A total of 2779 patients diagnosed between 2012 and 2015 were identified; the proportion of patients requiring hospitalisation or an outpatient visit was relatively similar between the subgroups with stage I-IIA and IIB-IIIC disease, the number of visits per patient-year was higher in patients with stage IIIb-IV NSCLC.

In addition, the number of days of hospitalisation per patient-year was higher in patients with stage IIIb-IV NSCLC than in patients with stage I-IIA disease.

Surgical interventions were most common for stage I-IIA disease.

The proportion receiving radiotherapy procedures was comparable across stage I-IIA and IIIb-IV subgroups, but a higher number of procedures per patient-year was observed in the stage IIIb-IV population.

A similar pattern was observed in relation to imaging tests.

Tissue sampling appeared to be more common among patients with stage I-IIA disease and biomarker tests more common among patients with stage IIIb-IV disease (Note that some biomarker tests were not routine in clinical practice during the study period).

Over the past decade, an increasing number of treatment options have become available for patients with NSCLC, most recently with the emergence of immunotherapies. In this rapidly evolving treatment landscape, a better understanding of real-world treatment patterns and associated healthcare burden is critical for informing clinical decision-making and optimising patient benefits.

SCOPE-LEAF is a retrospective longitudinal study that aims to describe the epidemiology, clinical care, and outcomes of patients with NSCLC in Scandinavia.

The SCOPE-LEAF project is part of I-O Optimise, a multinational collaboration aimed at developing a research framework to provide timely insights into the real-world management of oncology patients. I-O Optimise is a platform for multinational collaboration on clinical practice.

The SCAN-LEAF project is based on 2 partly overlapping cohorts

Cohort 1 includes the entire NSCLC population across 3 Scandinavian countries (Denmark, Norway, and Sweden) undergoing radiation procedures, use of systemic anti-cancer therapy (SACT), tissue sampling, imaging tests, and biomarker tests from date of diagnosis to death or end of observational period – cohort 1 is restricted to patients with NSCLC.

Cohort 2 includes NSCLC patients diagnosed at 2 select clinics in Sweden (CoHort 2).

Electronic medical record (EMR) data were extracted using the Pygargus CRF software platform linked with national registries.

Patients were followed from the date of their first diagnosis of NSCLC until death, emigration, or the end of the study period (31 December 2016).

A cancer was considered concomitant if it occurred within 5 years prior to the index date.

The proportion of patients undergoing imaging tests appeared to reflect the proportions of patients not dying during each LoT, with around one-third to one-half undergoing a test across the health systems and LoTs were not clear trends between LoTs in relation to the rates per 100 patient-years.

Data for surgical interventions are not shown as no lung surgeries were performed on patients included in this study.

Conclusions

NSCLC was associated with a substantial HCRU burden among this sample of Swedish patients, with a particularly high burden for those diagnosed with stage I-IIA NSCLC. Likewise, data for tissue sampling and biomarker tests are not shown as these HCRUs relate to the periods prior to the observed outcomes. Data on laboratory tests for monitoring of disease progression were available for analysis of HCRU during LoTs.

Regardless of histology, the proportions of patients undergoing imaging tests appeared to reflect the proportions of patients not dying during each LoT, with around one-third to one-half undergoing a test across the health systems and LoTs were not clear trends between LoTs in relation to the rates per 100 patient-years.

Data for surgical interventions are not shown as no lung surgeries were performed on patients included in this study.

Conclusions

NSCLC was associated with a substantial HCRU burden among this sample of Swedish patients, with a particularly high burden for those diagnosed with stage I-IIA NSCLC. Likewise, data for tissue sampling and biomarker tests are not shown as these HCRUs relate to the periods prior to the observed outcomes. Data on laboratory tests for monitoring of disease progression were available for analysis of HCRU during LoTs.

Regardless of histology, the proportions of patients undergoing imaging tests appeared to reflect the proportions of patients not dying during each LoT, with around one-third to one-half undergoing a test across the health systems and LoTs were not clear trends between LoTs in relation to the rates per 100 patient-years.

Data for surgical interventions are not shown as no lung surgeries were performed on patients included in this study.

Conclusions

NSCLC was associated with a substantial HCRU burden among this sample of Swedish patients, with a particularly high burden for those diagnosed with stage I-IIA NSCLC. Likewise, data for tissue sampling and biomarker tests are not shown as these HCRUs relate to the periods prior to the observed outcomes. Data on laboratory tests for monitoring of disease progression were available for analysis of HCRU during LoTs.

Regardless of histology, the proportions of patients undergoing imaging tests appeared to reflect the proportions of patients not dying during each LoT, with around one-third to one-half undergoing a test across the health systems and LoTs were not clear trends between LoTs in relation to the rates per 100 patient-years.

Data for surgical interventions are not shown as no lung surgeries were performed on patients included in this study.

Conclusions

NSCLC was associated with a substantial HCRU burden among this sample of Swedish patients, with a particularly high burden for those diagnosed with stage I-IIA NSCLC. Likewise, data for tissue sampling and biomarker tests are not shown as these HCRUs relate to the periods prior to the observed outcomes. Data on laboratory tests for monitoring of disease progression were available for analysis of HCRU during LoTs.

Regardless of histology, the proportions of patients undergoing imaging tests appeared to reflect the proportions of patients not dying during each LoT, with around one-third to one-half undergoing a test across the health systems and LoTs were not clear trends between LoTs in relation to the rates per 100 patient-years.