

Methodology for Adaptive Treatment Strategies for Chronic Disorders: Focus on Pain

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Institute for Social Research
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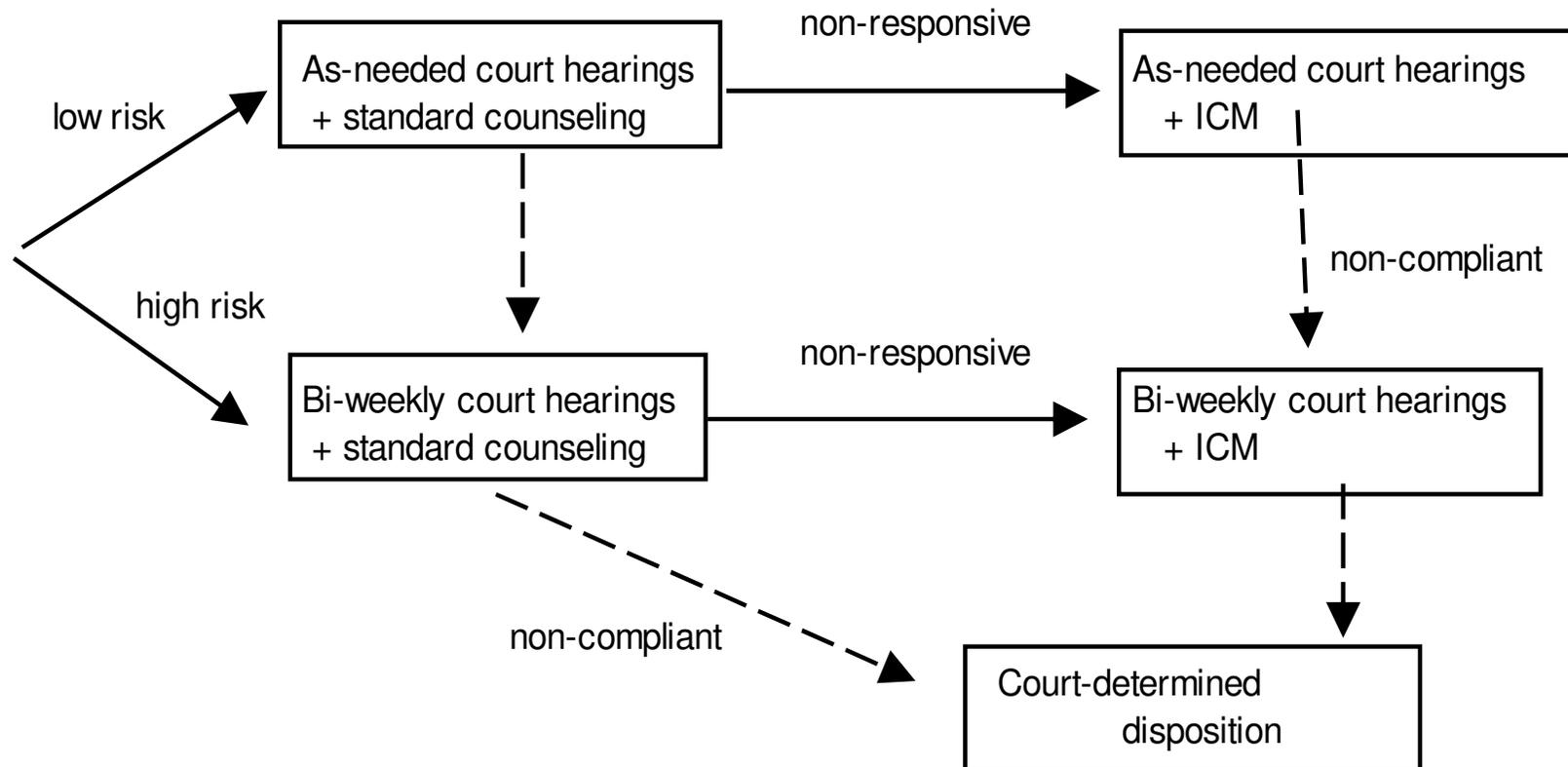
Adaptive Treatment Strategies are individually tailored treatments, with treatment type and dosage changing according to patient outcomes. Operationalize clinical practice.

- Brooner et al. (2002, 2007) Treatment of Opioid Addiction
- McKay (2009) Treatment of Substance Use Disorders
- Marlowe et al. (2008) Drug Court
- Rush et al. (2003) Treatment of Depression

Why Adaptive Treatment Strategies?

- High heterogeneity in response to any one treatment
 - What works for one person may not work for another
 - What works now for a person may not work later
- Improvement often marred by relapse
- Lack of adherence or excessive burden is common
- Intervals during which more intense treatment is required alternate with intervals in which less treatment is sufficient

Adaptive Drug Court Program (Marlowe, PI)



The Big Questions

- What is the best sequencing of treatments?
- What is the best timings of alterations in treatments?
- What information do we use to make these decisions?
(how do we *individualize* the sequence of treatments?)

