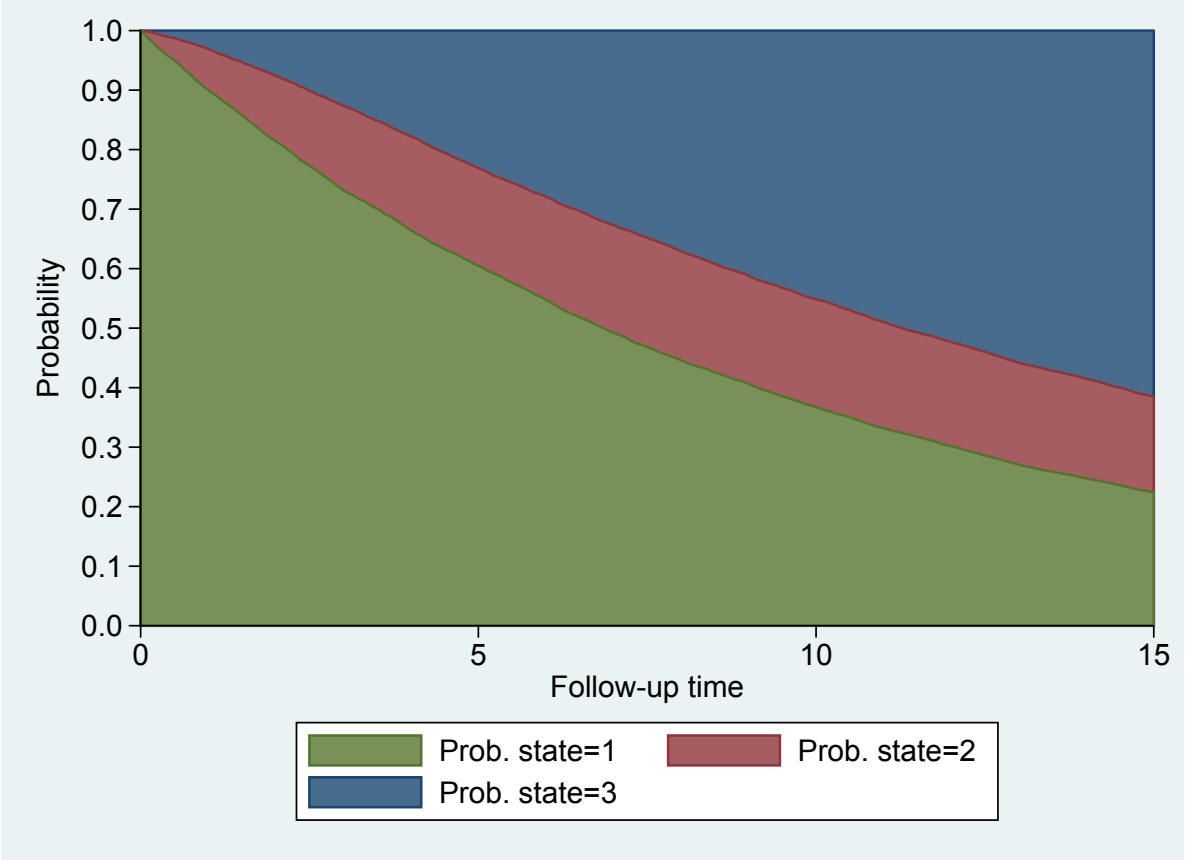


Figure: Predicted transition probabilities.

Extending multi-state models

```
 . streg age_trans1 age_trans2 age_trans3 _trans2 _trans3 ,
> dist(weibull) anc(_trans2 _trans3)

// Is equivalent to...

. streg age if _trans==1, dist(weibull)
. est store m1

. streg age if _trans==2, dist(weibull)

. est store m2

. streg age if _trans==3, dist(weibull)

. est store m3
```

Extending multi-state models

```
 . streg age_trans1 age_trans2 age_trans3 _trans2 _trans3 ,
> dist(weibull) anc(_trans2 _trans3)
// Is equivalent to...
. streg age if _trans==1, dist(weibull)
. est store m1
. streg age if _trans==2, dist(weibull)
. est store m2
. streg age if _trans==3, dist(weibull)
. est store m3


//Predict transition probabilities
. predictms, transmat(tmat) models(m1 m2 m3) at(age 50)
```

Separate models...we can now use *different* distributions

Building our model

Returning to the breast cancer dataset

- Choose the best fitting parametric survival model, using AIC and BIC
- We find that the best fitting model for transitions 1 and 3 is the Royston-Parmar model with 3 degrees of freedom, and the Weibull model for transition 2.
- Adjust for important covariates; age, tumour size, number of nodes, progesterone level
- Check proportional hazards assumption

