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Short Report

Potential implications of practice effects in Alzheimer's disease prevention trials

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Abstract

Introduction: Practice effects (PEs) present a potential confound in clinical trials with cognitive outcomes. A single-blind placebo run-in design, with repeated cognitive outcome assessments before randomization to treatment, can minimize effects of practice on trial outcome.

Methods: We investigated the potential implications of PEs in Alzheimer's disease prevention trials using placebo arm data from the Alzheimer's Disease Cooperative Study donepezil/vitamin E trial in mild cognitive impairment. Frequent ADAS-Cog measurements early in the trial allowed us to compare two competing trial designs: a 19-month trial with randomization after initial assessment, versus a 15-month trial with a 4-month single-blind placebo run-in and randomization after the second administration of the ADAS-Cog. Standard power calculations assuming a mixed-model repeated-measure analysis plan were used to calculate sample size requirements for a hypothetical future trial designed to detect a 50% slowing of cognitive decline.

Results: On average, ADAS-Cog 13 scores improved at first follow-up, consistent with a PE and progressively worsened thereafter. The observed change for a 19-month trial (1.18 points) was substantively smaller than that for a 15-month trial with 4-month run-in (1.79 points). To detect a 50% slowing in progression under the standard design (i.e., a 0.59 point slowing), a future trial would require 3.4 times more subjects than would be required to detect the comparable percent slowing (i.e., 0.90 points) with the run-in design.

Discussion: Assuming the improvement at first follow-up observed in this trial represents PEs, the rate of change from the second assessment forward is a more accurate representation of symptom progression in this population and is the appropriate reference point for describing treatment effects characterized as percent slowing of symptom progression; failure to accommodate this leads to an oversized clinical trial. We conclude that PEs are an important potential consideration when planning future trials.
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Keywords: Alzheimer's disease; Practice effects; Clinical trial; Single-blind run-in design; Prevention; Preclinical

1. Introduction

Practice effects (PEs) are improvements in cognitive test performance over serial assessments attributed to repeated exposure to test stimuli or procedures. Clinically, PEs can provide valuable information about level of cognitive

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functioning, vis-à-vis ability to benefit from repeated exposure [1,2]; however, in randomized controlled trials, they introduce a source of external signal that may confound observation of the target outcome [3].

Various methods have been proposed to address PEs, including statistical corrections and use of alternate test forms [3–5]. Although alternate forms may minimize memory for specific test items, they do not account for improvements that arise from increased familiarity with test procedures in general [6–8], and equivalent alternate forms are not available for many neurocognitive measures.

Another method to accommodate for PEs in clinical trials is to use a test run-in or "dual baseline" wherein the cognitive outcome measure(s) are administered twice before randomization and scores from the second testing are used as the baseline reference. This approach helps to account for the initial, rapid improvements that occur with repeated testing, which are typically most pronounced between the first and second test administration [5,8]. In a variant of this approach, often referred to as a single-blind placebo run-in design, participants are randomized to treatment or placebo, but all receive placebo during the run-in period between dual baseline assessments and only receive the treatment to which they had been randomized (i.e., active or placebo) after the second assessment. Dual baseline or run-in designs have been used to reduce the influence of practice and placebo effects on clinical trials with neuropsychological outcomes in a variety of diseases and interventions [9–11].

We investigated the impact of a cognitive test run-in design on magnitude of potential effect size and power calculations by examining the performance of participants in the placebo arm of a secondary prevention trial to delay progression from mild cognitive impairment (MCI) to Alzheimer's disease (AD) dementia.

2. Methods

2.1. Overview

We conducted retrospective analyses of placebo arm data from a multicenter, randomized, double-blind, placebo-controlled trial of vitamin E and donepezil HCL to delay clinical progression from MCI to AD dementia; design and results of the trial are described elsewhere [12].

2.2. Participants

Data were obtained from participants in the placebo arm of the donepezil/vitamin E study. All participants were between the age of 55 to 90 years and met diagnostic criteria for amnestic MCI [13]. The placebo group comprised 259 participants with a mean age of 72.9 years (standard deviation [SD] = 7.6), and an average of 14.7 years of education (SD = 3.1); 47% were female, 53% were *APOE* ε4 carriers, and the mean score on the MMSE at screening was 27.35 (SD = 1.8). Data from only the first 18 months of the 36-month trial were used for these analyses because converters to AD dementia were offered open-label donepezil, precluding the ability to look at PEs separate from potential treatment effects in subjects who converted.

2.3. Procedure

The modified 13-item Alzheimer's Disease Assessment Scale, cognitive subscale (ADAS-Cog 13), was administered at the screening visit (1 month before randomization), 3 and 6 months after randomization, and semiannually thereafter. The ADAS-Cog 13 includes all items from the original ADAS-Cog (i.e., word list recall and recognition; measures of language, orientation, constructional and ideational praxis), plus a number cancellation task and a delayed free recall task for a total of 85 points, with higher scores indicating greater cognitive impairment [14]. Three alternate forms of the word-recall word list component were used in the trial: list 1 was administered at screening and 12 months, list 2 at 3 and 18 months, and list 3 at 6 months.

2.4. Data analyses

Sample size calculations informed by placebo arm data from the MCI trial were performed assuming a mixed-model repeated-measures (MMRM) analysis using standard methods we have described [15] and implemented in the R statistical programming language package longpower [16] using a type-I error rate of 5%, power of 80%, and assuming equal allocation to arms. The mean and covariance matrix of repeated ADAS-Cog measures were supplied to the power.mmrm function within the longpower package. To simplify presentation, we assumed no covariate adjustment and no loss to follow-up in power calculations. MMRM, as used in contemporary secondary prevention trials, compares change from randomization to final visit in the treatment arm versus change in control [17]. Mean and SD at each assessment are reported, as is the mean and SD of change from treatment randomization to month-18 visit. We compare the relative sample size required for the two trial designs by example, calculating sample size required to detect a 50% slowing of decline. Under our assumptions, the relative sample size required when effect size is expressed as percent slowing of decline is solely a function of the mean and covariance structure of the pilot data for this analysis plan [18]. Hence, relative sample size for our reported findings for the 50% slowing of decline generalize to any effect size expressed as percent slowing of decline.

3. Results

Participant mean scores on the ADAS-Cog 13 are shown in Fig. 1. At screening, the group mean score was 17.40 (SD = 6.0). At 3-month follow-up, the group mean score improved slightly to 16.79 (SD = 7.0). At 6-month follow-up, the group mean returned to the baseline level (mean = 17.38; SD = 7.0), and performance progressively declined thereafter. Between screening and 18-month

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