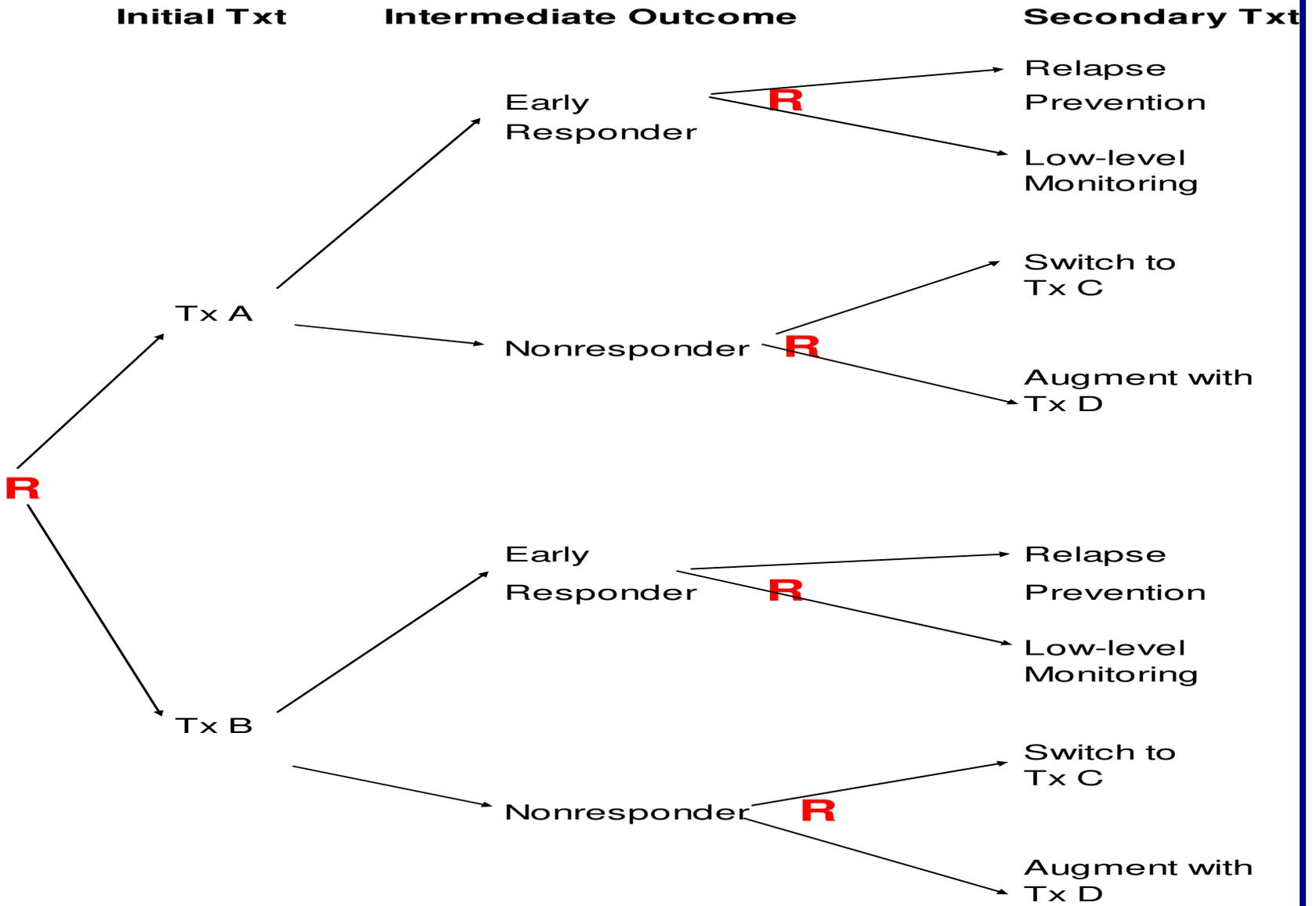
Why SMART Trials?

What is a sequential multiple assignment randomized trial (SMART)?

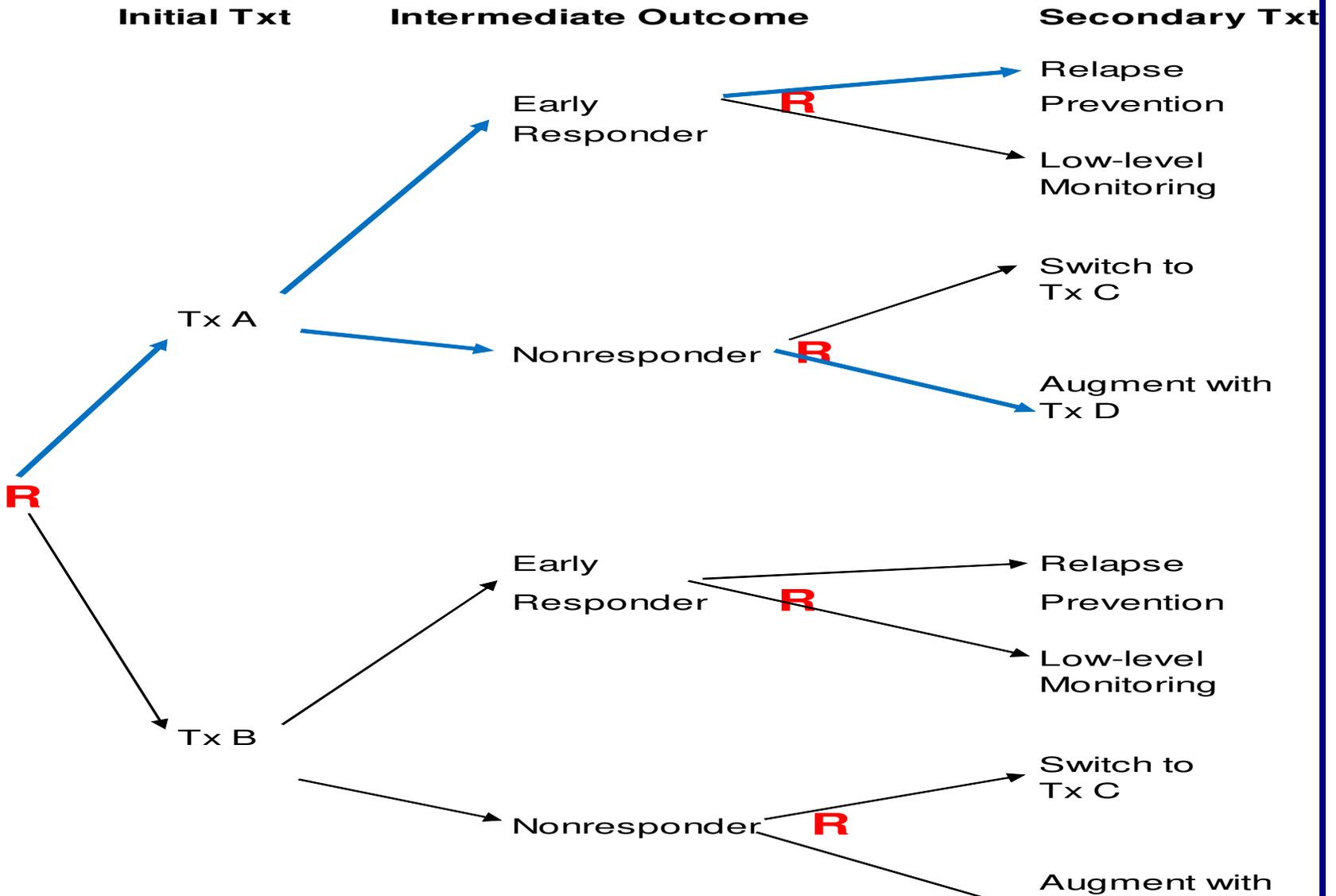
These are multi-stage trials; each stage corresponds to a critical decision and a randomization takes place at each critical decision.

