

Epidemiologia

lezione 0



Programma del corso 1

- *Introduzione: Epidemiologia finalità e definizioni*
- *Le radici dell'epidemiologia: sviluppo dei modelli di studio per indagare i fenomeni sanitari*
- *Misure epidemiologiche di frequenza e associazione*
- *Cause e determinanti della salute e delle malattie*
- *La distorsione sistematica dei risultati : i bias*
- *Disegno dello studio epidemiologico: classificazione*
- *Demografia (cenni)*
- *Sorveglianza e valutazione con dati ordinariamente disponibili – statistiche sanitarie correnti*
- *Lo studio dei trend*
- *Lo studio della distribuzione spaziale delle patologie e dei determinanti*
- [Epidemiologia delle malattie infettive]

Programma del corso 2

- Lo studio epidemiologico attraverso gli errori sistematici
 - *Bias di selezione*
 - *Bias di informazione*
 - *Confondimento*
- *Modifica di effetto o interazione*
- *Analisi statistica degli studi epidemiologici*
- Studi trasversali
- *Studi ecologici*
- *Studi di coorte*
- *Studi caso-controllo*
- *Altri disegni*
- *Studi sperimentali e meta-analisi*
- [Medicina preventiva]

Finalità del corso

- *Comprensione della rilevanza del metodo epidemiologico in medicina*
- *Acquisizione di capacità di lettura critica del disegno dello studio nella letteratura medica scientifica*
- *Definizione degli elementi di base per la realizzazione di ricerche in campo medico*
- *Analisi dei dati epidemiologici: comprensione e calcolo di misure epidemiologiche di base*

Testi in italiano

- *Rothman K J. Epidemiologia* · Idelson-Gnocchi 2007
- *Faggiano F, Donato F, Barbone F. Manuale di epidemiologia per la sanità pubblica.* Centro Scientifico Editore 2005
- *Beaglehole R, Bonita R, Kjellström T. Epidemiologia di base* Folini editore 2003
[http://whqlibdoc.who.int/publications/1997/887266031_ita.pdf]
- Vineis P, Duca , Pasquini, *Manuale di metodologia Epidemiologica*, La Nuova Italia Scientifica, Roma, 1988
- [Ricciardi W et al. *Igiene. Medicina Preventiva. Sanità Pubblica.* · Idelson-Gnocchi 2013]
- [*La Rosa F.: Elementi di statistica medica ed epidemiologia.* Perugia, 2008]



Testi in lingua inglese

- Bhopal R. **Concepts of Epidemiology**: Integrating the ideas, theories, principles and methods of epidemiology. Oxford University Press 2008
- Kenneth J Rothman Sander Greenland Timothy L Lash. **Modern Epidemiology**. Lippincott 2008
- Gordis L. Epidemiology. Saunders Elsevier 2008
- *David E. Lilienfeld and Paul D. Stolley Foundations of Epidemiology. Oxford University Press 1994*

Complementari:

- Kelsey JL et al. Methods in Observational Epidemiology Oxford University Press 1996
- Selvin S. Epidemiologic Analysis: A Case-Oriented Approach

Nota

- La mancanza di testi universitari in italiano non è in alcun modo indice della natura accessoria o ornamentale della Metodologia epidemiologica

Altro

- Materiali: a disposizione per il download ma non sono pensati come prodotto autonomo...
- Presenza a lezione
- Spiegazioni
- Siti della rete:
 - <http://www.docstoc.com/docs/108111962/Variation-in-disease-by-time-place-and-person->
 - <http://www.teachepi.org/resources/bfiles.htm>
- [Tesine]
- [Auto valutazione ed esoneri]

Struttura

- Enunciazione teorica
- Esempio tratto dalla letteratura
- Analisi di articoli scientifici dedicati [limiti e difficoltà delle ricerche]
- Revisione della letteratura scientifica dedicata [processo di formazione delle conoscenze scientifiche]

Esame

Risposta multipla

4. (punti 2)

Gli studi di epidemiologia descrittiva

- a. sono caratterizzati dalla presenza di un gruppo di confronto o di controllo
- b. si basano sull'analisi di un evento morboso rispetto alle categorie di tempo, luogo, e caratteristiche personali
- c. possono essere suddivisi in studi trasversali, caso-controllo e di coorte
- d. non includono l'analisi della mortalità specifica per causa

Completa la definizione

17. (punti 2)

La _____ è un metodo sistematico che utilizza tecniche statistiche per combinare i risultati di studi indipendenti in modo da produrre una stima quantitativa complessiva dell'effetto di un particolare intervento o di una variabile su un esito definito.

19

Per studio caso-controllo a base primaria si intende uno studio in cui controlli ospedalieri sono selezionati in modo da essere rappresentativi della popolazione che ha dato origine ai casi

- a. Vero
- b. Falso

Vero o falso?

Fornisci una definizione sintetica e precisa di fattore di confondimento (max 5 punti)

Domanda aperta (breve)

Calcolare Rischio Relativo (RR) e Odds ratio (OR) di eccesso ponderale complessivo in base all'abitudine di praticare attività fisica agonistica (max 3 punti) utilizzando i dati riportati in tabella

Calcolare (portare calcolatrice)

Attività agonistica	BMI		
	Normale	Sovrappeso	Obeso
Sì	40	10	5
No	50	30	10

Definizione 1

- Studio della distribuzione delle malattie nelle popolazioni e dei fattori che influenzano o determinano tale distribuzione
- Distribuzione delle malattie
- Popolazione
- Fattori che influenzano o determinano le malattie



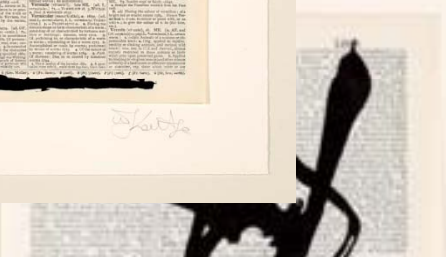
popolazione



individuo



W. Laity



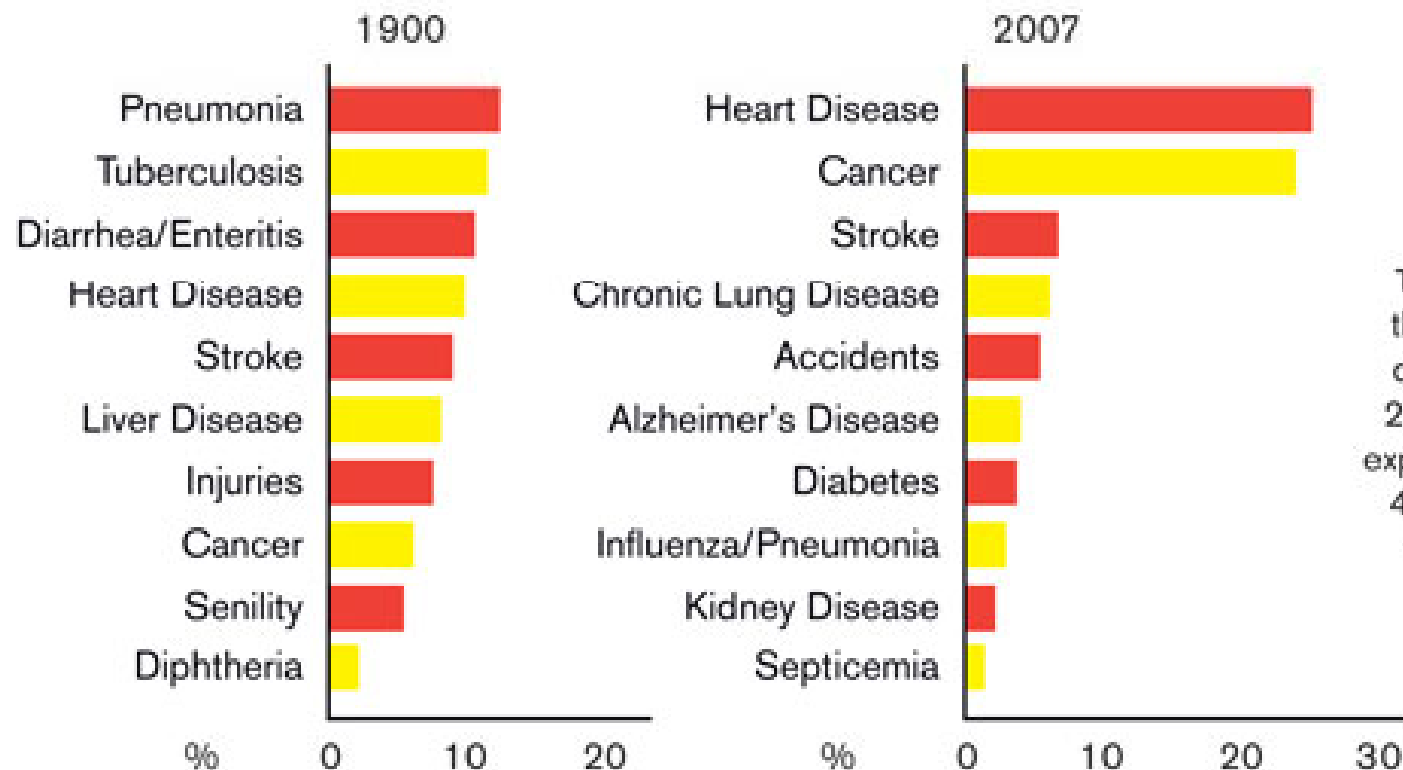
Scopi della epidemiologia

(in base alla definizione 1)

- Sorveglianza sanitaria: distribuzione delle malattie nelle popolazioni in base a Tempo, Luogo, Caratteristiche delle persone (tipicamente sesso ed età)
- Studio dell'eziologia delle malattie (base della prevenzione)

Principali cause di morte negli US nel 1900 e nel 2007

TOP TEN CAUSES OF DEATH, 1900 VERSUS 2007.



