How NCIN may help the NCRN in Achieving its Goals

Professor Mahesh Parmar

NCRN Coordinating Centre
and
MRC Clinical Trials

The National Cancer Research Network

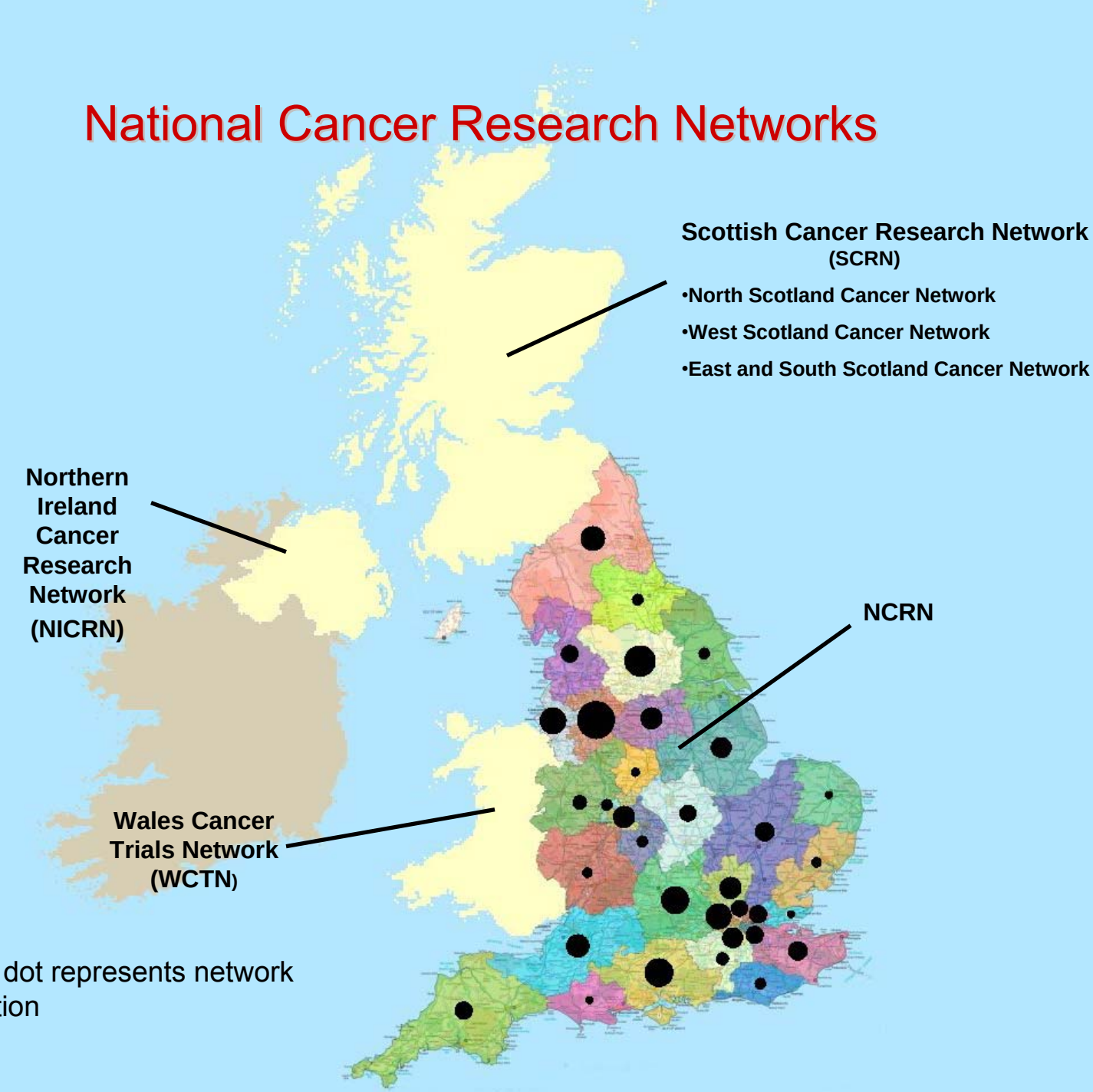
- The NCRN is a managed research network mapping directly onto the NHS cancer service networks across England
- NCRN works closely with equivalent organisations in Scotland, Wales and Northern Ireland
- Funding for NCRN supports the provision of research nurses, data managers and – to a limited extent – the expertise of radiologists, pharmacists, pathologists and other clinicians
- The NCRN Coordinating Centre is based at Leeds & London an
- The NCRN Coordinating Centre also co-ordinates the (separately funded) NCRI *Clinical Studies Groups* and committee of NCRI *Accredited Trials Units* (≈ Data and Coordinating Centres)