Goal is to inform the construction of adaptive treatment strategies.

Sequential Multiple Assignment Randomization



One Adaptive Treatment Strategy



Alternate Approach to Constructing an Adaptive Treatment Strategy

- Why not use data from multiple trials to construct the adaptive treatment strategy?
- Choose the best initial treatment on the basis of a randomized trial of initial treatments and choose the best secondary treatment on the basis of a randomized trial of secondary treatments.

Delayed Therapeutic Effects

Why not use data from multiple trials to construct the adaptive treatment strategy?

Positive synergies: Treatment A may not appear best initially but may have enhanced long term effectiveness when followed by a particular maintenance treatment. Treatment A may lay the foundation for an enhanced effect of particular subsequent treatments.

Delayed Therapeutic Effects

Why not use data from multiple trials to construct the adaptive treatment strategy?

Negative synergies: Treatment A may produce a higher proportion of early responders but also result in side effects that reduce the variety of subsequent treatments for those that do not respond. Or the burden imposed by treatment A may be sufficiently high so that nonresponders are less likely to adhere to subsequent treatments.

Prescriptive Effects

Why not use data from multiple trials to construct the adaptive treatment strategy?

Treatment A may not produce as high a proportion of early responders as treatment B but treatment A may elicit symptoms that allow you to better match the subsequent treatment to the patient and thus achieve improved response to the sequence of treatments as compared to initial treatment B.

Selection Effects

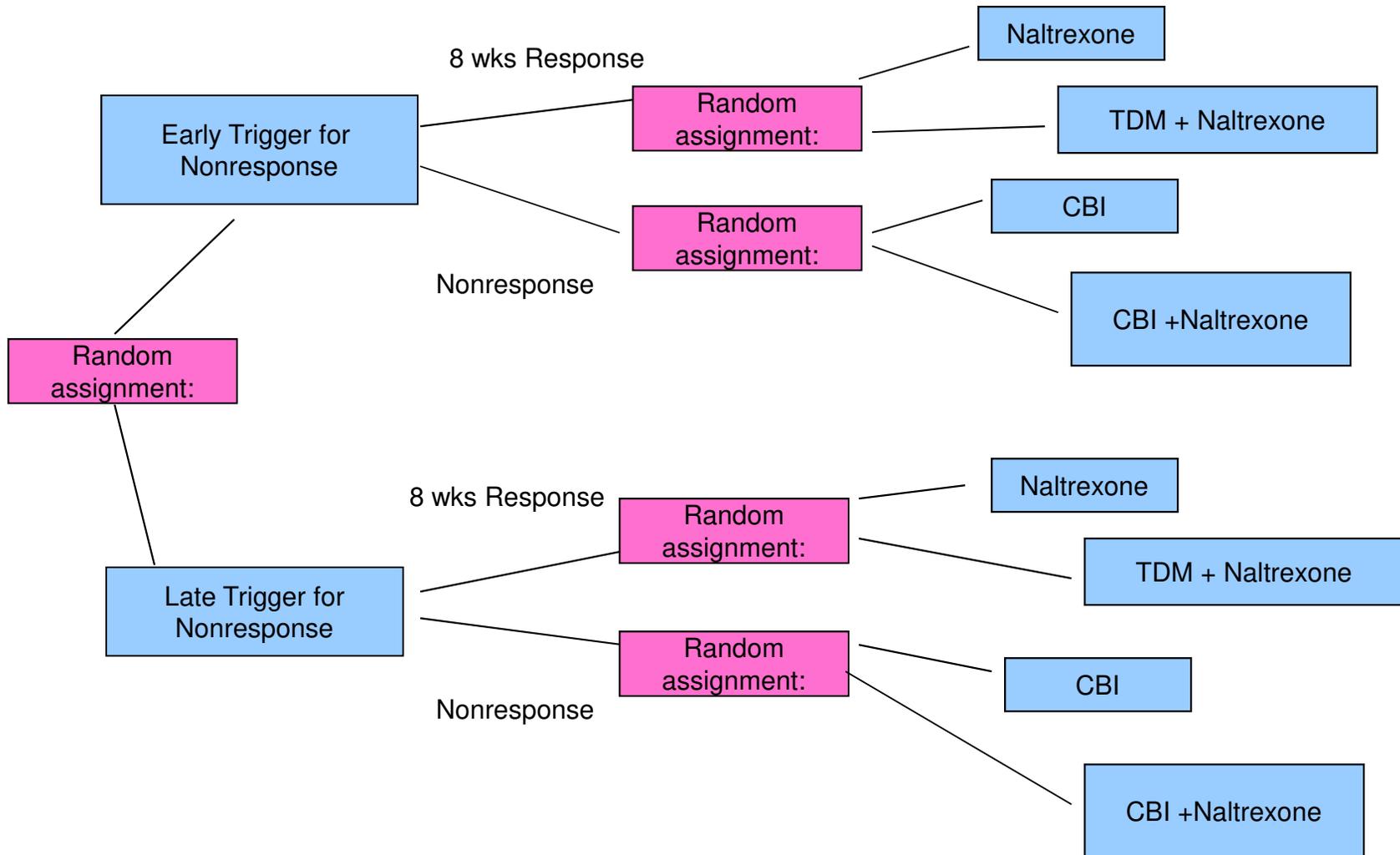
Why not use data from multiple trials to construct the adaptive treatment strategy?

Subjects who *will enroll in*, who *remain in or* who *are adherent in* the trial of the stand-alone treatments may be quite different from the subjects in SMART.

Summary:

- When evaluating and comparing initial treatments, *in a sequence of treatments*, we need to take into account, e.g. control, the effects of the secondary treatments thus SMART
- Standard one-stage randomized trials may yield information about different populations from SMART trials.