This graphic depicts the top ten causes of death in 1900 and in 2007. The average life expectancy in 1900 was 47.8 years. In 2007, it was 77.9 years.³⁶⁻³⁸

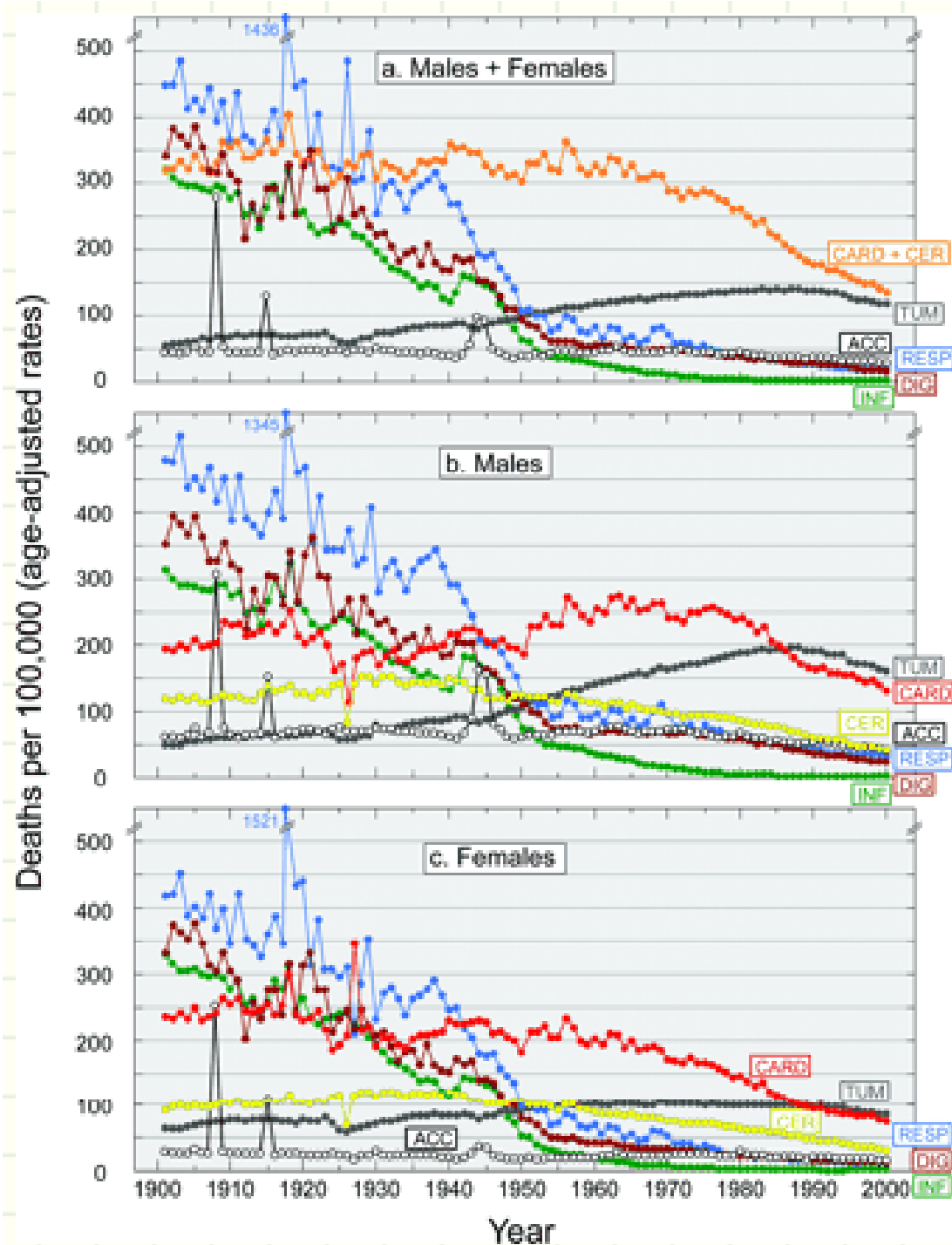


Figure 2. Mortality rates (age-adjusted data) in Italy from 1901 to 2000, year by year, for the main diseases responsible for death in the population. The reported diseases include

infectious and parasitic diseases (INF), malignant tumors (TUM), cardiovascular diseases (CARD), cerebrovascular diseases (CER), respiratory diseases, including influenza (RESP), digestive system diseases (DIG), and accidents (ACC).

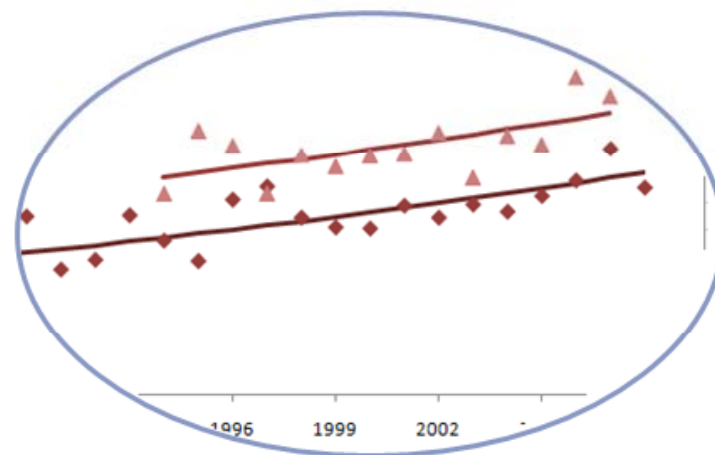
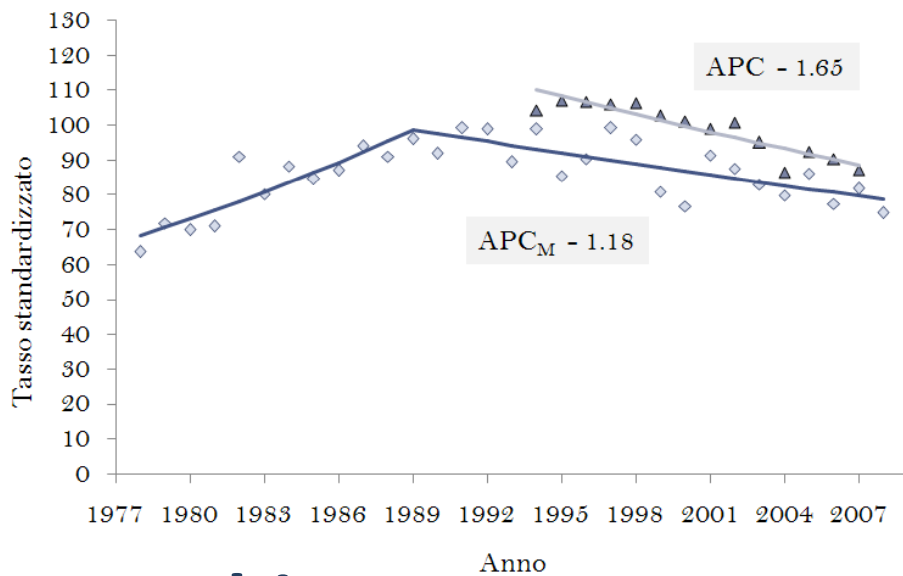
See text for the ICD-10 categories of diseases included in the analysis and for the procedure used for age-adjustment.

De Flora S, Quaglia A, Bennicelli C, Vercelli M. The epidemiological revolution of the 20th century. *FASEB J.* 2005;19:892-7.

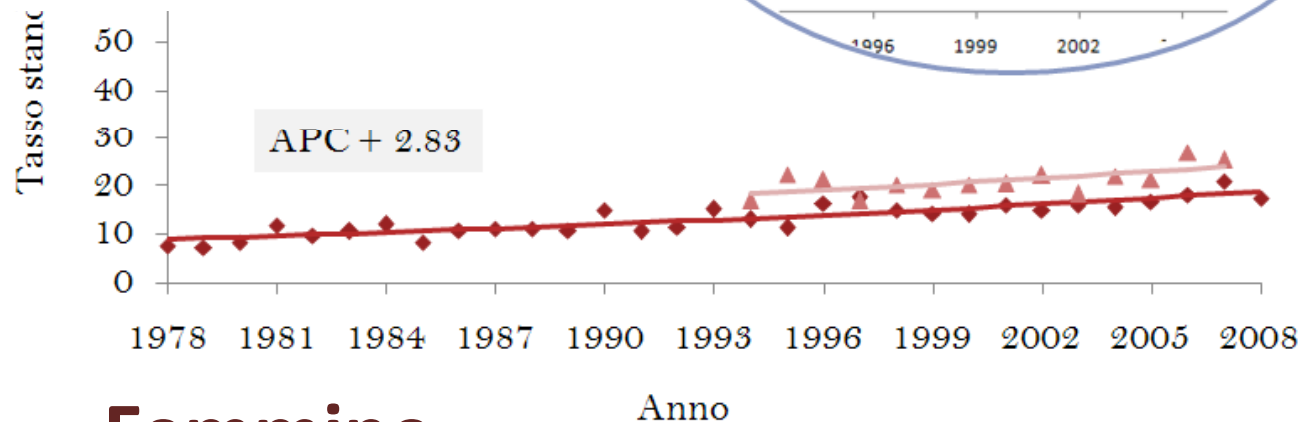
Origini

- ἔπί(epi, "su") + δῆμος (dēmos, "popolo")
- Epidemia: verificarsi di casi di malattia in eccesso rispetto a quanto "normalmente atteso"
- Epidemiologia (studio delle epidemie)