NCRI Partners

NCRN

National Cancer Research Network

National Cancer Research Networks



Size of dot represents network population

NCRN
National Cancer Research Network

Clinical Studies Groups

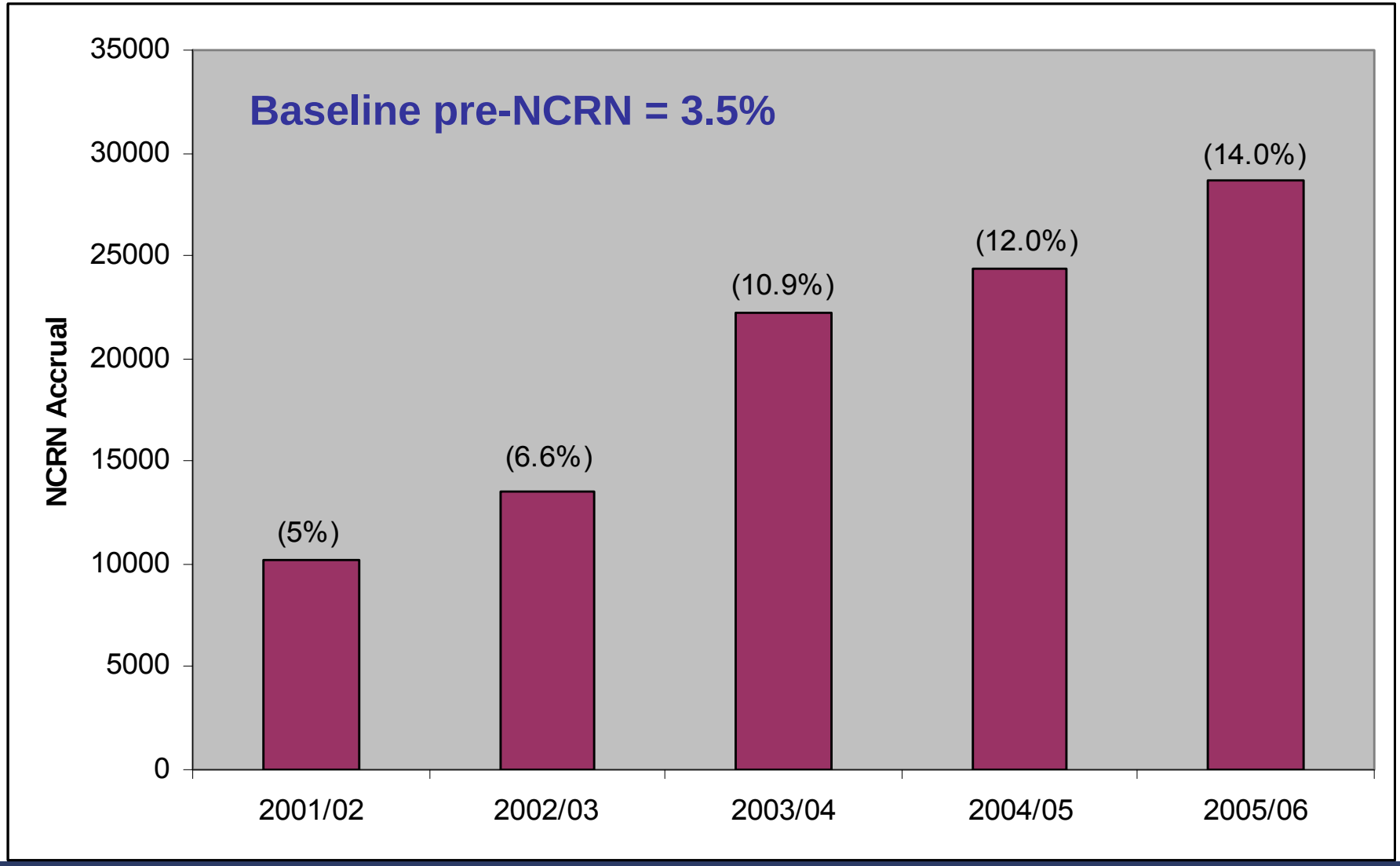
- 23 Groups
- Expert involvement from across UK
- Central support under NCRN management
- User/consumer input on every group
- 15 tumour specific + a radiotherapy group
- Cross-cutting & development groups
  - Primary Care
  - Palliative Care
  - Psychosocial Oncology
  - Complementary Therapies
  - Teenagers & Young Adults
- Translational CSG
- Consumer Liaison Group

Original aims of the NCRN

- To benefit patients by improving the coordination, integration, quality, inclusiveness and speed of cancer research
- To develop a world class infrastructure
- To double the number of cancer patients entered into clinical trials and other well designed studies by April 2004
- Accrual is compared to annual incidence of all cancers (except non-melanoma skin cancer)

