

Why would Cardiovascular Outcomes Trials and Rare Disease Studies have Anything in Common?

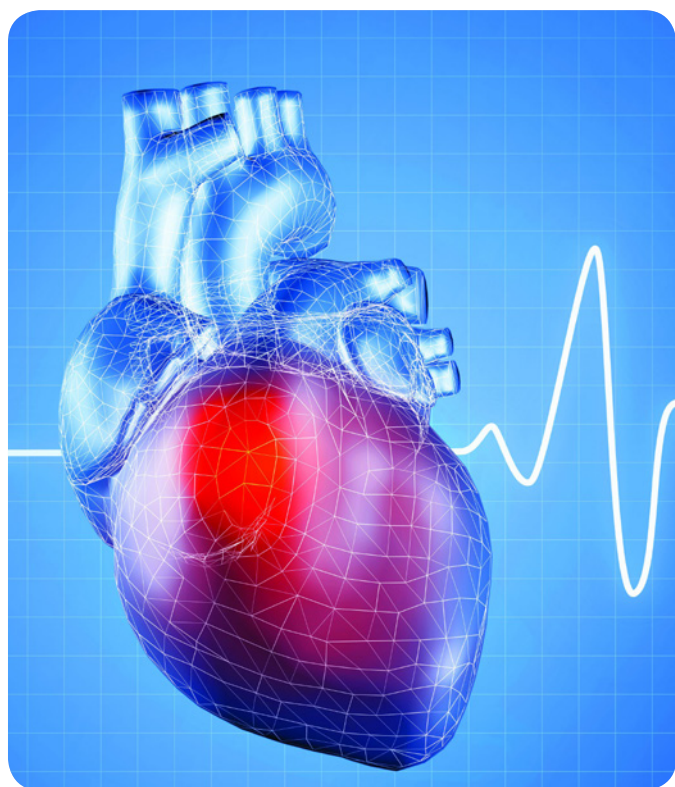
Cardiovascular outcomes trials (CVOTs) are some of the largest interventional trials being conducted, enrolling several thousand subjects, sometimes with follow-up over several years to accrue the required number of major adverse cardiovascular events. By contrast, and for obvious reasons, rare disease studies are very limited in size. Indeed, the ongoing anacetrapib CVOT (the REVEAL study) has enrolled 30,624 participants¹, which is almost four times the world total of 7713 diagnosed Fabry Disease patients². However, the general design of these two widely different and extreme types of trials is surprisingly similar. Does this have implications for other types of trials?

Studies on rare diseases are inherently limited by the availability of participants. Many rare diseases are multi-organ genetic diseases which have different manifestations, depending on the specific mutation. Patients present with significant comorbidities, but such studies cannot afford to have extensive exclusion criteria. The variability of the population can lead to challenges in demonstrating efficacy. For example, the orphan drug, ixazomib, initially received negative EMA CHMP opinion because the data from the main study were insufficient to demonstrate a benefit. The company had proposed restricting the use of ixazomib to patients with refractory multiple myeloma, which relapsed after a treatment, and those whose disease had returned after at least two treatments. However, the data in these subgroups were not compelling enough and the risk-benefit-ratio was insufficiently favourable³ (conditional approval was subsequently granted).

CVOTs, as relatively late-phase large trials (III, IIIB or IV), generally try to target a broad range of subjects in an attempt to replicate the real-world use of the drugs. The expense of performing such huge studies can only be ventured in common conditions, where the potential return on investment exists, i.e. where large and widespread sales can be achieved. But just as in rare disease studies, the enrolment of subjects is the rate-limiting issue, and the designers of such trials need to be as inclusive as possible to maximise enrolment.

It may be that the very different requirements of these two types of studies both tend to push the study designers towards the pragmatic end of the explanatory -> pragmatic continuum. This axis was first explored by Schwartz and Lellouch almost 50 years ago⁴, but still generates discussion today⁵. One might expect these two types of studies to lie at opposite ends of the pragmatic explanatory axis. While CVOTs could certainly not be described as pragmatic studies, they are certainly further down the continuum than the 'average' study. The shortage of subjects for rare disease studies and the





sheer number of subjects required by CVOTs means that the same pressures on inclusivity affect both types of studies.

Retention of subjects is equally vital to both. For rare disease studies, the need to retain subjects is obvious, but identifying and enrolling patients is so difficult that having non-evaluable data is a critical waste. On CVOTs, the sample sizes for analysis are actually the endpoint events, and those numbers will be much smaller than the number of participants. An extreme example is the celecoxib PRECISION study that was reported recently in the NEJM⁶. This study involved 24,081 subjects in three arms and ran for nearly 10 years. However the actual number of events in the primary analysis was only 607, and the difference in the number of events between the “best” and “worst” arms was only 30! This number is much smaller than the number of subjects that were lost to follow-up. Had this been an efficacy study (it was not), it is certain that the data would not have been acceptable to regulatory bodies. Similarly, in 2013, the FDA Advisory Committee recommended rejection of tolvaptan for the indication of slowing kidney disease in adults with autosomal dominant polycystic kidney disease (ADPKD), partially because of the amount of missing data, especially from the higher number of patients lost to follow-up in the tolvaptan group⁷.

Does this observation about rare disease trials and CVOTs, at opposite ends of the trial spectrum, have any implications for other trials? It is clear that purely exploratory studies are necessary to early phase research, but does the more pragmatic approach used in such disparate trials suggest that the same could be true for many more trials in the middle ground? Treweek and

Zwarenstein argue this would be better for patients in the long run. As for patient retention, this is just good science!

References

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