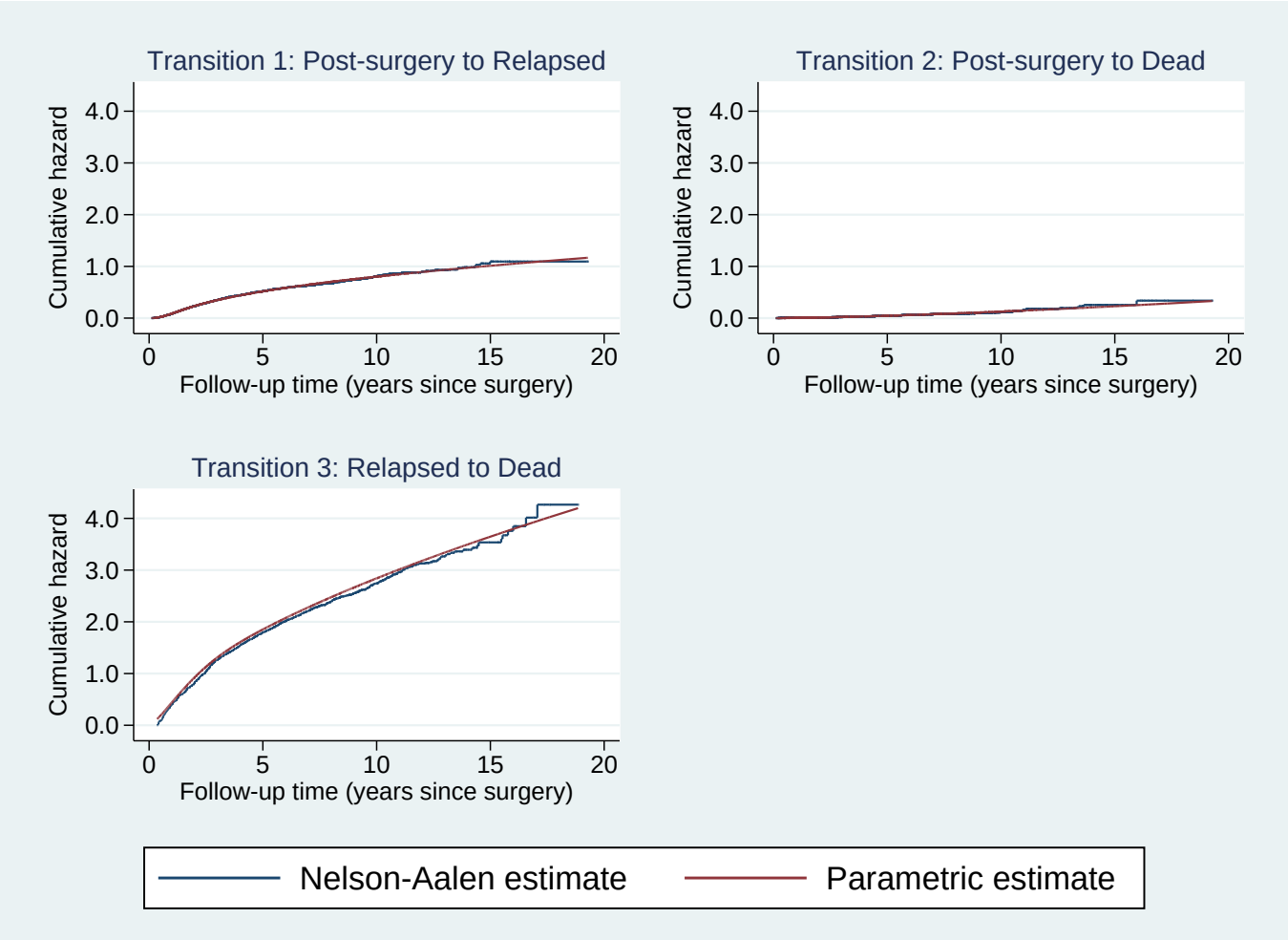


Figure: Best fitting parametric cumulative hazard curves overlaid on the Nelson-Aalen estimate for each transition.