Oslin ExTENd



SMART Design Principles

- **KEEP IT SIMPLE:** At each stage (critical decision point), restrict class of treatments only by ethical, feasibility or strong scientific considerations. Use a low dimension summary (responder status) instead of all intermediate outcomes (adherence, etc.) to restrict class of next treatments.
- Collect intermediate outcomes that might be useful in ascertaining for whom each treatment works best; information that might enter into the adaptive treatment strategy.

SMART Design Principles

- Choose primary hypotheses that are both scientifically important and aids in developing the adaptive treatment strategy.
 - Power trial to address these hypotheses.
- Choose secondary hypotheses that further develop the adaptive treatment strategy and use the randomization to eliminate confounding.
 - Trial is not necessarily powered to address these hypotheses.

SMART Designing Principles: Primary Hypothesis

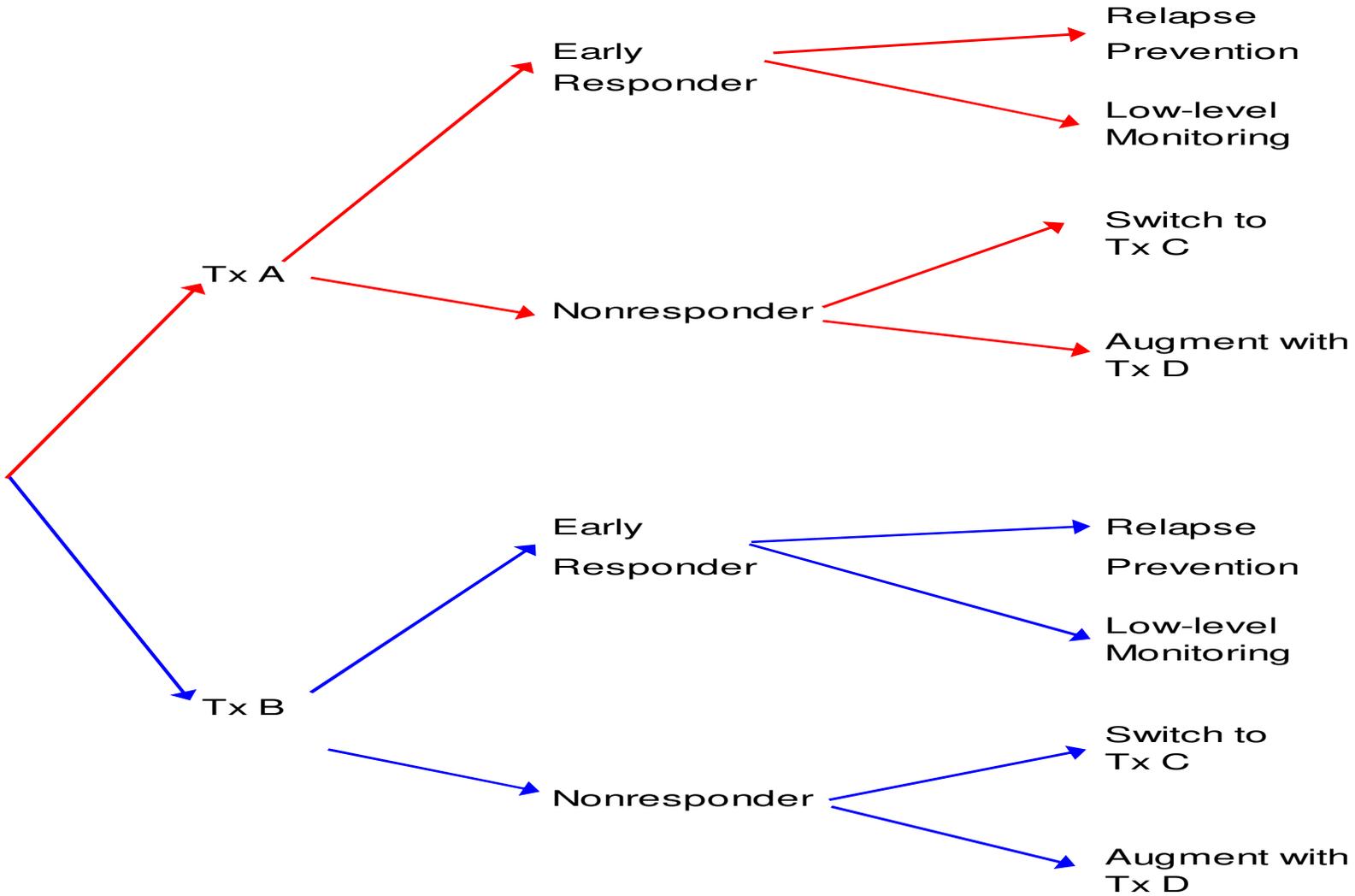
- EXAMPLE 1: (*sample size is highly constrained*):
Hypothesize that controlling for the secondary treatments, the initial treatment A results in lower symptoms than the initial treatment B.
- EXAMPLE 2: (*sample size is less constrained*):
Hypothesize that among non-responders a switch to treatment C results in lower symptoms than an augment with treatment D.

