Special Features of Randomized Controlled Trials

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Critical Methodological Elements in RCTs

- Randomization
- Avoiding and handling exclusions after trial entry
- Blinding
A. Bradford Hill’s Early Attempts at “Randomization”

“The reason . . . the allocation of alternate cases to the treated and untreated groups is often satisfactory, is because no conscious or unconscious bias can enter in, as it may in any selection of cases, and because in the long run we can fairly rely upon this random allotment of the patients to equalise in the two groups the distribution of other characteristics that may be important.”

Early Glimpses at the Importance of Quality in RCTs

“I suspect that Hill’s failure initially to distinguish clearly between alternation and randomization was due partly to an underestimate of the danger of selection bias, and partly to a feeling that alternation would be easier to swallow than randomization.”

“The problem is one of ‘selection bias’.”

The First Real Randomized Trial

- Realization of selection bias problems with alternate allocation
- Hill looked for opportunities to employ proper randomization
- Pertussis vaccine trial; pilot in 1944; completed in 1950
- Streptomycin for tuberculosis; initiated later; published in the BMJ in 1948
Randomization

- Principal bias reducing technique
- Success depends upon successful implementation
- Chance rather than choice eliminates selection bias
“Randomization” or “Random Allocation”

- Success depends upon two interrelated processes
  - Sequence generation
  - Allocation concealment
“Randomization”

Sequence Generation

- An unpredictable allocation sequence must be generated based on a random procedure

Allocation Concealment

- Strict implementation of that schedule must be secured through an assignment mechanism that prevents foreknowledge of treatment assignment.
Sequence Generation

- Whim
- Judgement
- Chance
- The Quasi- Simulated “Randomized” Approach
Allocation Methods (Cont’d)

- Alternate assignment
- Chart number
- Date of birth

Random?
Two Problems

• Non-random

• Difficult to conceal anyone assigning or referring patients know in advance the next assignment
  
  ◆ Decide eligibility
  ◆ Time their referral
Sequence Generation

- Flipping a coin?
- Shuffling cards?
- Random but tempt investigators toward non-randomness (independent events - Jack B)
  - Adequate methods but not optimal
  - Cannot be checked - no audit trail
  - More difficult
  - Not recommended
<table>
<thead>
<tr>
<th>Random Sequences ?</th>
</tr>
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<tbody>
<tr>
<td>• AABABBBABABAB</td>
</tr>
<tr>
<td>• ABBABAABABAB</td>
</tr>
<tr>
<td>• AABBAABBABAB</td>
</tr>
<tr>
<td>• BAAABBAAABAB</td>
</tr>
<tr>
<td>• ABBAABABABBA</td>
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<td>• ABABABABABBA</td>
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<td>• ABBABBAABAAB</td>
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<tr>
<td>• ABBAABBBABAB</td>
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<td>• ABBAABBAABAB</td>
</tr>
</tbody>
</table>
Human Notions (20 of 22 had 5-5) (18 of 21 w/o more than 2 As or Bs in a row)

- AABABBABABAB 5-5
- ABBABAABABAB 5-5
- AABBAABBABAB 5-5
- BAABBAABABAB 5-5
- ABBAABABABBA 5-5
- ABABABABABBA 5-5
- ABBABBAABBA 5-5
- AABAAABBABABB 5-5
- ABBAABBAABA 5-5
- ABBAABBAABAB 5-5

24.6% chance of an exact 5-5 split
### Random Sequences

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAABAABABABA</td>
<td>7-3</td>
</tr>
<tr>
<td>BBBABBBBBBBB</td>
<td>1-9</td>
</tr>
<tr>
<td>ABAABABBBB</td>
<td>5-5</td>
</tr>
<tr>
<td>BAAABBBBBB</td>
<td>4-6</td>
</tr>
<tr>
<td>ABABAAAAAA</td>
<td>8-2</td>
</tr>
<tr>
<td>BABABBBBAA</td>
<td>5-5</td>
</tr>
<tr>
<td>AAABBBABBBB</td>
<td>4-6</td>
</tr>
<tr>
<td>AABABABBBAA</td>
<td>6-4</td>
</tr>
<tr>
<td>ABBBBBBBBBBAB</td>
<td>2-8</td>
</tr>
<tr>
<td>ABBAAAAAABB</td>
<td>6-4</td>
</tr>
</tbody>
</table>
Sequence Generation (Cont’d)