Trend di incidenza e mortalità per cancro del polmone

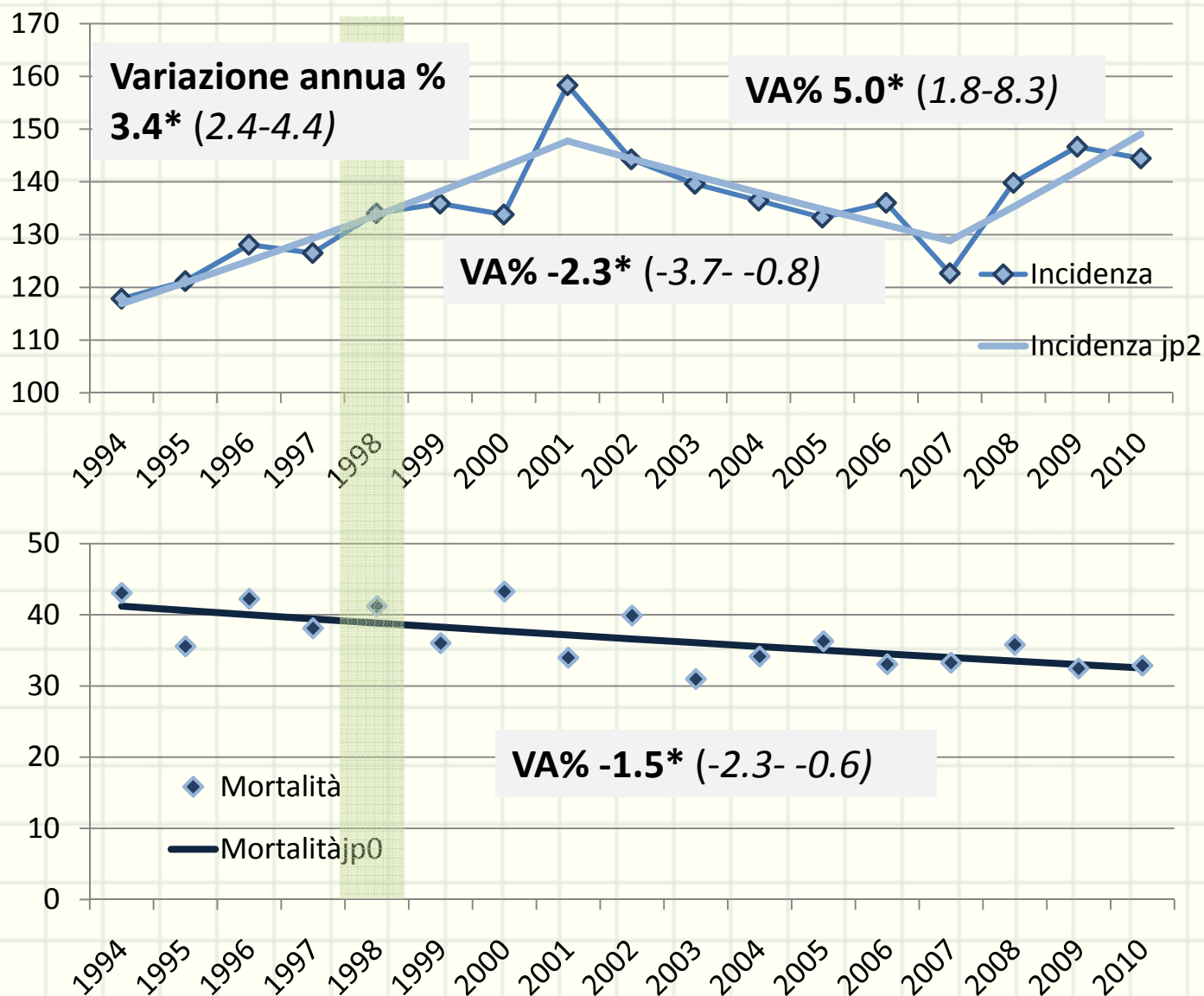


Maschi

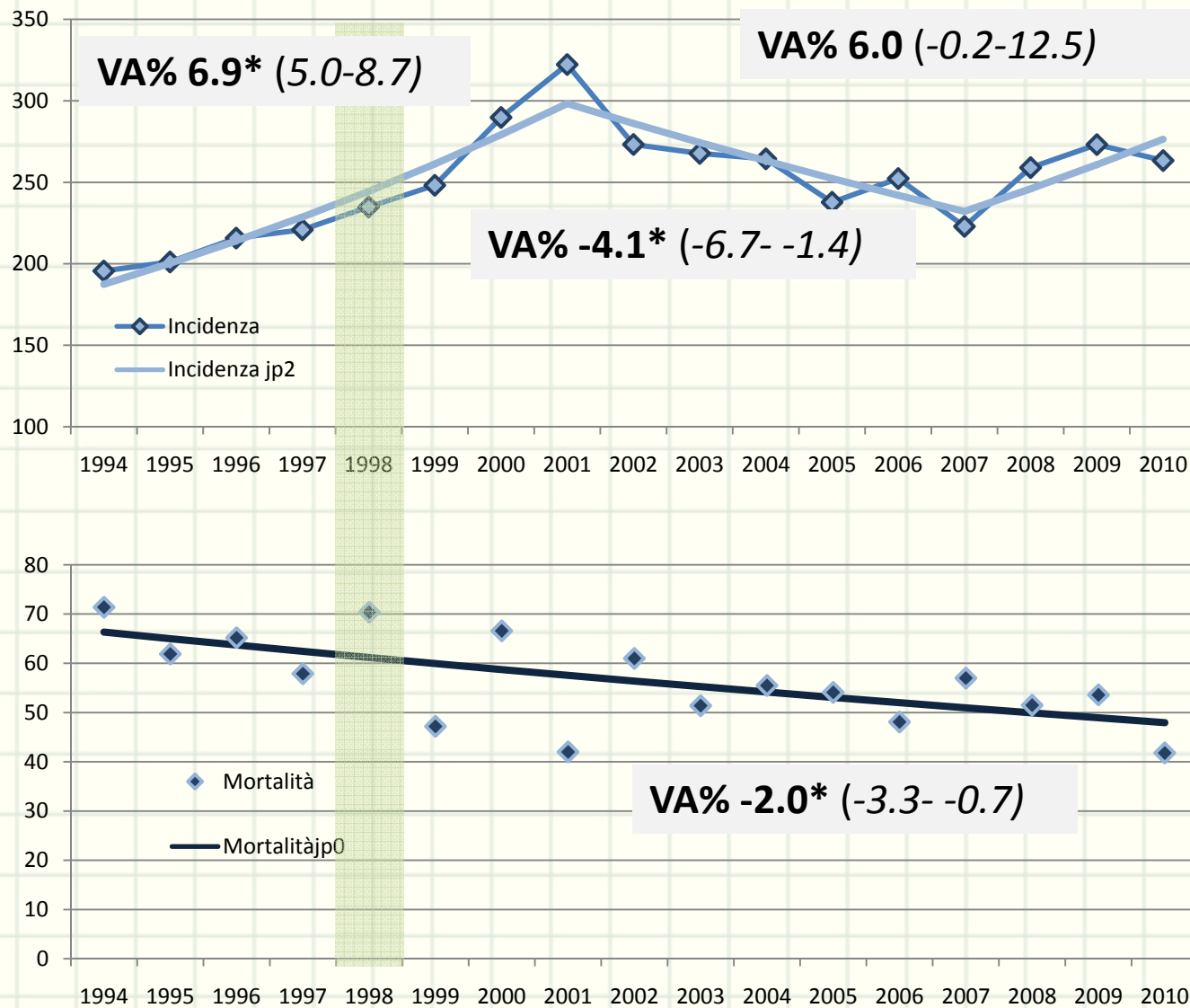


Femmine

Cancro della mammella: Trend di incidenza e mortalità, tutte le età (tassi st. Umbria 2001)



Nella classe d'età screening (50-69 anni)



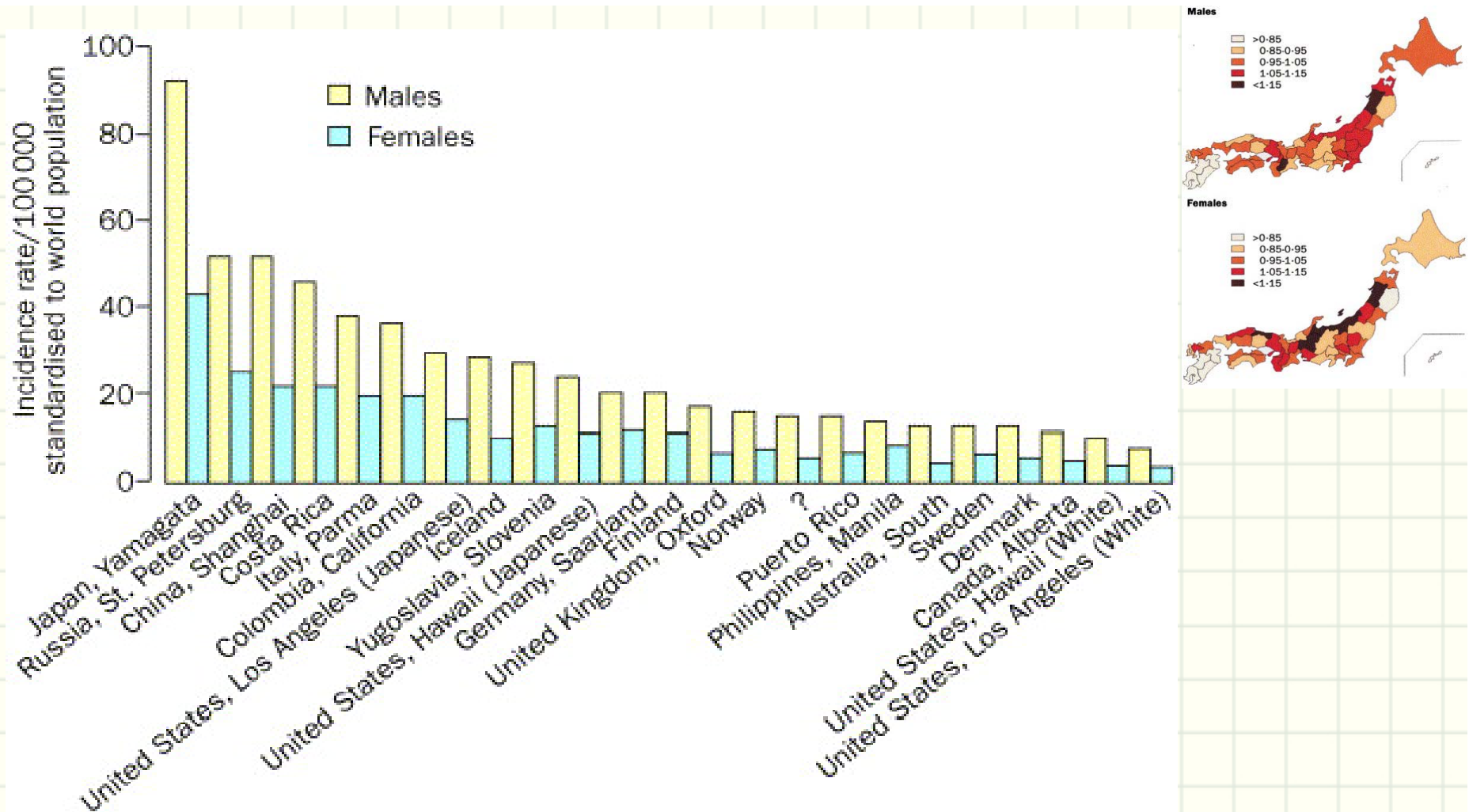
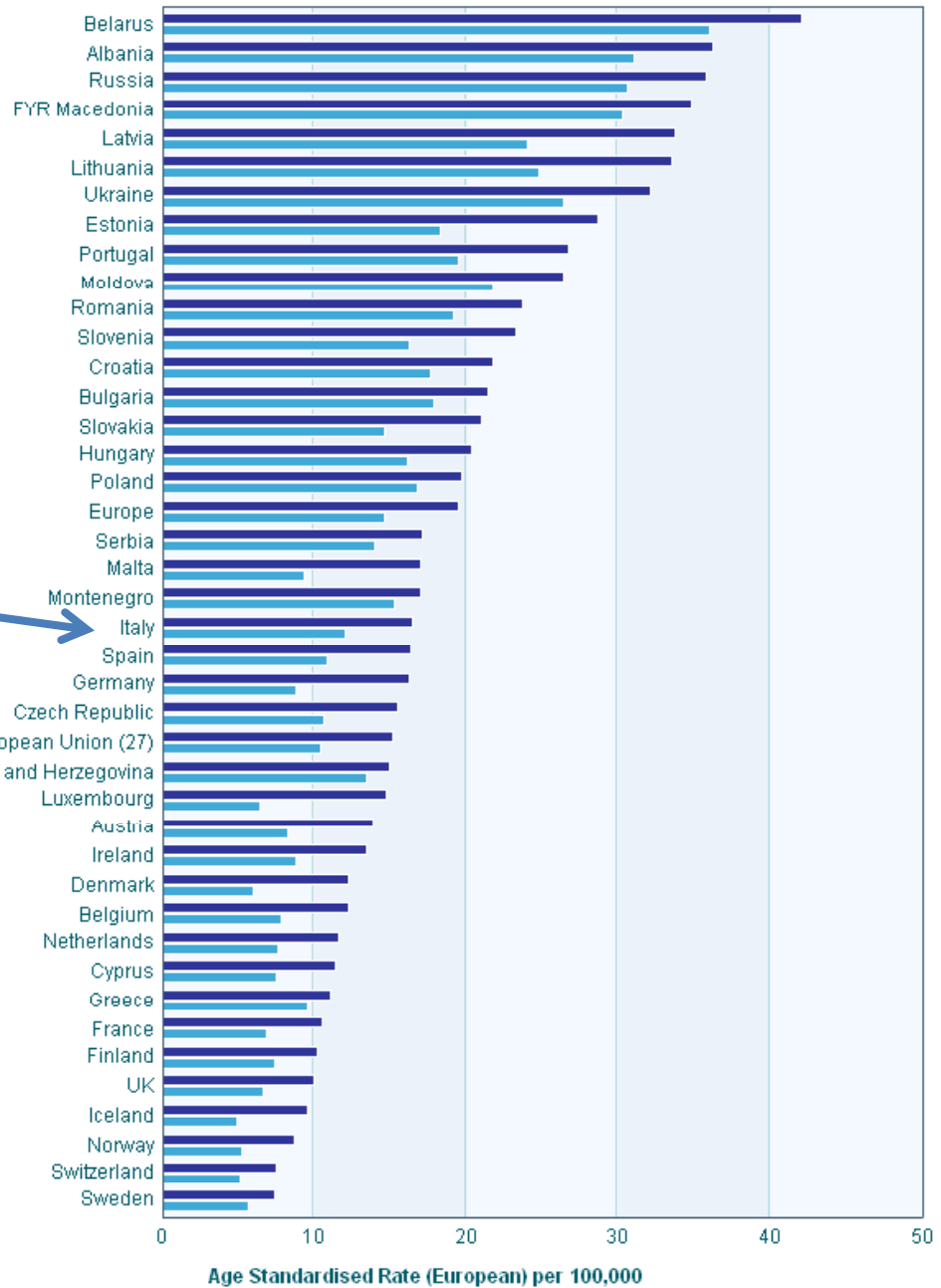


Figure 2 Incidence rates of gastric cancer in 1992 in selected regions and populations reported by population-based cancer registries. The incidence rates are age-standardised to the world population model.