Final model

- Transition 1: Royston-Parmar baseline with df=3, age, tumour size, number of positive nodes, hormonal therapy. Non-PH in tumour size (both levels) and progesterone level, modelled with interaction with log time.
- Transition 2: Weibull baseline, age, tumour size, number of positive nodes, hormonal therapy.
- Transition 3: Royston-Parmar with df=3, age, tumour size, number of positive nodes, hormonal therapy. Non-PH found in progesterone level, modelled with interaction with log time.

```
predictms, transmat(tmat) at(age 54 pr_1 3 sz2 1)
> models(m1 m2 m3)
```

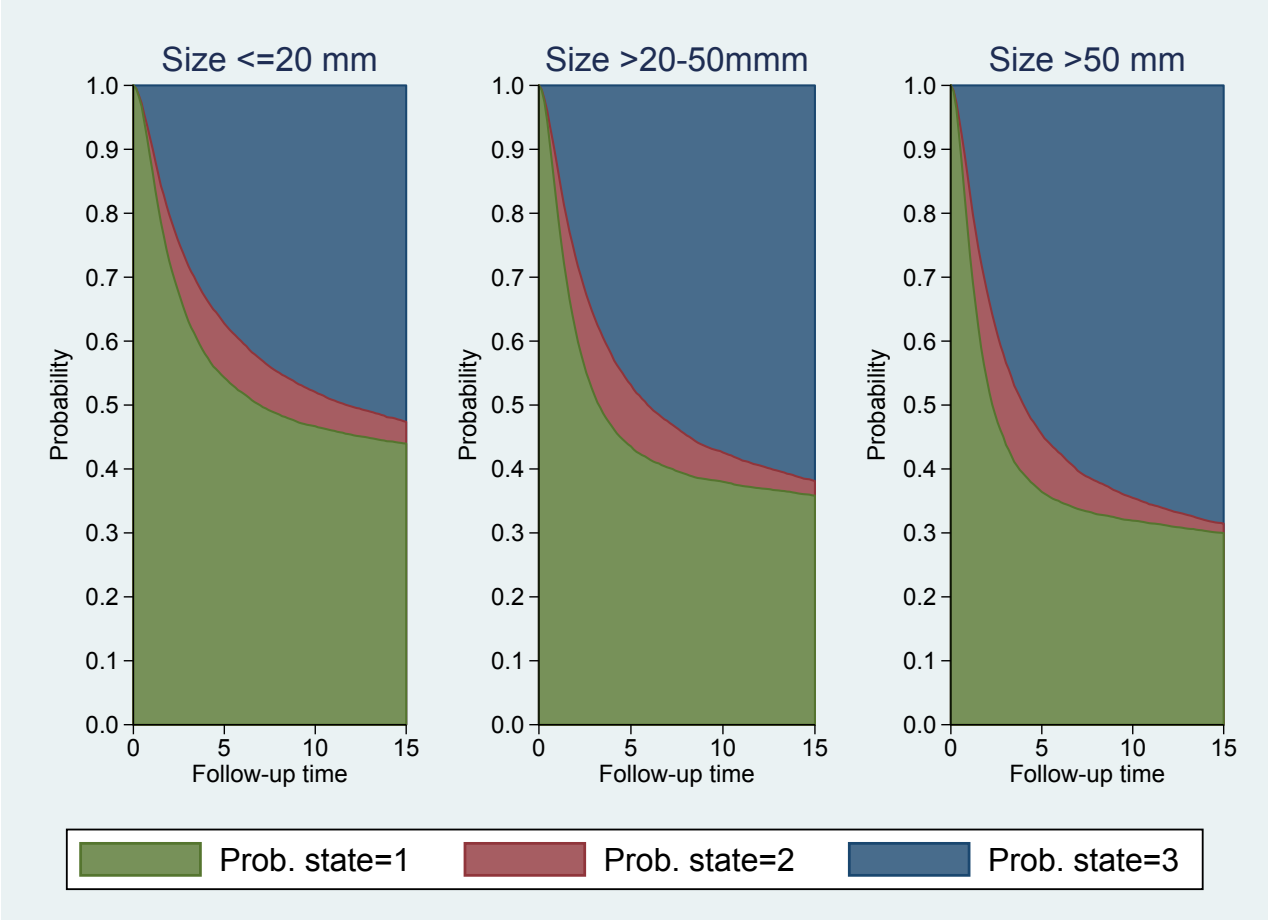


Figure: Probability of being in each state for a patient aged 54, with progesterone level (transformed scale) of 3.

```
predictms, transmat(tmat) at(age 54 pr_1 3 sz2 1)
> models(m1 m2 m3) ci
```