→ Doubling of accrual achieved in < 3 years

Accrual to NCRN Portfolio studies English Cancer Research Networks

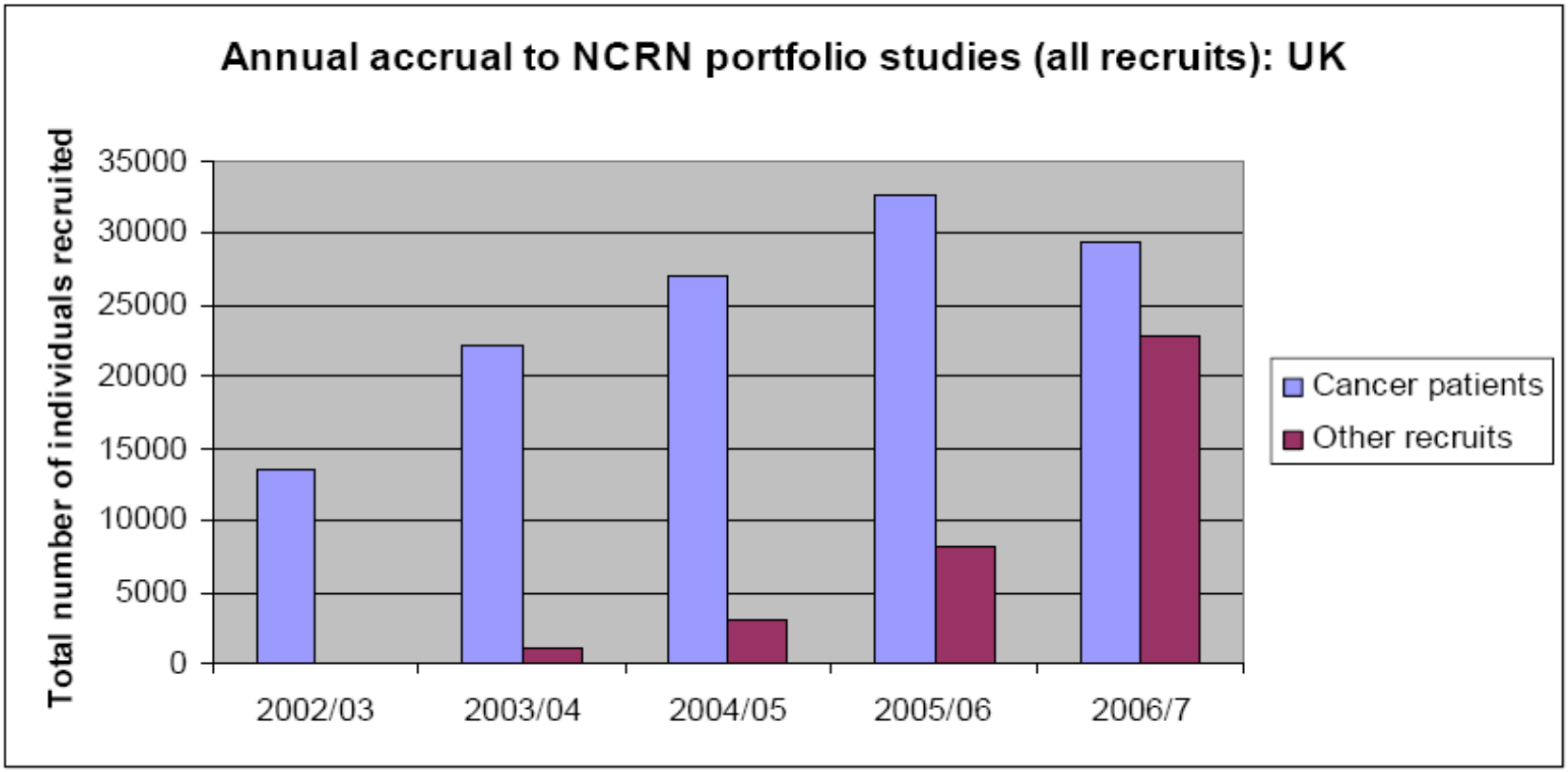


How was NCRN successful?

- Accrual more than trebled in 5 years, reaching a peak of >13% against annual incidence
- Raw numbers now roughly equal to US Cooperative Group system, with about 1/5 the population
- Both momentum and availability of increased research funding led to major increase in number of trials, as well as rate of completion
- Expansion of activity was greatest in district hospitals previously not research active
- The new resources (research nurse staff) seems to be the most important driver of success

Volume of accrual

Figure 2a: Annual national accrual of all individuals to NCRN portfolio studies (UK)



Typical information collected for individual trials

- Patient demographics (age, sex, ..., social class)
- Patients disease status (site of disease, stage of disease, size of tumour, ...)
- Histopathology (differentiation, ...)
- Concomitant treatment
- Treatment
- Recurrence/Progression (+treatment for recurrence)
- Survival - may take many, many years

How Can the NCIN Help?

- Monitoring entry rates into NCRN clinical trials, both randomised and observational
  - Examining geographic, ethnic and socio-economic characteristics of patients in trials
  - Comparing characteristics of trial entrants with non-entrants
  - Comparing tumour characteristics against population based incidence
  - Current ability to look across trials is very limited
- Long-term follow-up of trial patients
  - >20 000 patients on follow-up
- Examination of rare but important events – c.f. effects of Cox-2 inhibitors (Vioxx)
- Impact of Trials
- Joint NCIN/NCRN post to explore some of these possibilities

Conclusions

- The NCRN has been a major success
- Directly led to the formation of the UKCRN – ‘NCRN’ for many other diseases
- The NCIN offers the opportunity to do more, for relatively modest extra investment
- No other country gives the opportunities provided by NCRN and NCIN