Estimated incidence & mortality from gastric cancer in men, 2012



EUCAN
EUROPEAN UNION CANCER

Research on Cancer

International Agency
for Research on Cancer

World Health
Organization

GLARA
Gastric Cancer Research



Estimated incidence from gastric cancer in men, 2012

- <42.1
- <26.7
- <20.3
- <16.2
- <11.6

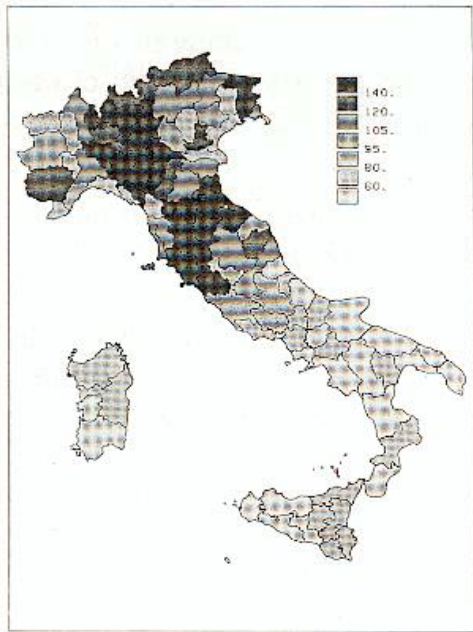
Age Standardised Rate (European) per 100,000

International Agency for Research on Cancer

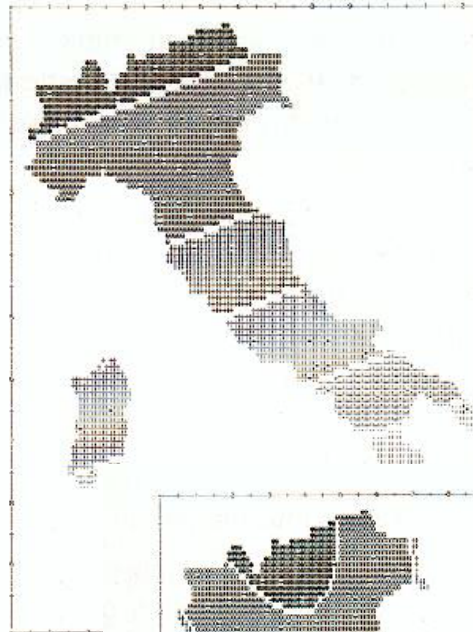
World Health Organization



<http://eco.iarc.fr/EUCAN/Cancer.aspx?Cancer=8>



a



b



c



d

Gastric cancer mortality in Italy

in

Figure 3.5 Mortalité par cancer de l'estomac – Italie – Sexe masculin – 1975-1977
 a : SMR observés, b : ajustement linéaire,
 c : ajustement quadratique, d : ajustement par un polynôme de degré 5
 Source : Cislighi et al. [2] et communication personnelle

L'esempio del cancro gastrico

1978-1982

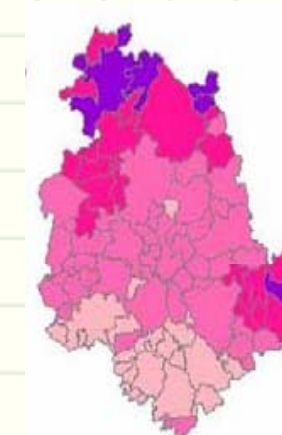
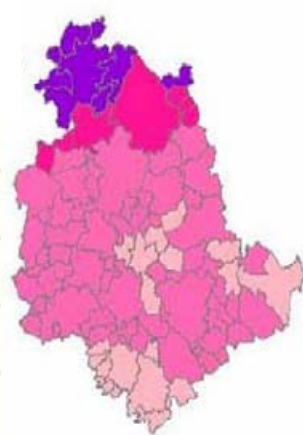
1994-1998

1999-2003

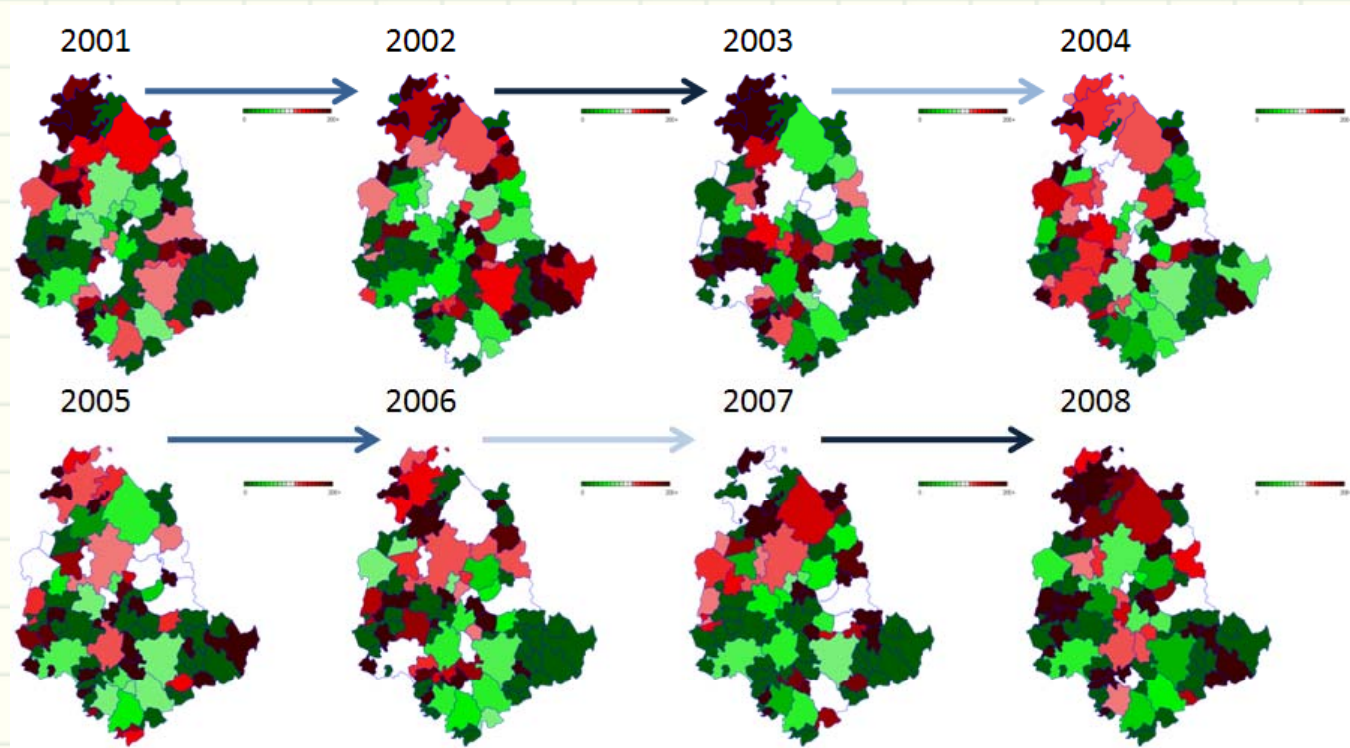
MALE



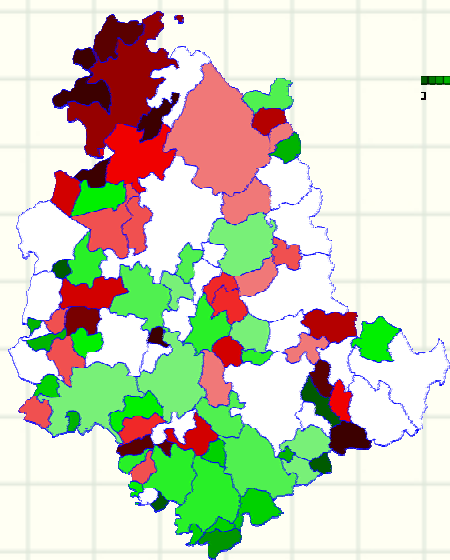
FEMALE



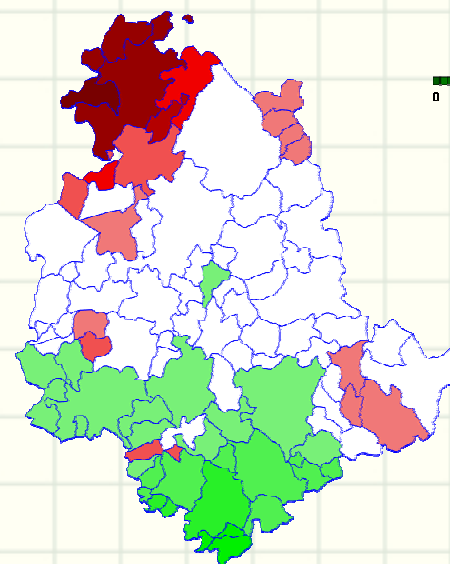
Incidenza di cancro gastrico in Umbria



2001-08

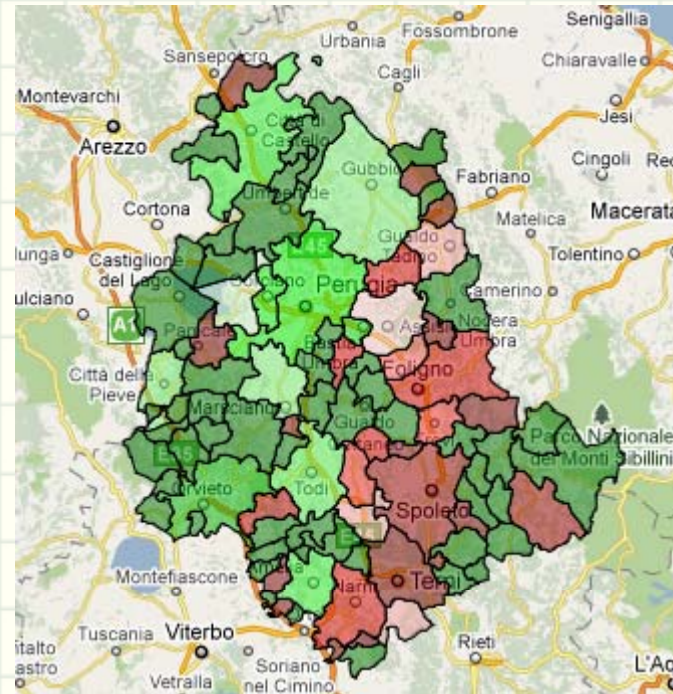
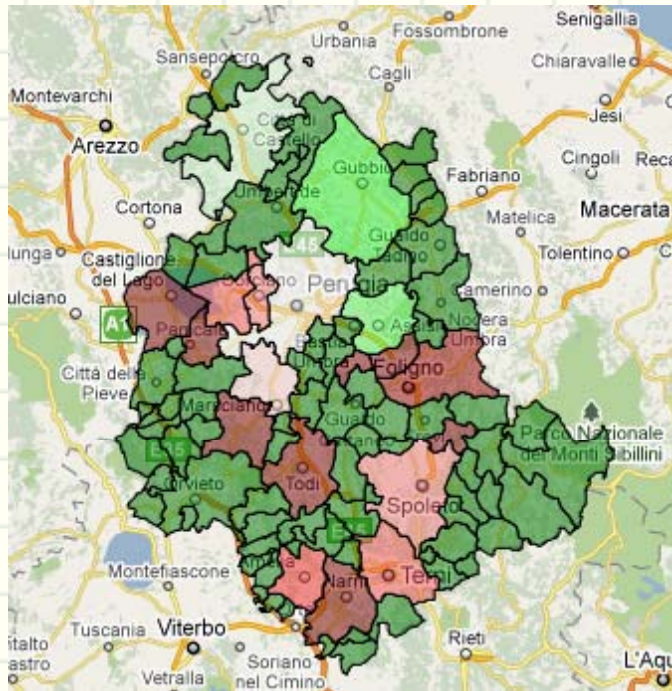