EXAMPLE 1

Initial Txt

Intermediate Outcome

Secondary Txt

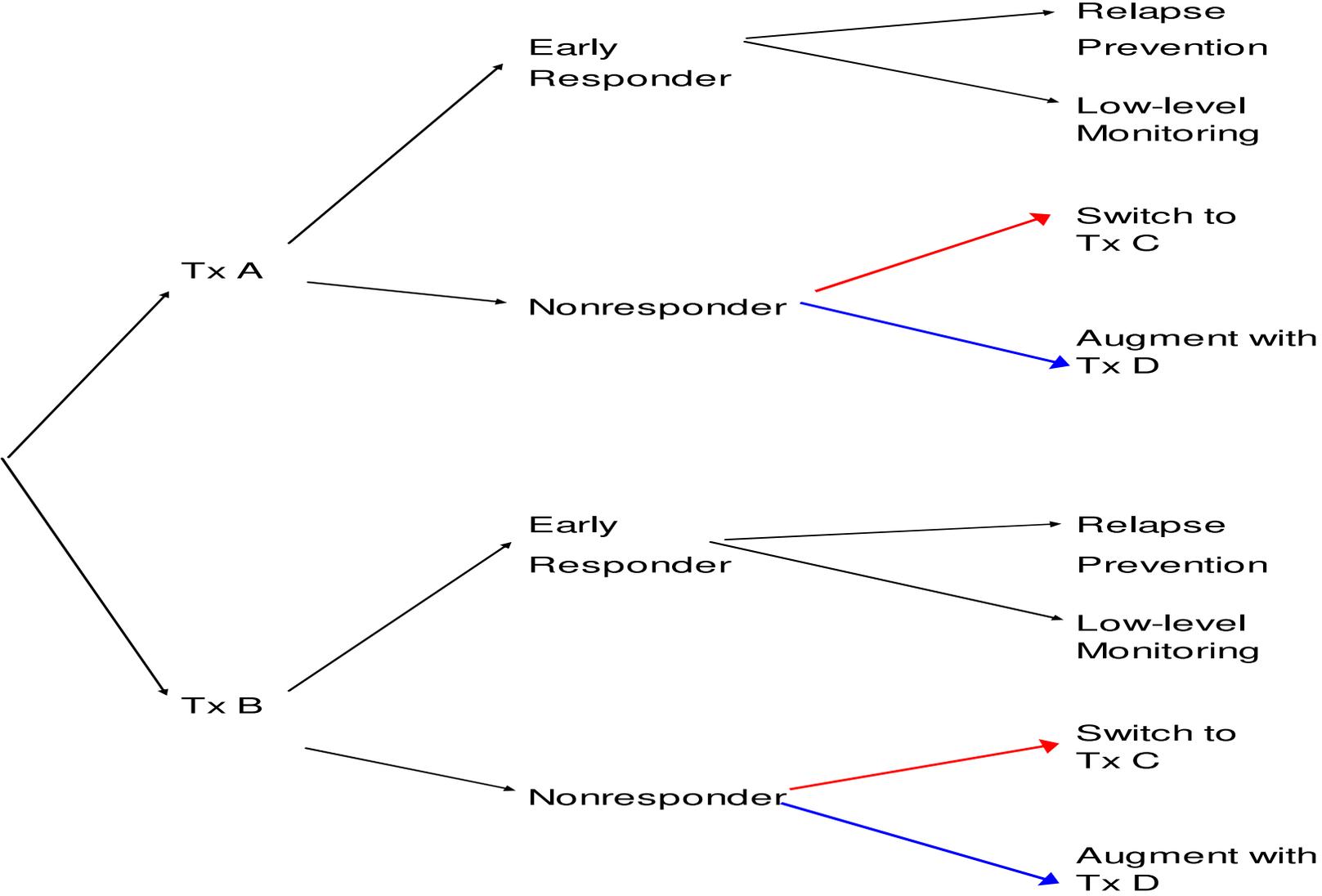


EXAMPLE 2

Initial Txt

Intermediate Outcome

Secondary Txt



Sample Sizes

N=trial size

Example 1

Example 2

$\Delta\mu/\sigma = .3$

N = 402

N = 402/initial
nonresponse rate

$\Delta\mu/\sigma = .5$

N = 146

N = 146/initial
nonresponse rate

$\alpha = .05,$

power = $1 - \beta = .85$

SMART Designing Principles

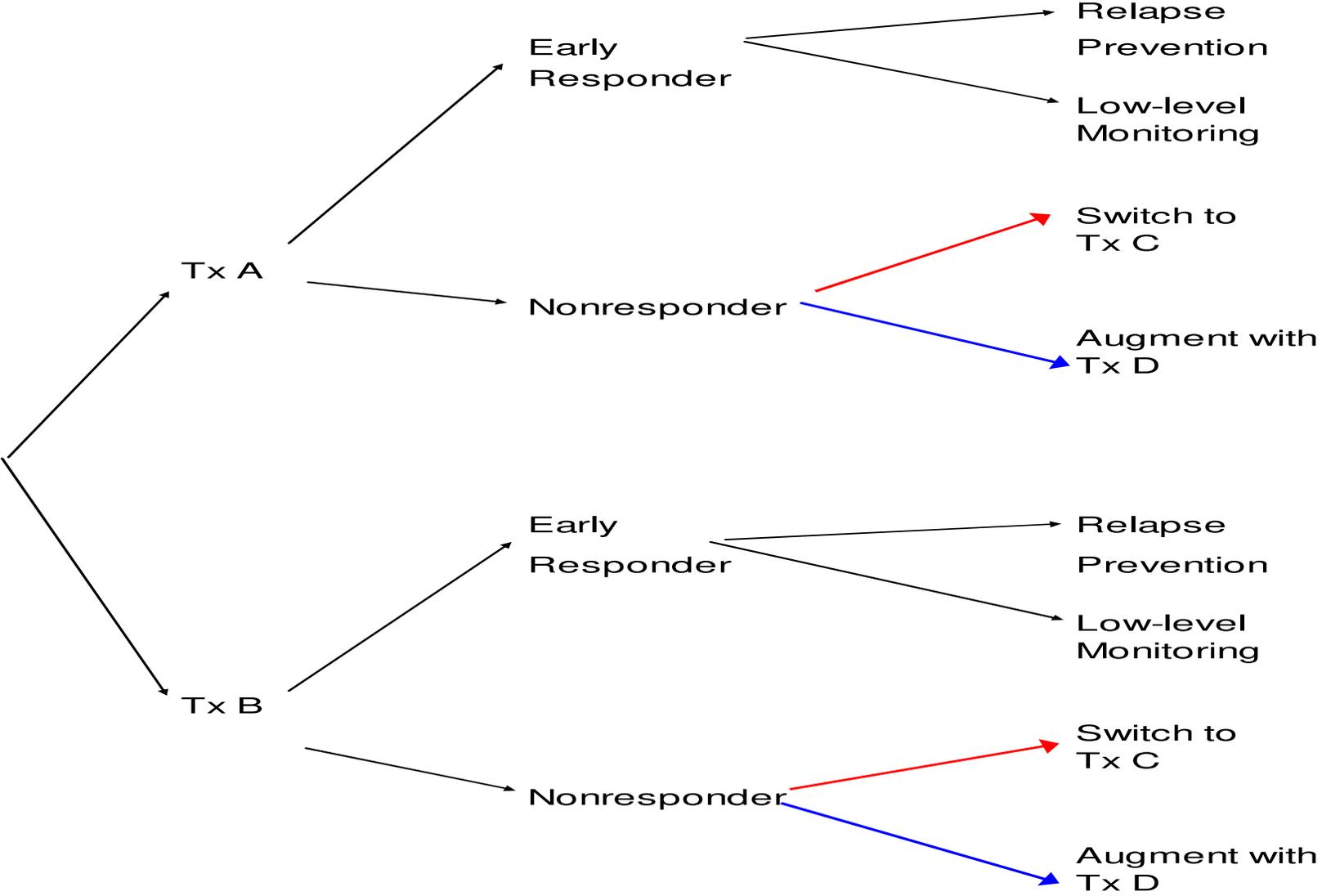
- Choose secondary hypotheses that further develop the adaptive treatment strategy and use the randomization to eliminate confounding.
- EXAMPLE: Hypothesize that *non-adhering* non-responders will exhibit lower symptoms if their treatment is augmented with D as compared to an switch to treatment C (e.g. augment D includes motivational interviewing).