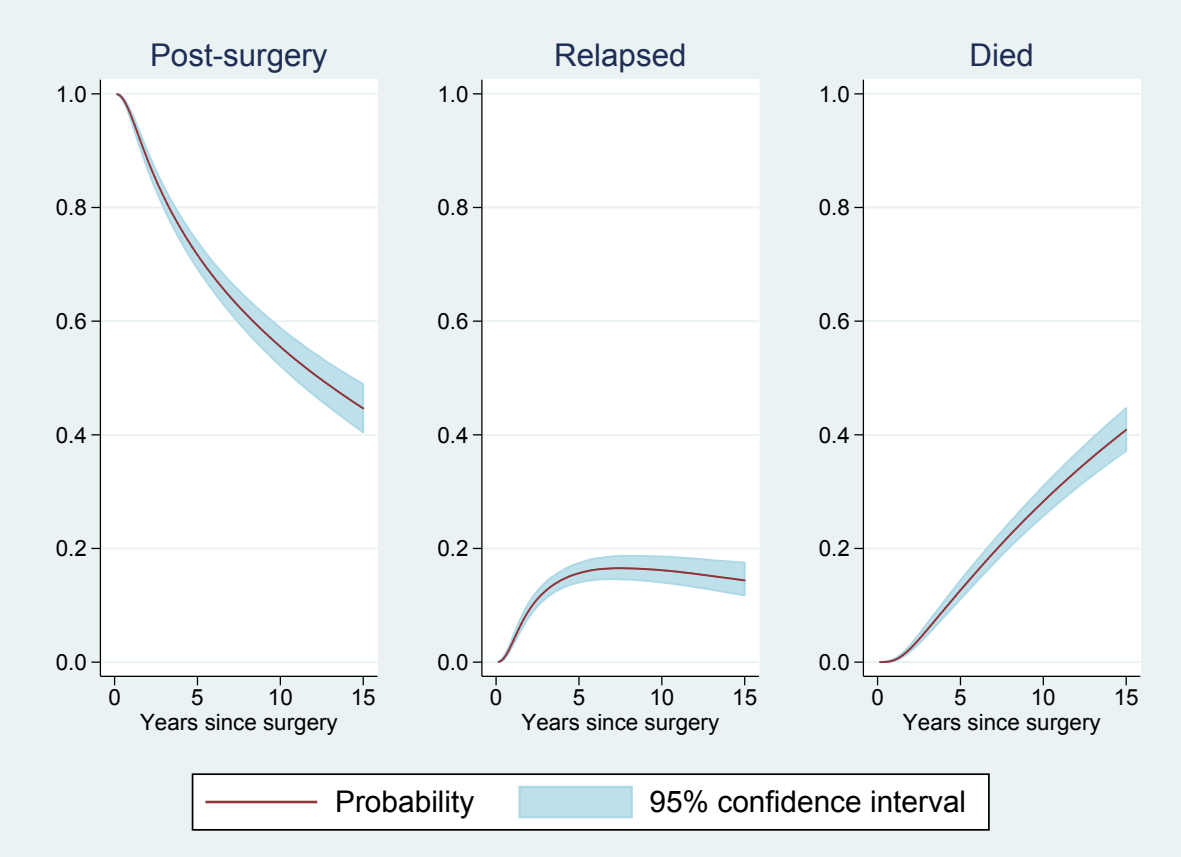
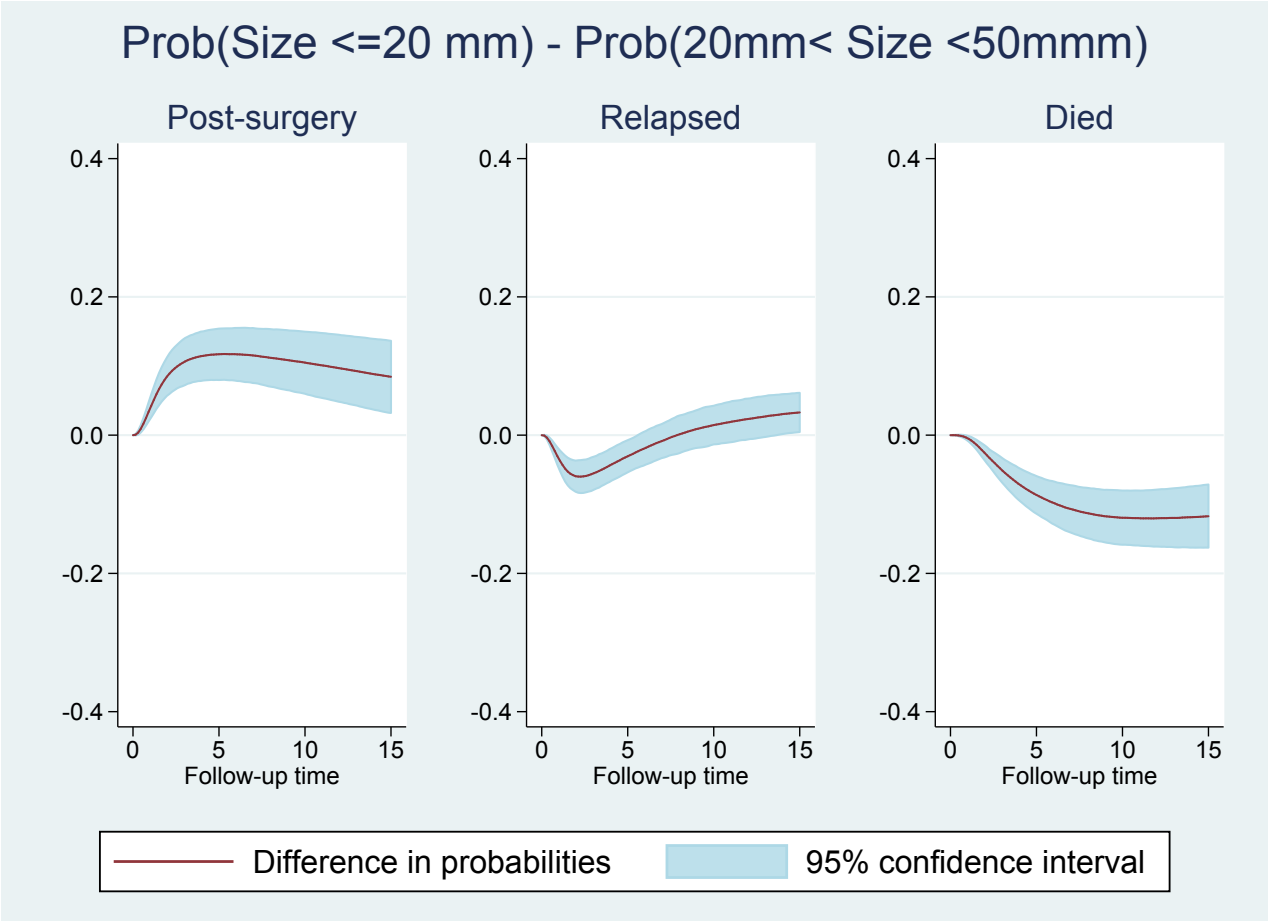