2001-08
Levigata
(smoothed)



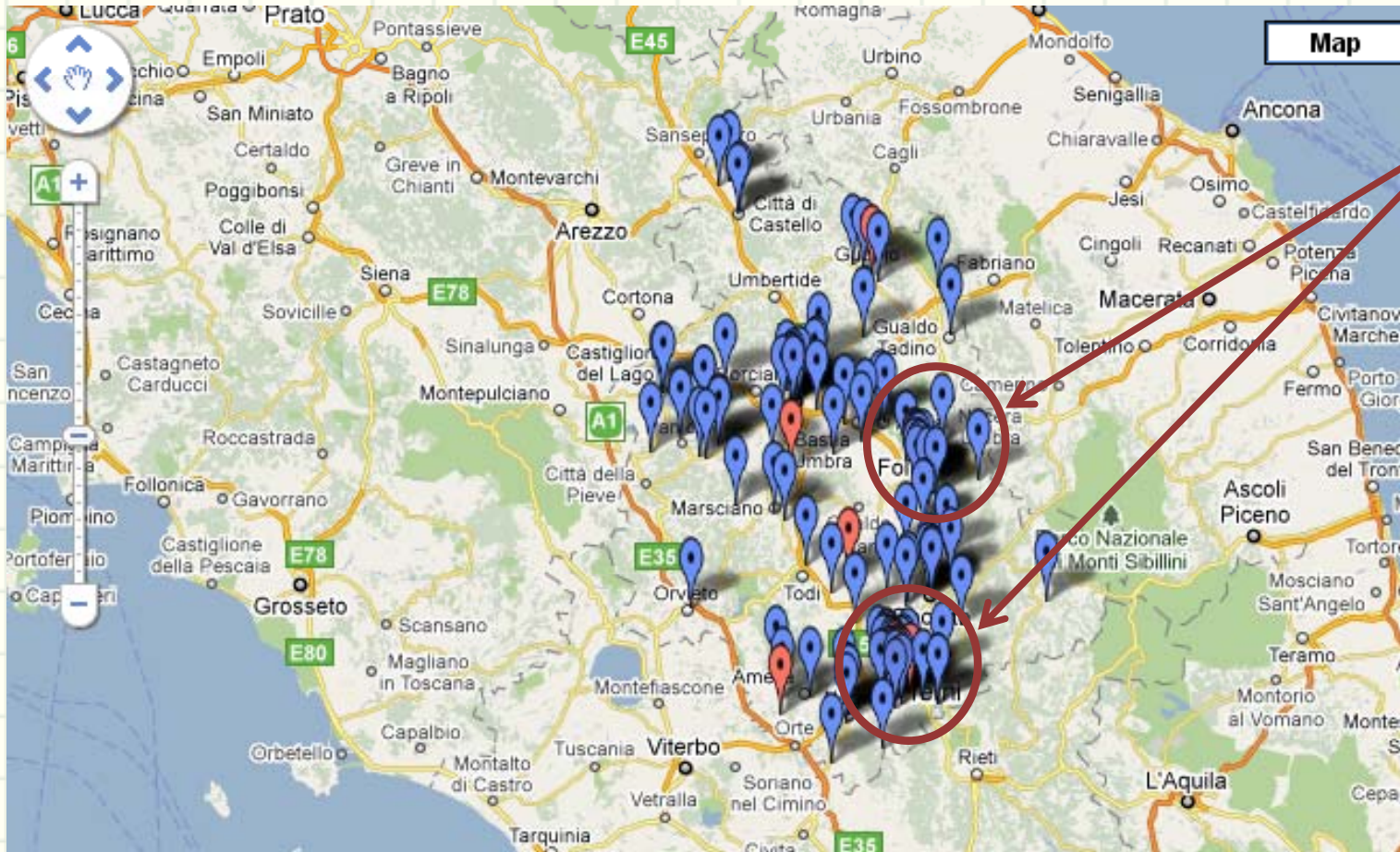
Mesotelioma in Umbria

SIR maschi



SIR femmine

La georeferenziazione dei casi



Analisi per sezione di censimento

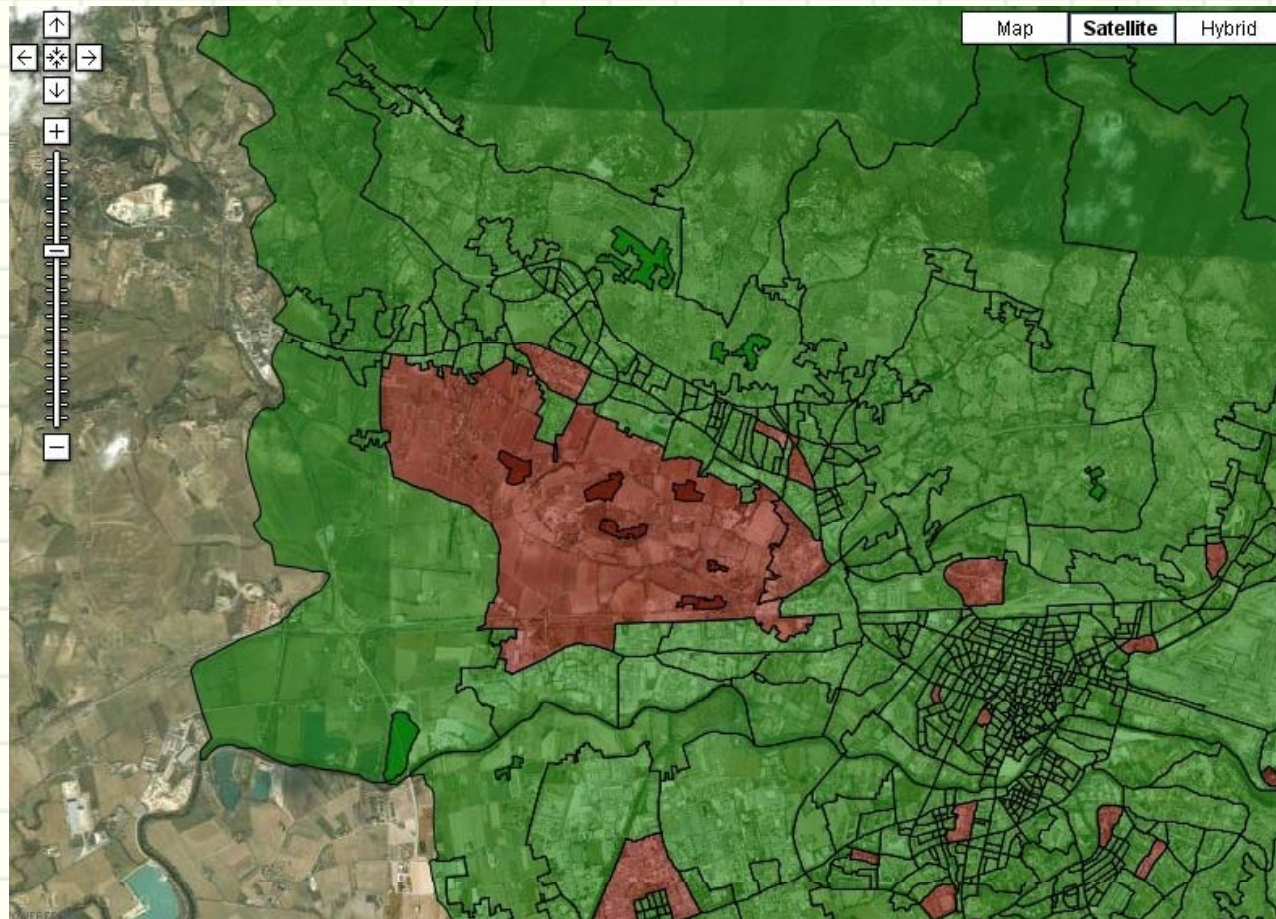
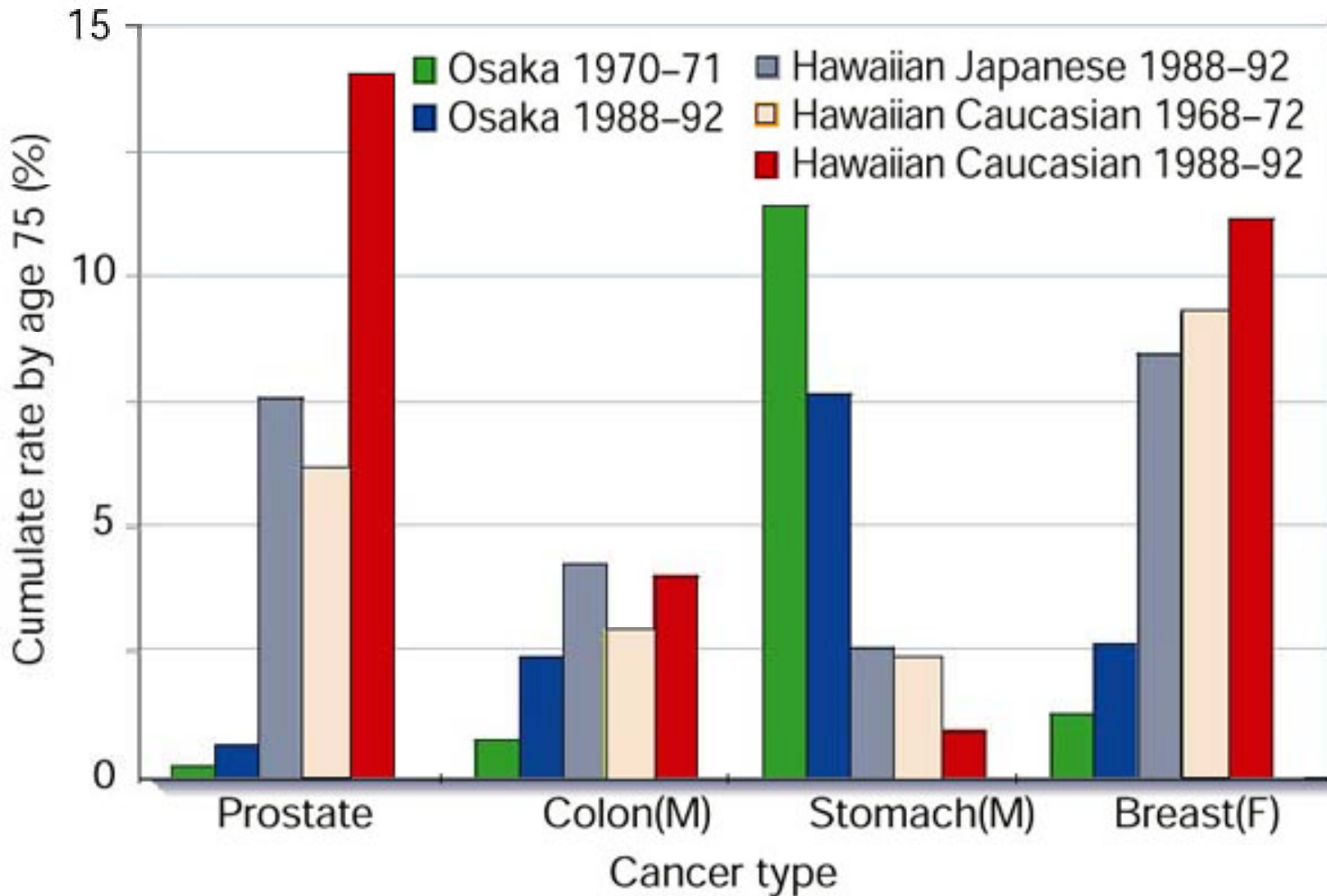


Figure 1 Cancer rates in migrants become similar to those in the local population.