EXAMPLE 2

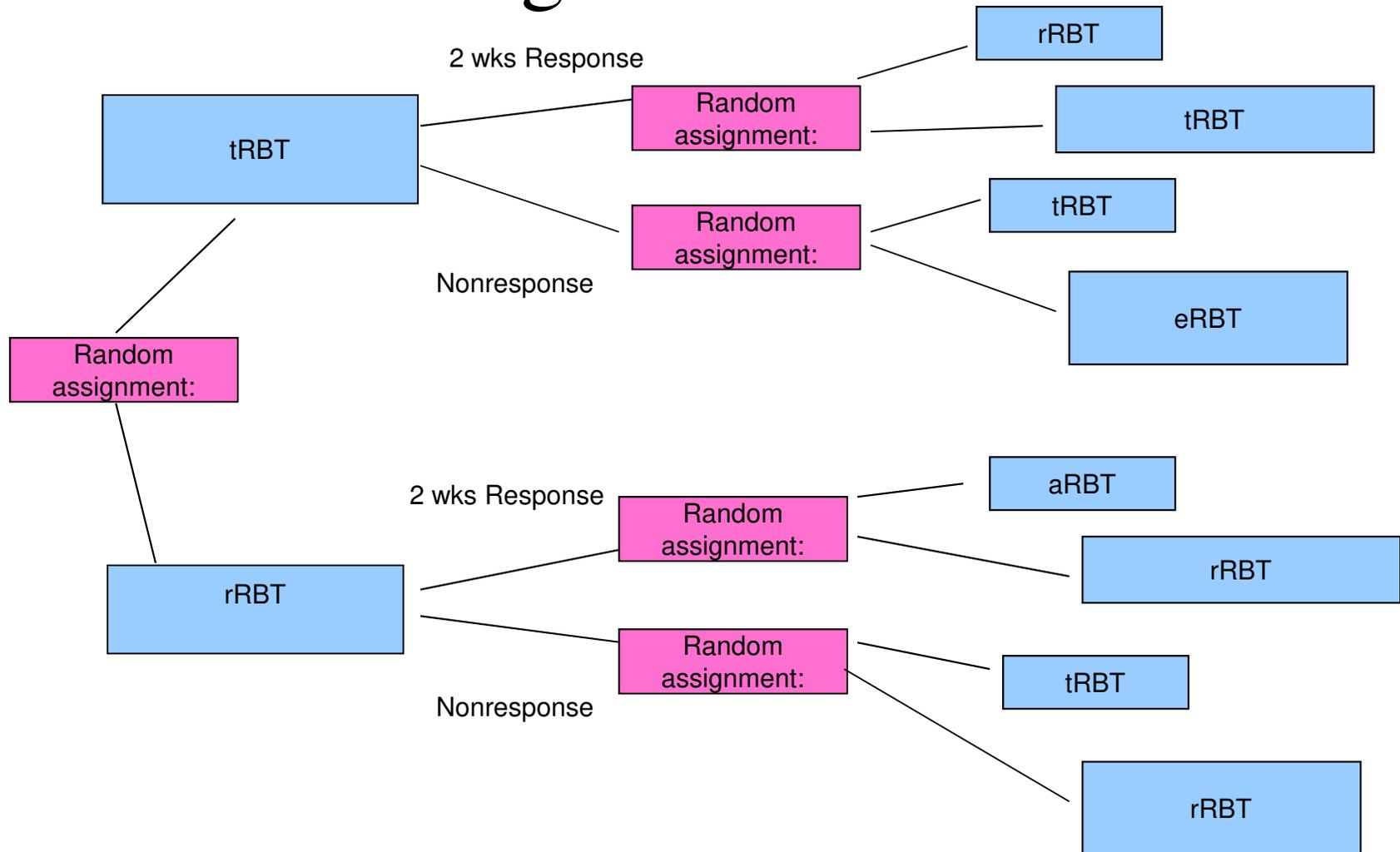
Initial Txt

Intermediate Outcome

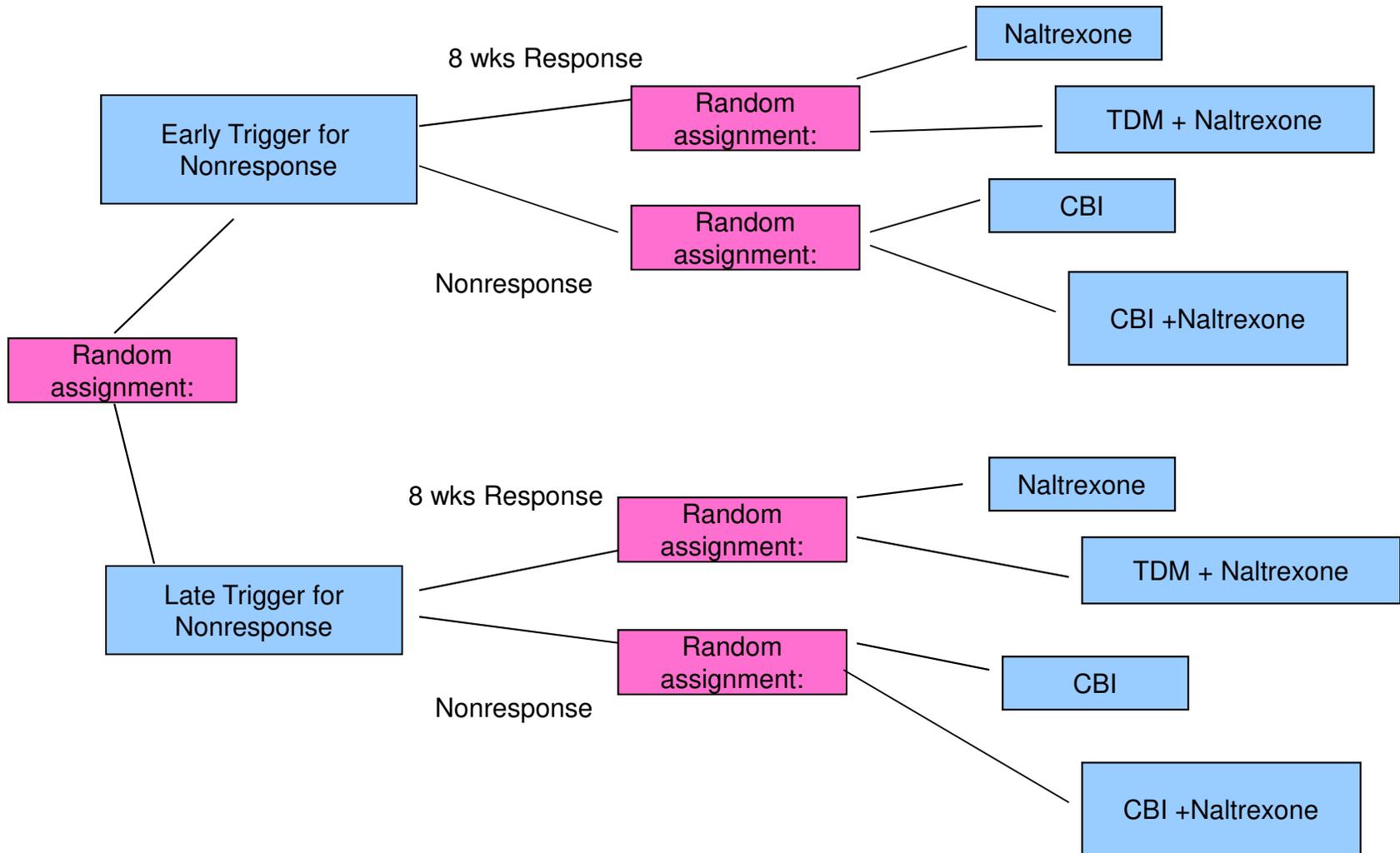