- Table of random numbers? Preferable & Recommended
  - Random
  - Reproducible - can be checked
  - Easier (not widely recognized)

- Same can be said for most random number generations
Types of Sequence Generation

- Simple randomization
- Replacement randomization
- Blocked \( (\text{random permuted blocks}) \) randomization
  - Small or large block sizes
  - Randomly varied block sizes
  - Restricted shuffled randomization
- Stratified randomization
Allocation Concealment

- Crucially, allocation concealment shields those who admit participants to a trial from knowing upcoming assignments.
  - Accept or reject decisions and informed consent obtained without foreknowledge.
Traditionally, Many Medical Researchers Mistakenly Consider Simply the Sequence Generation as “Randomization”

- Frequently slight allocation concealment while stressing sequence generation
- Without adequate allocation concealment, however, even random unpredictable sequences can be subverted
e.g. Investigator Adequately Generates a Sequence, Then Posts on a Bulletin Board

- Basically, equates to no allocation concealment (perhaps a little concealment if the bulletin board is up 5 flights of stairs)
- Those responsible for admitting participants could detect the upcoming allocations and then channel them based on prognosis
- Bias easily introduced
Minimal Standards: Common Allocation Concealment Approaches

- Sequentially numbered, opaque, sealed envelopes (SNOSE)
- Pharmacy control
- Numbered or coded containers
- Central randomization

Realistically, these standards should be exceeded
Allocation Concealment **Envelopes**

- More susceptible to manipulation through human ingenuity
- Less than ideal method of allocation concealment
- If used, investigators must diligently develop and monitor the process
Envelopes (Cont’d)

- SNOSE

- Ensure that the envelopes are opened sequentially, and only after the P’s name and other details are written on the appropriate envelope
Envelopes (Cont’d)

- Pressure-sensitive or carbon paper inside
  - creates valuable audit trail
- Cardboard or aluminum foil inside envelope
Do Not Confuse Allocation Concealment with Blinding

• Allocation concealment seeks to prevent selection bias, protects assignment sequence before and until allocation, and can always be successfully implemented
Do Not Confuse Allocation Concealment with Blinding (Cont’d)

- In contrast, blinding seeks to prevent ascertainment bias, protects sequence after allocation, and cannot always be successfully implemented.
RCTs Annoy Humans

- Investigators
  - Certain Ps to benefit
  - May want the results of study to reveal the “truth”

- Some aspects of properly conducted RCTs annoy investigators
  - Trial procedures attempt to impede human inclinations
• The challenge of deciphering may frequently become too great a temptation to resist
  
  ❖ Even without intent to bias
    
    “The only way to get rid of a temptation is to yield to it”
    
    - Oscar Wilde

• Whatever the motivations, such actions undermine validity of the trial
RCTs: Anathema to the Human Spirit

- Must acknowledge the vagaries of human nature
- Must establish methodological safeguards that thwart attempts to contaminate trials with bias
Exclusions Before Randomization

- Whether for valid or whimsical reasons, do not bias the randomized treatment comparison.
- If done to extreme, will limit inferential capability (external validity).
Exclusion Criteria

- Patients may have a condition for which the trial treatment is contraindicated
- Patients may be taking confounding medication
- They may be unlikely to remain “observable”
- Other plausible reasons
Key Points

- Before randomization
- Criteria should be clear and specific
- Once in, stays in
- Minimize criteria so as not to limit ability to extrapolate - i.e. results will have little meaning from a greatly restricted subset
Exclusions After Randomization

- Can introduce bias
- Should be carefully scrutinized
Deviations from the Protocol

Some investigators suggest that if a patient deviates substantially from the allocated exposure, then the patient should not be included in that group.