Cancer rates in 1990 among Japanese migrants to Hawaii, and around 1970 and 1990 in Japan (Osaka) and in Hawaiian Caucasians.

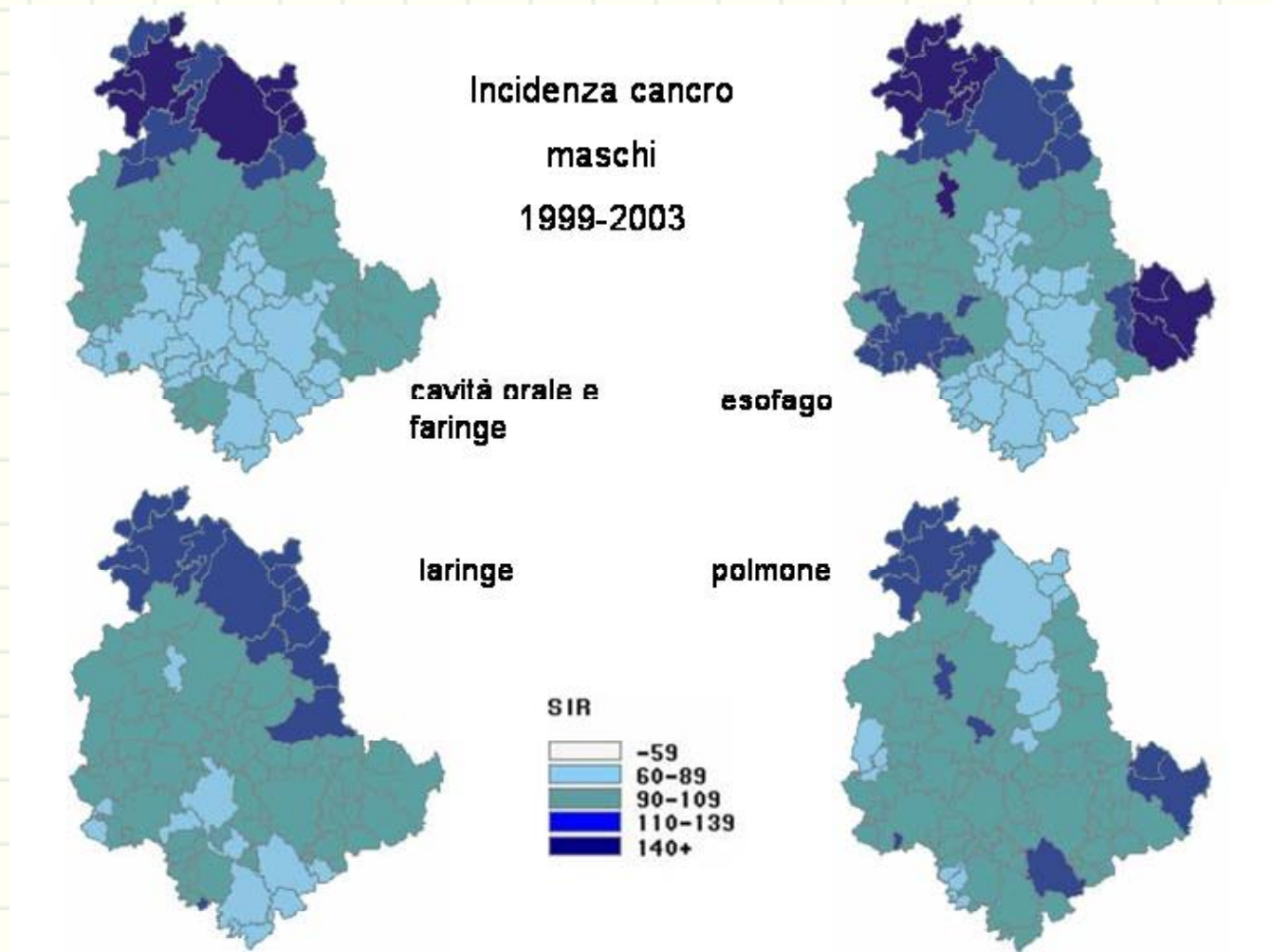
Peto J. Cancer epidemiology in the last century and the next decade. *Nature* 2001;411:390-5.



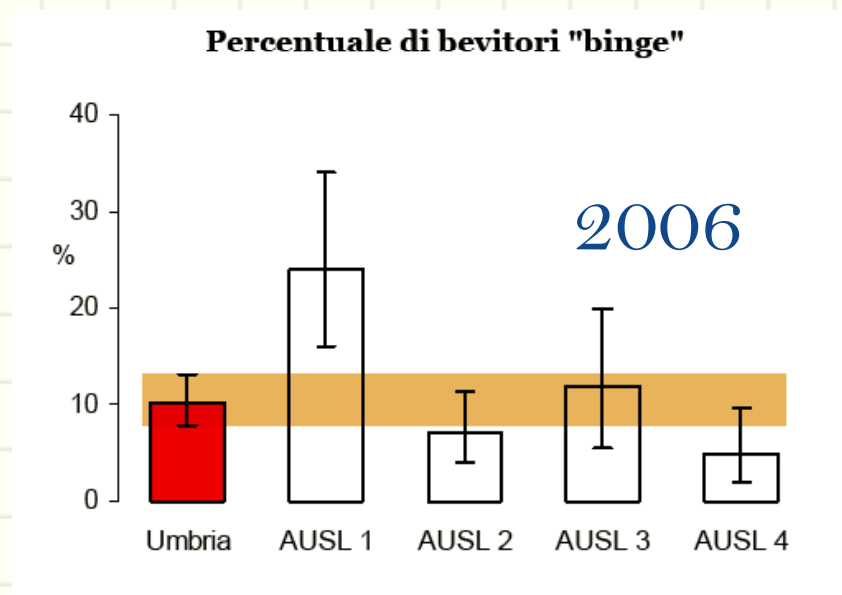
Finalità degli studi di epidemiologia descrittiva

- Quantificare la rilevanza dei fenomeni sanitari
- Fornire la base per predire l'impegno dei servizi sanitari
- Evidenziare l'evoluzione dei fenomeni sanitari
- Contribuire a definire priorità di intervento
- Ipotesizzare relazioni tra i dati descrittivi e gli interventi sanitari o, in generale, variazioni dei determinanti

Distribuzione regionale dei tumori delle alte vie aerodigestive

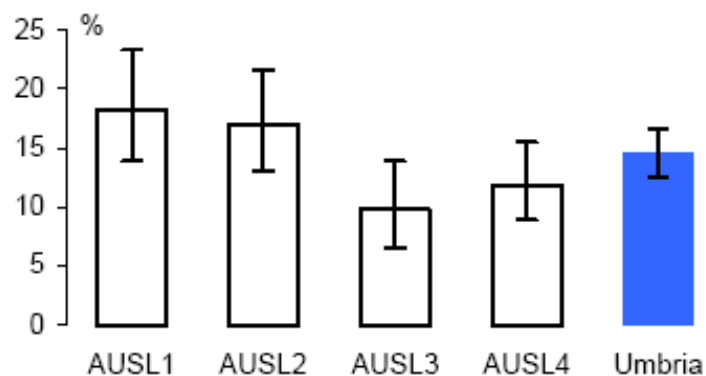


I bevitori a rischio nelle indagini PASSI

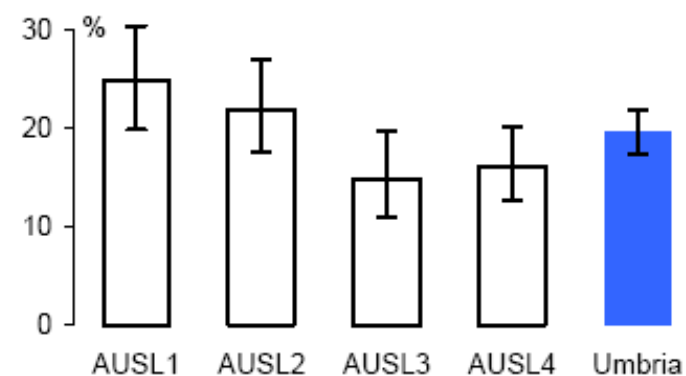


2008

Bevitori a rischio Vecchia definizione INRAN di "forte bevitore"
Umbria - PASSI 2008



Bevitori a rischio Nuova definizione INRAN di "forte bevitore"
Umbria - PASSI 2008



Nelle AUSL regionali non sono emerse differenze statisticamente significative per le modalità di assunzione dell'alcol ritenute a rischio anche per la limitata numerosità (range dal 10% dell'AUSL3 18% dell'AUSL1)

Studi eziologici

Modelli di studio della

- Epidemiologia analitica ed
- Epidemiologia sperimentale

- Evoluzione dei modelli di studio
- Classificazione degli studi e forza delle evidenze prodotte

Associazione e causalità

- Formazione progressiva delle evidenze
- Associazione tra esposizione ad un fattore e una malattia in studi ben disegnati ed analizzati: fattore di rischio o protettivo
- Conferme sperimentali: fattore causale

Studi epidemiologici

- Studi Osservazionali (“esperimenti naturali”)
 - Descrittivi
 - Longitudinali
 - Trasversali
 - Analitici
 - Trasversali
 - Caso-controllo
 - Coorte
 - Storico
 - Prospettico
 - Caso-coorte
- Studi sperimentali
 - Esperimenti randomizzati
 - Studi non randomizzati

- Studi Osservazionali (“esperimenti naturali”)

- Descrittivi

- Longitudinali
- Trasversali

- Analitici

- Trasversali
- Caso-controllo
- Coorte
 - Storico
 - Prospettico
- Caso-coorte

- Studi sperimentali

- Esperimenti randomizzati

- La somministrazione di un trattamento/intervento rappresenta la differenza tra studi sperimentali ed osservazionali
- La misura della esposizione ad uno o più fattori costituisce la differenza tra studi descrittivi e analitici
- Il confronto di gruppi definiti dalle esposizioni distingue gli studi sperimentali e analitici dagli studi sperimentali

Epidemiologia - definizione 2

- Studio della **distribuzione e dei determinanti di stati di salute o eventi sanitari in popolazioni** specificate e l'applicazione di questo studio al **controllo della salute**

Last JM. A dictionary of epidemiology. Oxford University press

Generalizzazione della definizione 1

- Da Malattia a stati di salute ed eventi (la comparsa di una malattia è un tipo di evento sanitario)
- Dalla descrizione della distribuzione e individuazione delle cause delle malattie (base della medicina preventiva) al controllo dei fenomeni sanitari (valutazione degli interventi sanitari: Epidemiologia clinica)