Secondary Txt



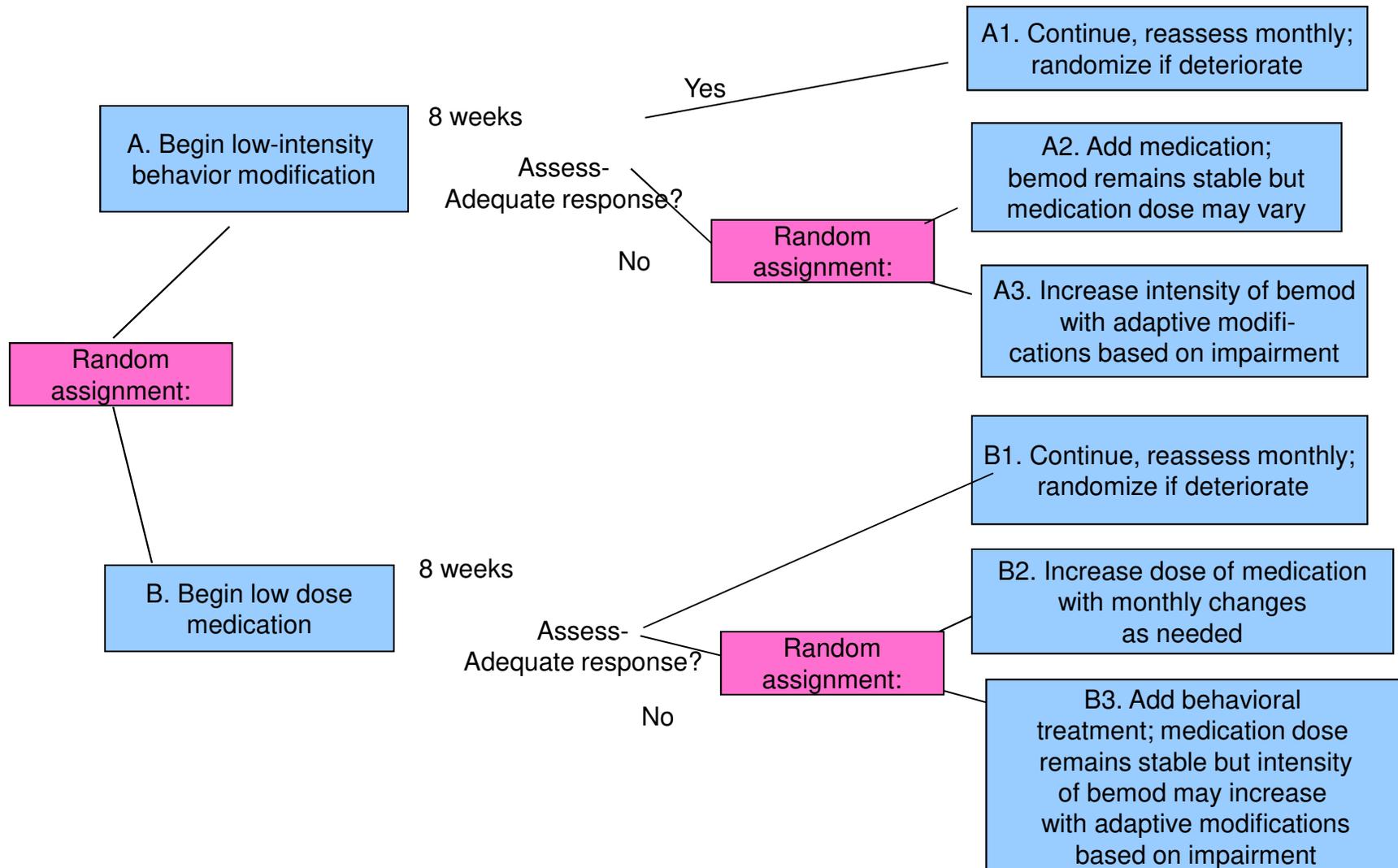
Jones' Study for Drug-Addicted Pregnant Women