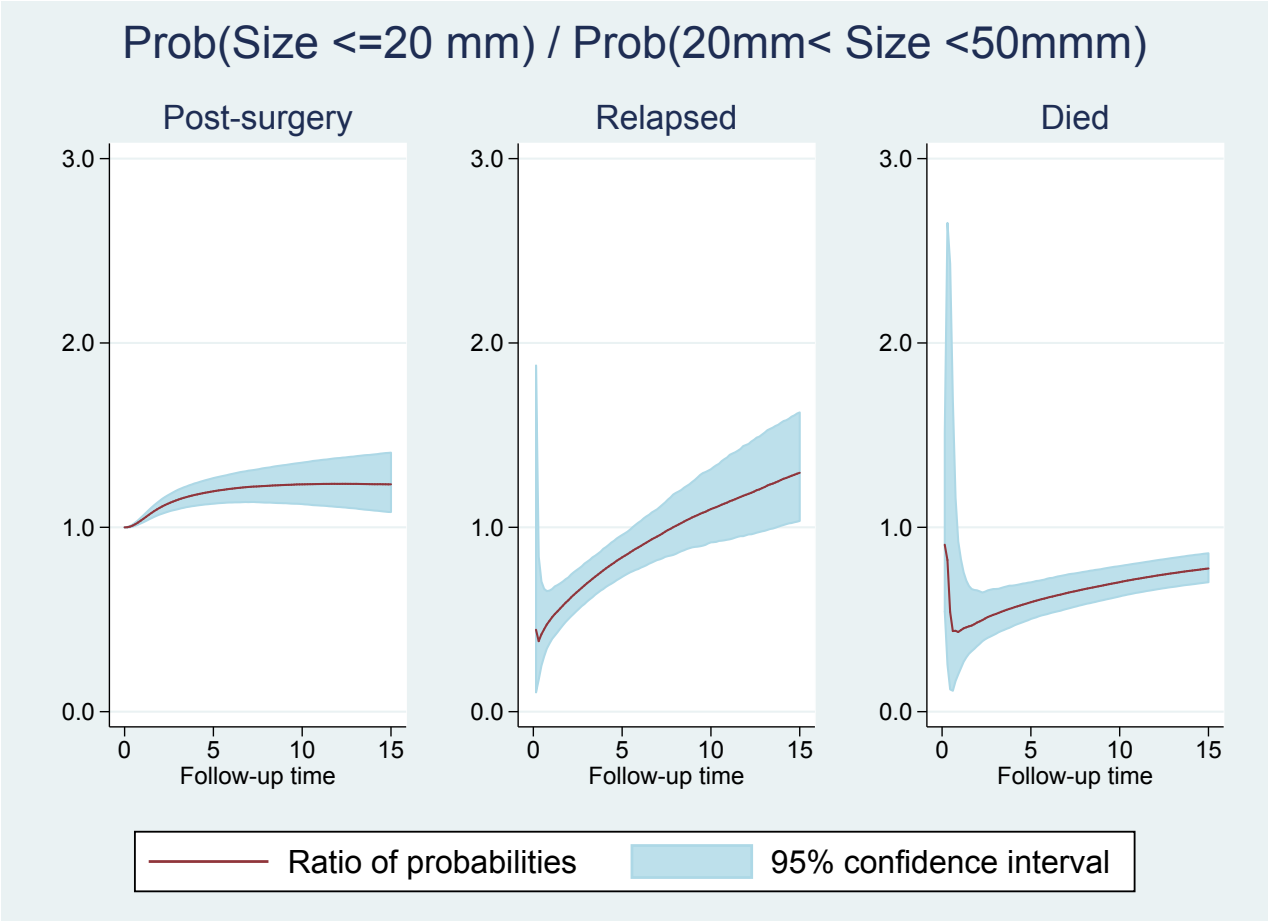
Figure: Probability of being in each state for a patient aged 54, 50$>$ size $\geq$20 mm, with progesterone level (transformed scale) of 3, and associated confidence intervals.