Eziologia

- “felix qui potuit rerum cognoscere causas”
(Virgilio, *Georgiche*, II, 490)
- Una delle principali finalità investigative della epidemiologia è la ricerca delle cause delle malattie
- [Possiamo facilmente estendere questo paradigma alla ricerca dei determinanti di effetti o esiti sanitari diversi dall’insorgenza di malattia]

Epidemiologia

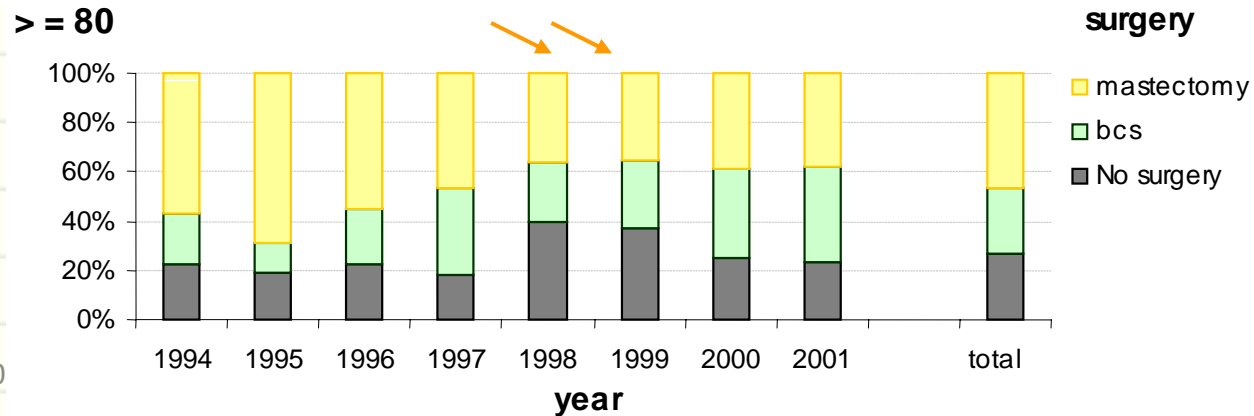
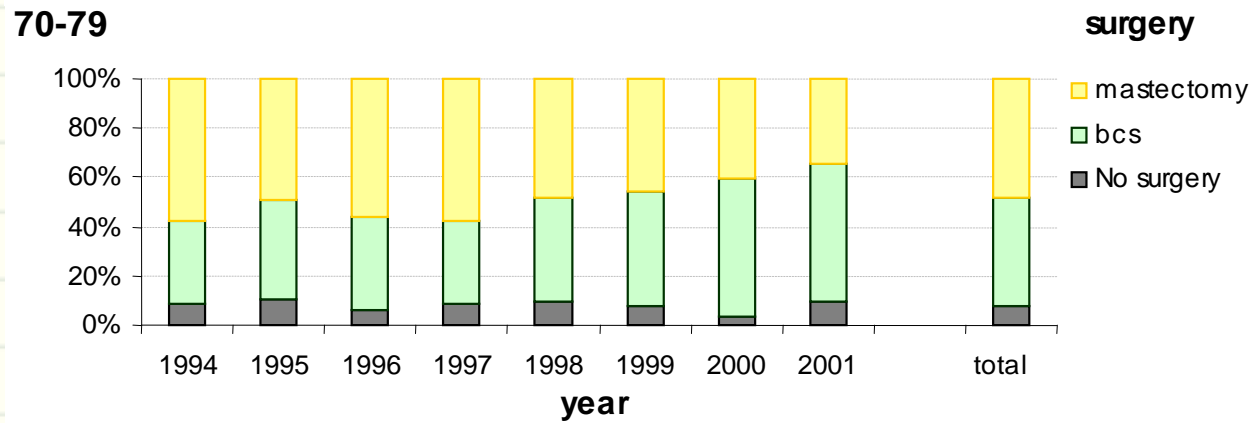
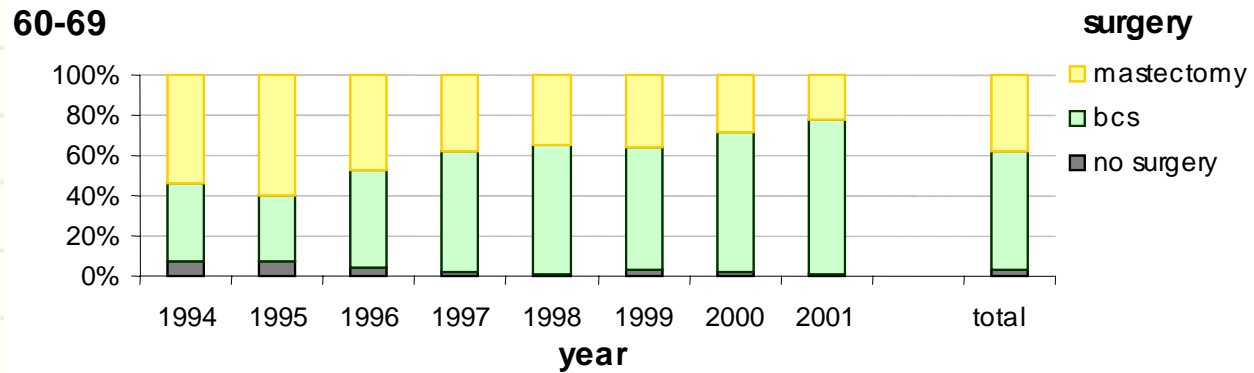
- Eziologica

Finalizzata alla identificazione delle cause di malattia e del benessere delle popolazioni

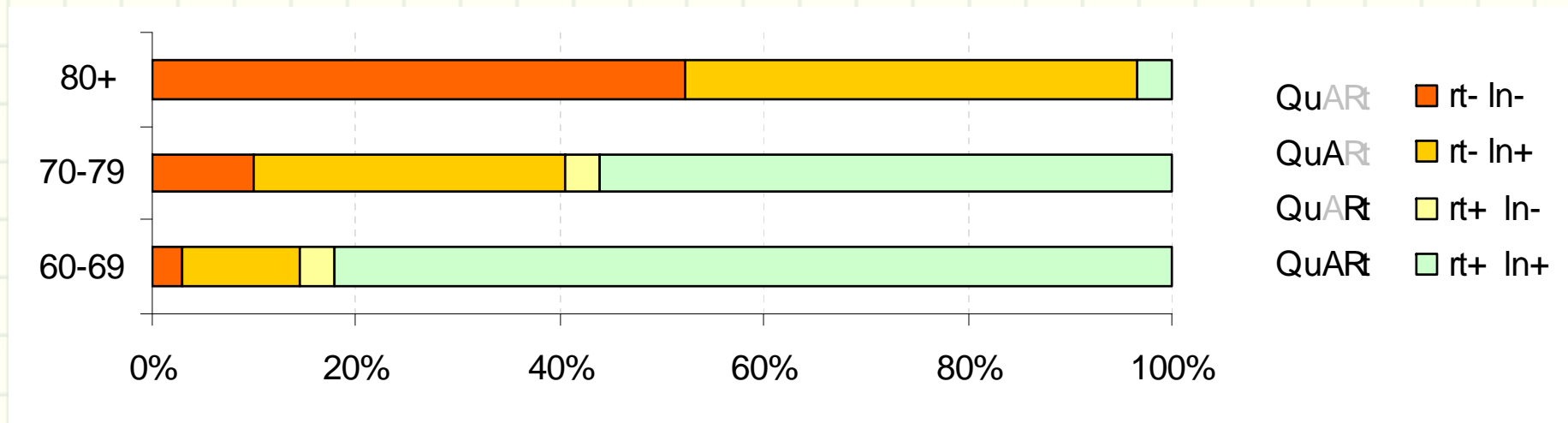
- Clinica e valutativa

Finalizzata alla identificazione di determinanti dei risultati dei trattamenti e, in generale, del decorso della malattia nelle popolazioni dei malati

Surgical treatment by year and age class

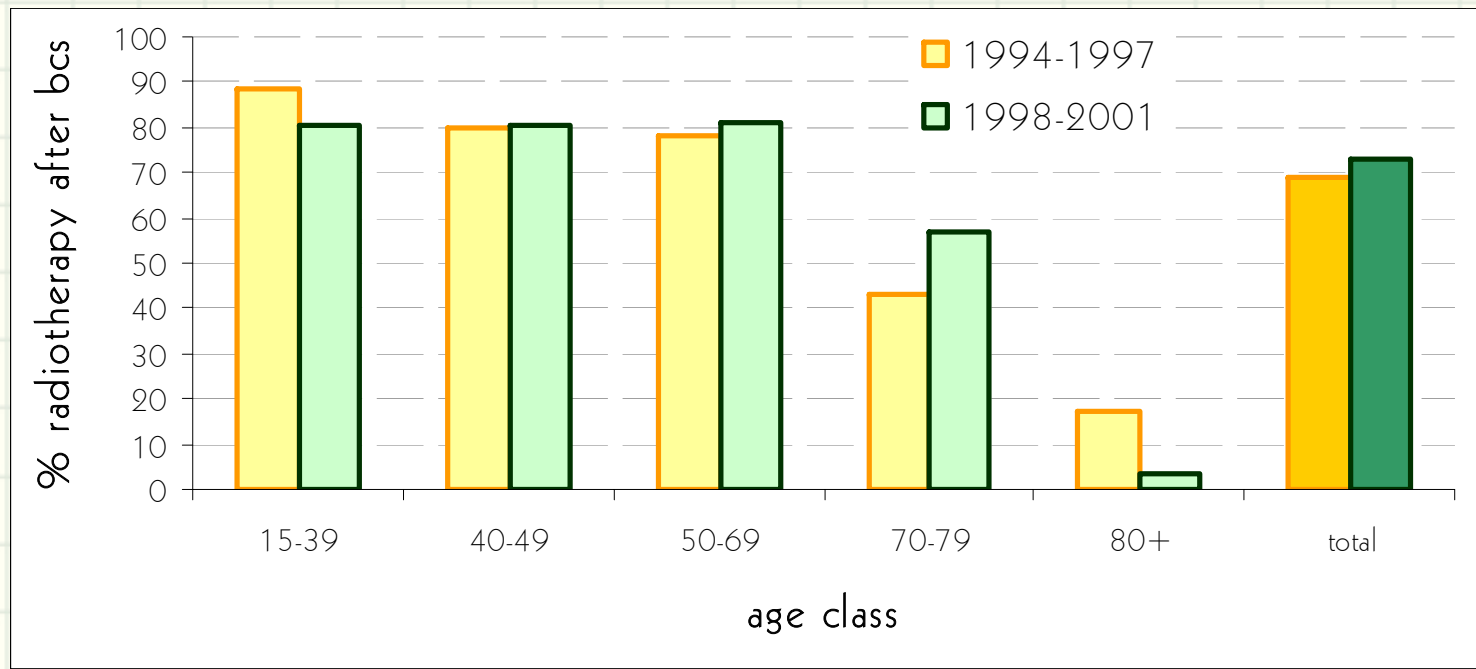


Treatment associated with BCS by age class (period 1998-2001)



- Axillary dissection after breast conserving surgery was frequently omitted in women ≥ 80 years old; about 30% of women in this age class were treated with BCS
- Radiotherapy use decreased with increasing age and was almost not used among the oldest old