Oslin ExTENd



Pellman ADHD Study



Discussion

- Secondary analyses can use pretreatment variables and outcomes to provide evidence for more deeply individualized adaptive treatment strategies are available. (when and for whom?)
- Sample Size formulae are available.
- Aside: Non-adherence is an outcome (like side effects) that indicates need to tailor treatment.

Questions? Email Susan Murphy at samurphy@umich.edu

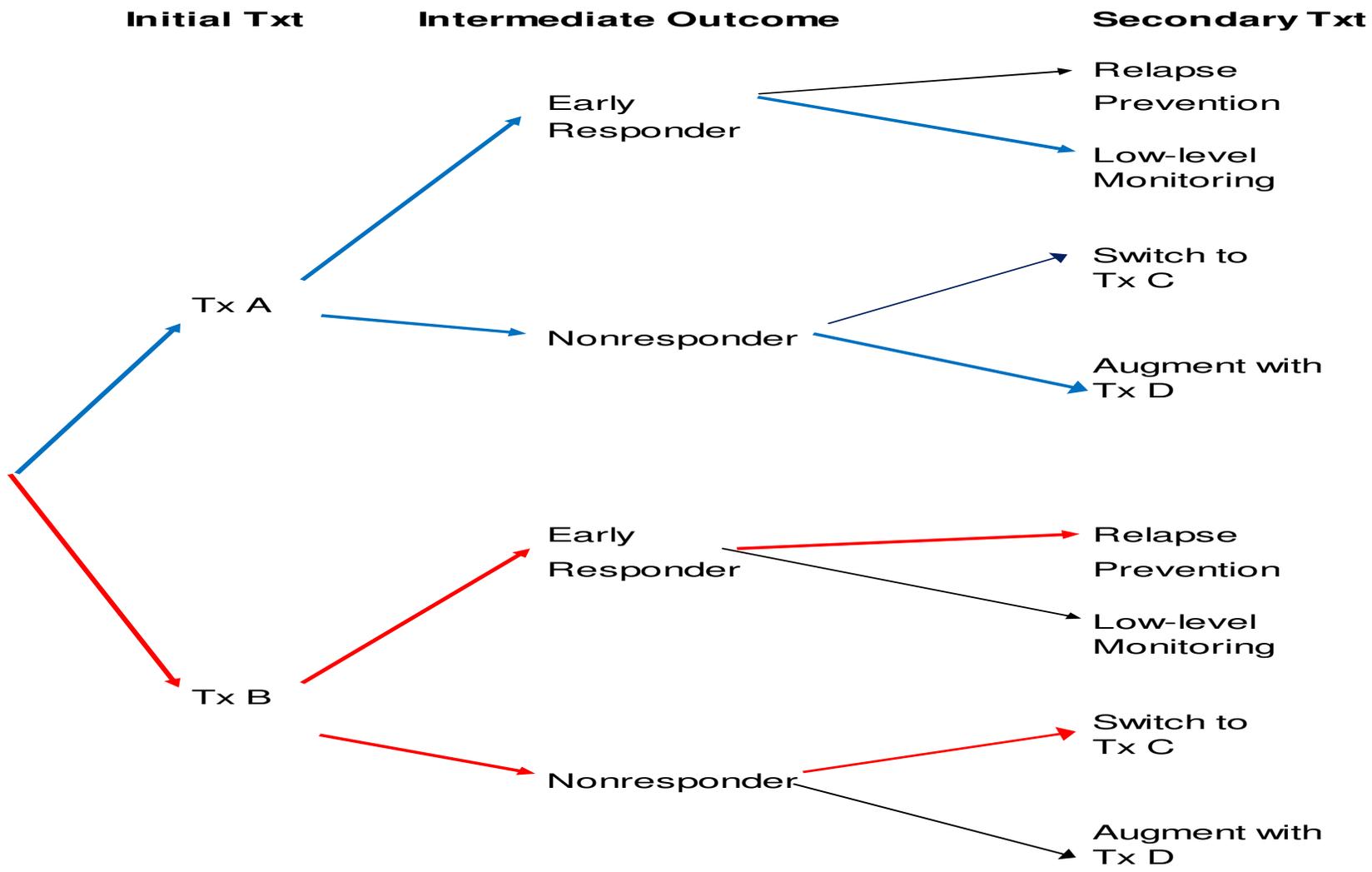
Examples of “SMART” designs:

- CATIE (2001) Treatment of Psychosis in Schizophrenia
- STAR*D (2003) Treatment of Depression
- Pelham (primary analysis) Treatment of ADHD
- Oslin (primary analysis) Treatment of Alcohol Dependence
- Jones (in field) Treatment for Pregnant Women who are Drug Dependent
- Kasari (in field) Treatment of Children with Autism

SMART Designing Principles: Primary Hypothesis

- EXAMPLE 3: (sample size is less constrained):
Hypothesize that adaptive treatment strategy 1 (in blue) results in improved symptoms as compared to strategy 2 (in red)

EXAMPLE 2



Why not combine all possible efficacious therapies and provide all of these to patient now and in the future?

- Treatment incurs side effects and substantial burden, particularly over longer time periods.
- Problems with adherence:
 - Variations of treatment or different delivery mechanisms may increase adherence
 - Excessive treatment may lead to non-adherence
- Treatment is costly (Would like to devote additional resources to patients with more severe problems)

More is not always better!

Kasari Autism Study