Differences in transition probabilities




```
. predictms, transmat(tmat) models(m1 m2 m3) ///
.   at(age 54 pgr 3 size1 1) at2(age 54 pgr 3 size2 1) ci
```

Ratios of transition probabilities




```
. predictms, transmat(tmat) models(m1 m2 m3) ///
.   at(age 54 pgr 3 size1 1) at2(age 54 pgr 3 size2 1) ci ratio
```

Length of stay

A clinically useful measure is called length of stay, which defines the amount of time spent in a particular state.

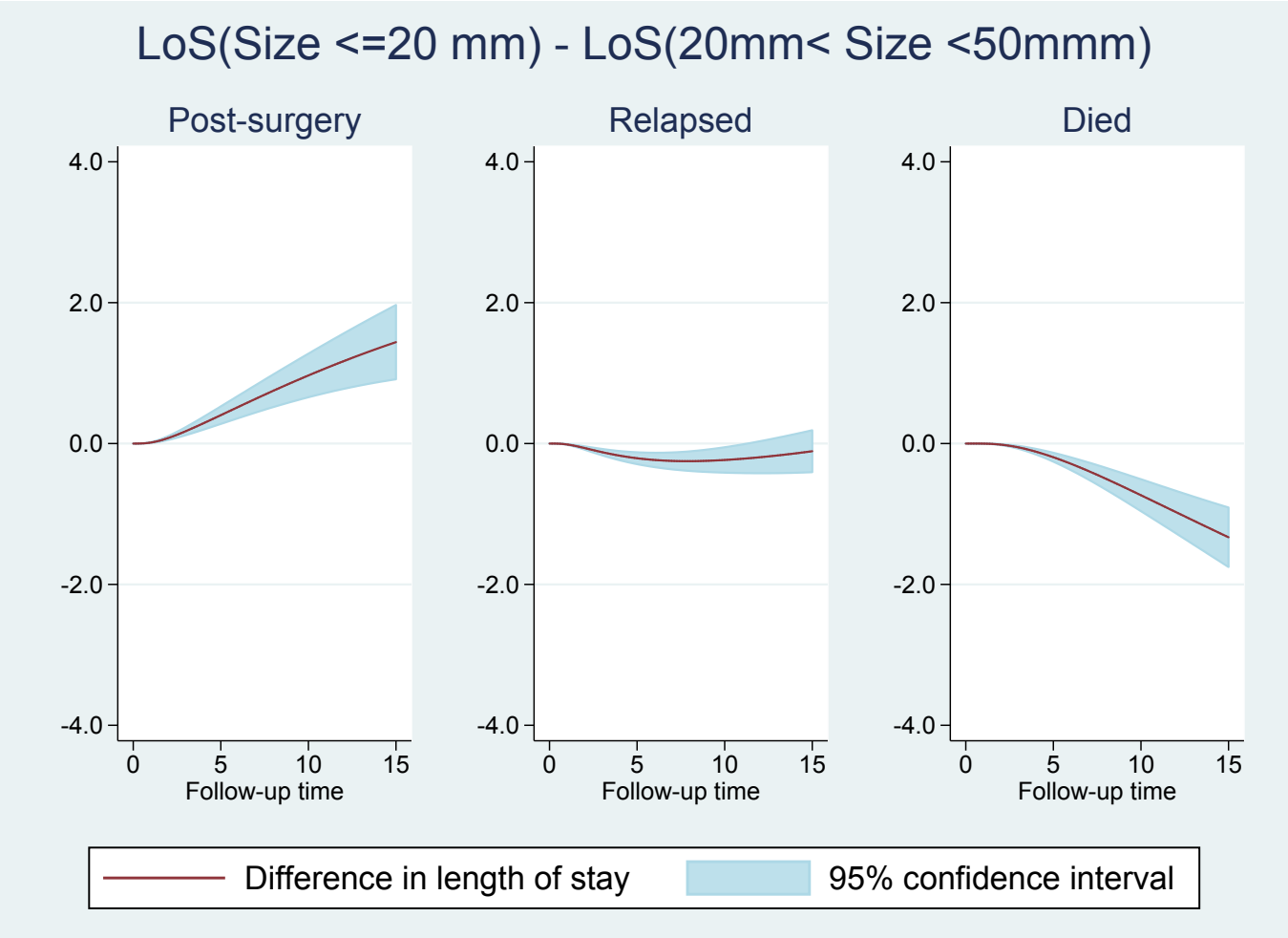
$$\int_s^t P(Y(u) = b | Y(s) = a) du$$

Using this we could calculate life expectancy if t $= \infty$, and $a = b = 1$ (Touraine et al., 2013). Thanks to the simulation approach, we can calculate such things extremely easily.

Length of stay

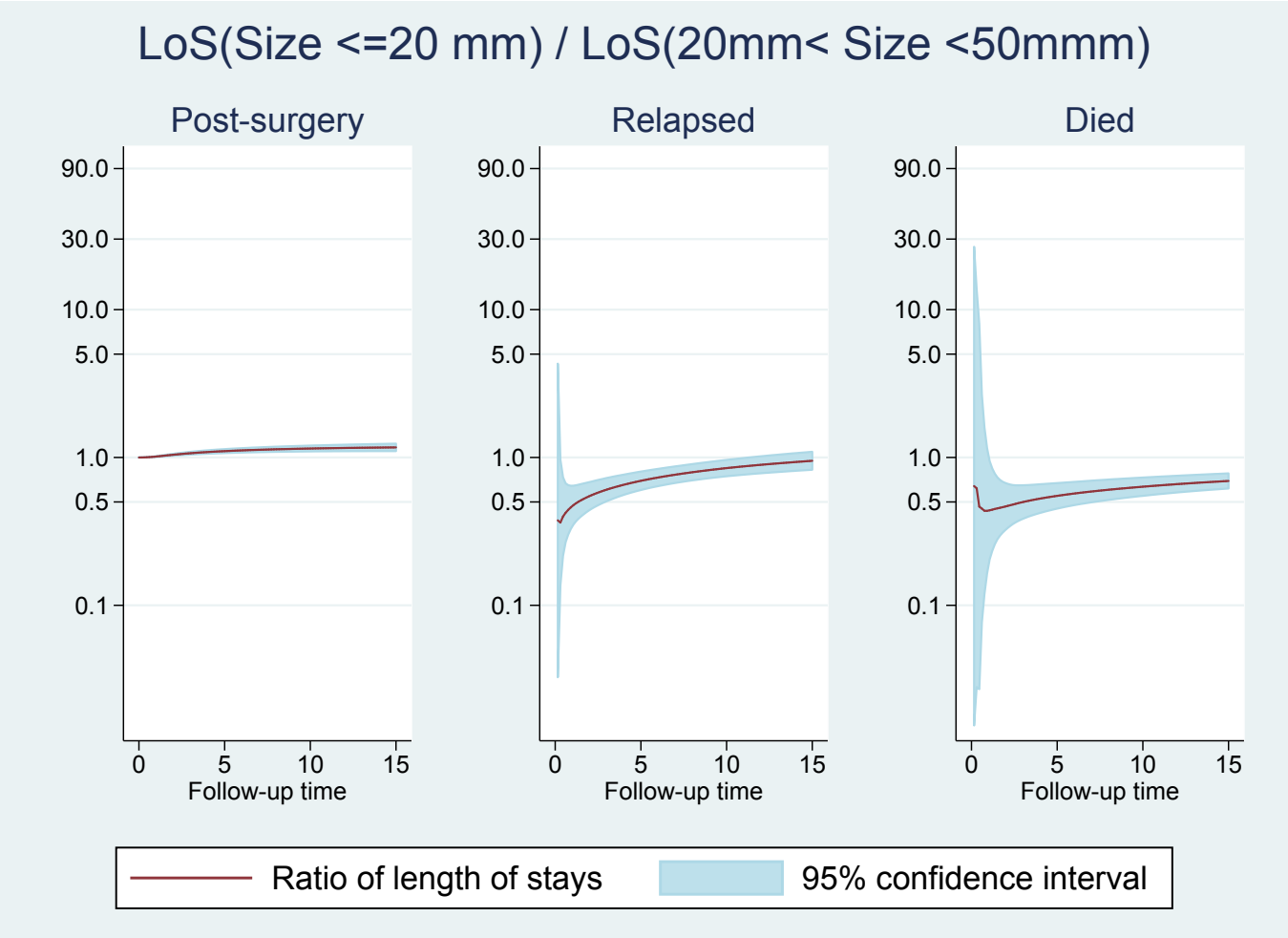

```
. predictms, transmat(tmat) models(m1 m2 m3) ///
.   at(age 54 pgr 3 size1 1) ci los
```