Radiotherapy use after BCS by age class and period

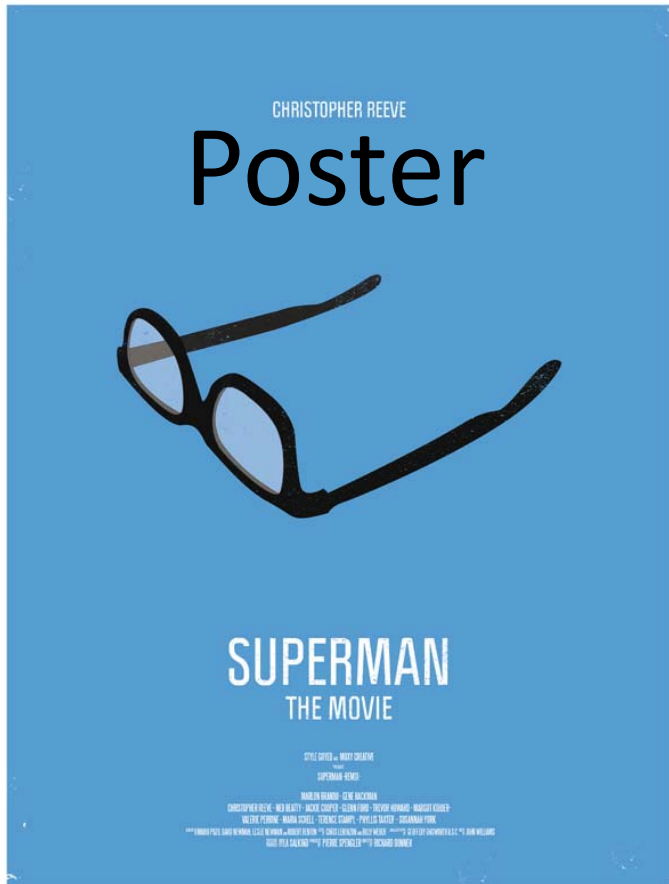


Radiotherapy use:

- decreased among youngest and, particularly, oldest women
- increased among screened age groups and 70-79 years old (largest increase)

Metodologia epidemiologica

- Ricerca e progresso in campo biomedico
 - Ragionamento biologico
 - Disegno dello studio
 - Analisi statistica



Poster

INFLUENCE OF SCREENING ON COLORECTAL CANCER INCIDENCE, SURVIVAL, AND STAGE AT DIAGNOSIS: DIFFERENCES BY GENDER

Fabrizio Stracchi (1,2), Fortunato Bianconi (2,3), Morena Malaspina (4), Antonella Monsignorini (5), Tiziana Marzulli (5), Rosa Corvetti (6), Annunziata Di Marco (7), Gabriella Vinti (8), Saba M. Petrucci(2) Francesco La Rosa (1,2,5)
 1. Dip.to di Spec. Med. Chir. e Sanità Pubblica – Università di Perugia; 2. Registro Tumori Umbro di Popolazione – Direzione Regionale Sanità Umbria; 3. Dip.to Ingegneria Elettronica e Informatica – Università di Perugia; 4. Servizio di Screening – ASL 2 dell'Umbria; 5. Scuola di Specializzazione in Igiene e Medicina Preventiva – Università di Perugia; 6. Servizio di Screening – ASL 4 dell'Umbria; 7. Servizio di Screening – ASL 3 dell'Umbria; 8. Servizio di Screening – ASL 1 dell'Umbria

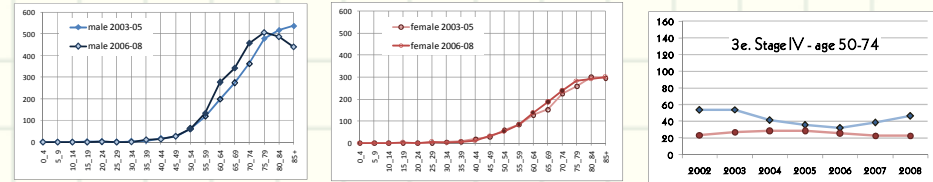


Figure 1a-b. Age-specific incidence rates by gender, before and after screening start in 2006

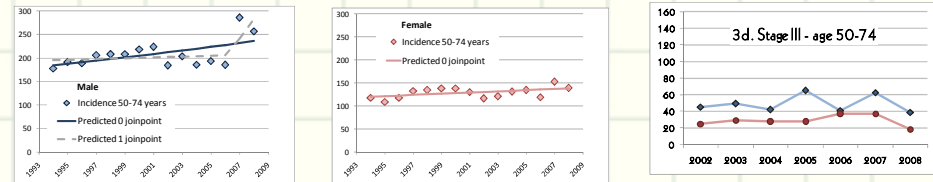


Figure 2a-b. Standardized incidence rates trend (observed and joinpoint)

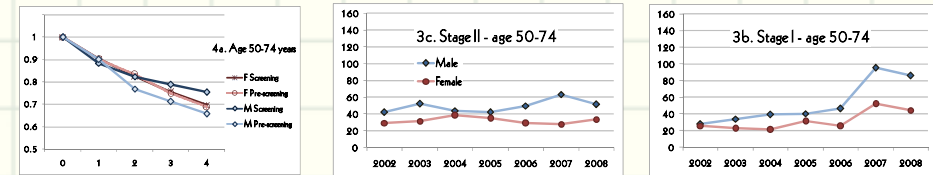


Figure 3a-e. Standardized incidence rates trend by stage and gender

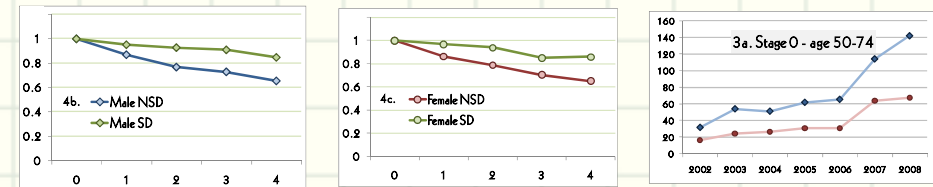


Figure 4a-c. Relative survival by gender, period (a), and mode of detection (b-c)

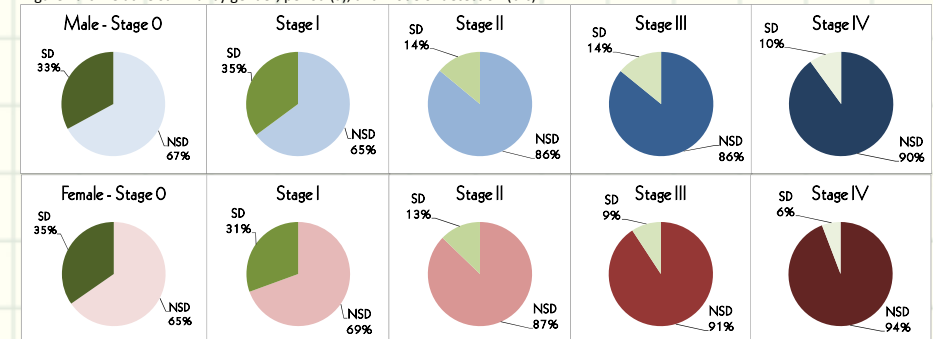


Figure 5a-l. Proportion of cases by gender, stage, and mode of detection (SD screen detected)

Struttura di un articolo scientifico

- Titolo
- Riassunto
- Base di partenza scientifica
- Scopo
- Casi e metodi
- Risultati
- Discussione
- Bibliografia

ORIGINAL ARTICLE

Trends in Treatment Costs for Localized Prostate Cancer *The Healthy Screenee Effect*

Steven B. Zeliadt, PhD, MPH,*† Ruth Etzioni, PhD,*† Scott D. Ramsey, MD, PhD,*†
David F. Penson, MD, MPH,*‡ and Arnold L. Potosky, PhD§

Objective: We sought to obtain estimates of trends in initial treatment costs during the prostate-specific antigen (PSA) era that account for the changing patient case-mix associated with screening.

Subjects: We used reimbursement claims for Medicare-eligible subjects diagnosed with nonmetastatic prostate cancer between 1991 and 1999. Patients were grouped by initial treatment, with 17,846 receiving radical prostatectomy (RP), 25,933 receiving external beam radiotherapy (XRT), and 4525 receiving brachytherapy (BT).

Methods: Cancer-attributable costs were computed by subtracting noncancer costs from total Medicare reimbursements among newly diagnosed cancer patients. Noncancer costs were estimated in 2 ways: (1) average costs among age-matched, cancer-free control subjects (control method) and (2) projections based on claims from subjects before diagnosis (prediagnosis method). Adjusted annual percent change in cancer-attributable costs was calculated using multivariate generalized linear models.

Results: Noncancer costs increased at a much lower rate among men prior to diagnosis (3.8% annually) than among the general Medicare population (10.9%). The 2 approaches yielded different results; RP costs declined by 2.4% annually (prediagnosis method) versus 6.2% (control method); XRT costs declined by 1.5% versus 5.8%; and BT costs declined by 4.1% versus 8.3%.

Conclusions: Because of self-selection of PSA screening, men diagnosed with prostate cancer today are now healthier overall than men in the general population and are considerably healthier than men diagnosed previously. Estimates of cancer-attributable costs that do not account for this healthy selection effect are likely to be biased. Declines in cancer-attributable treatment costs are evident

even after accounting for a healthy screenee effect, suggesting that there has been a real reduction in cancer treatment costs.

Key Words: prostate, prostatic neoplasms, costs, cancer-attributable costs, healthy screenee bias, SEER-Medicare
(*Med Care* 2007;45: 154–159)

Prostate cancer is the single most expensive cancer in terms of Medicare reimbursement costs, even considering the cost of lung cancer among both men and women.¹ The majority of prostate cancer care costs are related to initial treatment. There has not been a comprehensive examination of trends in treatment costs over time since the introduction of PSA, although several studies have considered costs of individual treatments for periods of up to 4 years.² Some studies have suggested that initial treatment costs for prostate cancer have been contained by clinical care pathways and a move to performing procedures in the outpatient setting.^{3–5} However, changing technologies may have mitigated these cost containment measures.²

Another explanation for observations of declining costs may be that the composition of the case population has become healthier as a result of increased prostate-specific antigen (PSA) screening, because men participating in screening tend to be relatively healthy. Registry data indicate that prostate cancer cases are now being diagnosed in patients at earlier stages of

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Geneva Cancer Registry, Institute for Social and Preventive Medicine, University of Geneva, Geneva, Switzerland.

Prostate specific antigen (PSA) screening was introduced to detect prostate cancer at an early stage and to reduce prostate cancer-specific mortality. Until results from clinical trials are available, the efficacy of PSA screening in reducing prostate cancer mortality can be estimated by surveillance of prostate cancer mortality trends. Our study analyzes recent trends in prostate cancer mortality in 38 countries. We used the IARC-WHO cancer mortality database and performed joinpoint analysis to examine prostate cancer mortality trends and identified 3 patterns. In USA, and to a lesser extent in Germany, Switzerland, Canada, France, Italy and Spain, prostate cancer-specific mortality decreased to a level lower than before the introduction of PSA screening. In Australia, New Zealand, Austria, Finland, The Netherlands, Norway, United Kingdom, Hungary, Slovakia, Israel, Singapore, Sweden and Portugal, mortality from prostate cancer decreased but rates remain higher than before the introduction of PSA screening. Prostate cancer mortality continued to increase in Belgium, Denmark, Greece, Ireland, Bulgaria, Czech Republic, Belarus, Ukraine, Russian Federation, Romania, Poland, Argentina, Chile, Cuba, Mexico, Japan, China Hong Kong and the Republic of Korea. The trends in prostate cancer mortality rates in examined countries suggest that PSA screening may be effective in reducing mortality from prostate cancer. (c) 2008 Wiley-Liss, Inc.

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