Other suggest otherwise.

An Example
Patients with TB

Randomize

Placebo

- 40% Non-compliance
  - Group representing the policy of no Tx

- 60% Compliance
  - Outcome

New Oral Drug

- 25% Non-compliance
  - Group representing the policy of oral treatment

- 75% Compliance
  - Outcome
RCT Compared the Effectiveness of Clofibrate in Preventing Cardiac Deaths in Men Who Had Survived a Myocardial Infarction

<table>
<thead>
<tr>
<th></th>
<th>Clofibrate</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-year mortality</td>
<td>20.2%</td>
<td>20.9%</td>
</tr>
<tr>
<td></td>
<td>(p = .55)</td>
<td></td>
</tr>
<tr>
<td>Eliminating deviates</td>
<td>15.0%</td>
<td>20.9%</td>
</tr>
<tr>
<td>from clofibrate (80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>adherence)</td>
<td>(p &lt; .05)</td>
<td></td>
</tr>
<tr>
<td>Eliminating deviates</td>
<td>15.0%</td>
<td>15.1%</td>
</tr>
<tr>
<td>from both groups</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Authors state that one can justify almost any conclusion, dependent upon the analysis chosen.
Actual Text Lifted from Protocols Submitted to DMID

- “Subjects may be withdrawn from the study for . . .”
  - “Protocol violation/deviation (including non-compliance”
  - “Other”

- “Reasons for drop-out”
  - “Protocol violation (to be specified)”
  - “Migration from the study area”
  - “Other (to be specified)”
• “Intent to Treat Population: all randomized subjects who received at least one dose of study medication (i.e. tafenoquine or chloroquine/primaquine).”

• “Subjects may be terminated from . . . .”
  - “Failure or inability to comply with the treatment protocol”
Exclusions After Randomization

• Can introduce bias and should be carefully scrutinized

• All randomized patients should be analyzed, and analyzed as part of the group to which they were initially assigned

• ITT (Intention-to-treat)
Blinding

- Usually reduces differential assessment of outcomes (information bias)
- May improve compliance and retention of trial participants while reducing biased supplemental care or treatment (co-intervention)
- Place greater credence in results when investigators at least blind outcome assessments, except with “hard” outcomes, such as death.
- Confusion with allocation concealment reflects misunderstandings of both
Blinded vs Masked
Double-Blind vs. Single-Blind
Blinding and Reporting

- Universally accepted definitions of single, double, and triple blinding elude the scientific community.
- Should explicitly state who was blinded – and how. With proper reporting, readers should be able to determine what benefits accrued.
- For “total-blinding” ensure that the intervention regimens are similar on, for example, appearance, shape, size, weight, taste, color, and administration.
  - provide details in the trial report
Many over-rate importance of double-blinding

Indeed, some consider a randomized trial as high quality if “double-blind”

- ... the sine qua non of an RCT

Unfortunately, scientific life is not that simple

A randomized trial can be methodologically sound and not be double-blind

- or, conversely, double-blind and not methodologically sound
**Importance of Blinding**

- **Double-blinding reflects a strong design**
  - but *not* the primary indicator of overall quality

- **Moreover, many trials cannot be double-blinded**
  - must be judged on overall merit *rather* than an inapplicable standard based on double-blinding

- **Blinding is important**
  - Intuitively, should reduce bias
  - Methodological investigations tend to show that double-blinding prevents bias but . . .
    - less important, on average, than allocation concealment
At a minimum, for a RCT, include in the protocol:

- Entry criteria
- Unit of randomization
- Method of generating the allocation sequence (including stratification if used)
- Method of allocation concealment
- Who will generate the allocation sequence and who will enroll and assign participants
For an RCT, include in protocol (Cont’d)

- The blinding procedures, if any, implemented after assignment.
- The approaches to handle losses, withdrawals, and deviations.
- Procedures to retain participants (later)