Differences in length of stay




```
. predictms, transmat(tmat) models(m1 m2 m3) ///
.   at(age 54 pgr 3 size1 1) at2(age 54 pgr 3 size2 1) ci los
```

Ratios in length of stay




```
. predictms, transmat(tmat) models(m1 m2 m3) ///
.   at(age 54 pgr 3 size1 1) at2(age 54 pgr 3 size2 1) ci los ratio
```

Sharing covariate effects

- Fitting models separately to each transition means we can no longer share covariate effects - one of the benefits of fitting to the stacked data
- We therefore want to fit different distributions, but jointly, to the stacked data, which will allow us to constrain parameters to be equal across transitions

Transition-specific distributions, estimated jointly

```
. stms (age sz2 sz3 nodes pr_1 hormon, model(rp) df(3) scale(h)) ///
.      (age sz2 sz3 nodes pr_1 hormon, model(weib)) ///
.      (age sz2 sz3 nodes pr_1 hormon, model(rp) df(3) scale(h)) ///
.      , transvar(_trans)
```

Transition-specific distributions, estimated jointly

```
. stms (age sz2 sz3 nodes pr_1 hormon, model(rp) df(3) scale(h)) ///
.      (age sz2 sz3 nodes pr_1 hormon, model(weib)) ///
.      (age sz2 sz3 nodes pr_1 hormon, model(rp) df(3) scale(h)) ///
.      , transvar(_trans) constrain(age 1 3 nodes 2 3)
```

Transition-specific distributions, estimated jointly

```
. stms (age sz2 sz3 nodes pr_1 hormon, model(rp) df(3) scale(h)) ///
.      (age sz2 sz3 nodes pr_1 hormon, model(weib)) ///
.      (age sz2 sz3 nodes pr_1 hormon, model(rp) df(3) scale(h)) ///
.      , transvar(_trans) constrain(age 1 3 nodes 2 3)


. predictms, transmat(tmat) at(age 34 sz2 1 nodes 5) ci
```

Summary

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- Software now makes them accessible
  - `ssc install multistate`

Summary

- Multi-state survival models are increasingly being used to gain much greater insights into complex disease pathways
- The transition-specific distribution approach I've described provides substantial flexibility
- We can fit a very complex model, but immediately obtain interpretable measures of absolute and relative risk
- Software now makes them accessible
  - `ssc install multistate`
- Extensions:
  - Semi-Markov - `reset` with `predictms`
  - Cox model will also be available (`mstate` in R)
  - Reversible transition matrix
  - Standardised predictions - `std` (Gran et al., 2015; Sjölander, 2016)

References I

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