The PROTEUS-Trials Consortium

Patient-Reported Outcomes Tools: Engaging Users & Stakeholders

PROTEUS Handbook

TheProteusConsortium.org
How to Use This Handbook

This handbook accompanies a series of presentations about PROTEUS-Trials and the tools and resources available to optimize the use of patient-reported outcomes in clinical trials.

Chapter 1 introduces patient-reported outcomes and the PROTEUS-Trials Consortium. Chapters 2 to 7 present the six core PROTEUS-Trials tools and their role in guiding the design, conduct, analysis, reporting, and application of PRO clinical trial data. Additional information and resources are available on the PROTEUS website (TheProteusConsortium.org).

Use the headings in the Table of Contents on page 2 to go through the parts of the handbook suited to your current information needs. Important resources within this handbook can be jumped to via hyperlinks throughout the handbook for easier navigation.

Acknowledgements

This Handbook was developed by Dion Candelaria and The University of Sydney Quality of Life Office team (Claudia Rutherford, Rachel Campbell, and Margaret-Ann Tait) based on web tutorials presented by the PROTEUS-Trials Leadership Team and Steering Committee.

A Note on Referencing

This Handbook summarizes information described in detail in the primary research sources (listed under “References” for each chapter). To promote readability, we have limited in-text citations. However, when referencing the included information, we recommend citing the primary sources rather than the Handbook.

To reference the Handbook itself, please use:

## Contents

**PROTEUS-Trials Leadership Team** ........................................................................................................... 1

**Steering Committee** .................................................................................................................................. 2

**Chapter 1. Introduction to Patient-Reported Outcomes and PROTEUS-Trials** .......................... 3

- Types of Clinical Outcomes Assessment .................................................................................................. 3
- Patient-Reported Outcomes (PROs) ........................................................................................................... 4
  - How are Patient Perceptions ‘Measured’? .................................................................................................. 4
  - Example: Physical Function Measure ...................................................................................................... 4
- The PROTEUS-Trials Consortium .................................................................................................................. 5
  - Organizations with PROTEUS-Trials Participants* .................................................................................. 5
  - The PROTEUS-Trials Consortium’s Objective .......................................................................................... 6
- PRO Tools for PROTEUS-Trials .................................................................................................................... 6
- The PROTEUS-Trials Roadmap ..................................................................................................................... 7
- References ..................................................................................................................................................... 8

**Chapter 2. Writing PRO Protocols** ........................................................................................................... 9

- Why is This Resource Needed? .................................................................................................................... 10
- Objective of the Resource ............................................................................................................................. 10
- Methods for Resource Development ......................................................................................................... 10
- Overview of the SPIRIT-PRO Guidance ...................................................................................................... 11
- SPIRIT-PRO items by Protocol Sections ...................................................................................................... 12
  - Administrative Information & Introduction ............................................................................................... 12
  - Methods: Participants, Interventions, and Outcomes ................................................................................. 13
  - Methods: Data Collection, Management, and Analysis .............................................................................. 15
  - Methods: Monitoring ................................................................................................................................. 20
- Implications of Using SPIRIT-PRO Guidance .............................................................................................. 21
- Checklist for the SPIRIT-PRO Protocol Guidance .................................................................................... 22
- References ..................................................................................................................................................... 24
- Further Reading ............................................................................................................................................ 24

**Chapter 3. Selecting PRO Measures** ....................................................................................................... 25

- Why is This Resource Needed? .................................................................................................................... 26
- Objective of Resource .................................................................................................................................. 26
- Methods for Resource Development ......................................................................................................... 27
- Summary of Recommendations .................................................................................................................... 27
  - Conceptual and Measurement Model ...................................................................................................... 28
  - Reliability .................................................................................................................................................. 28
<table>
<thead>
<tr>
<th>Chapter 4. Analyzing PRO Data</th>
<th>34</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why is This Resource Needed?</td>
<td>35</td>
</tr>
<tr>
<td>Methods for Resource Development</td>
<td>35</td>
</tr>
<tr>
<td>SISAQOL Recommendations</td>
<td>36</td>
</tr>
<tr>
<td>Overview</td>
<td>36</td>
</tr>
<tr>
<td>Taxonomy of Research Objectives</td>
<td>36</td>
</tr>
<tr>
<td>Statistical Methods</td>
<td>37</td>
</tr>
<tr>
<td>Missing Data</td>
<td>37</td>
</tr>
<tr>
<td>Implications of Using the SISAQOL Guidance</td>
<td>38</td>
</tr>
<tr>
<td>Checklist for the SISAQOL Analysis Guidance for Clinical Trials</td>
<td>39</td>
</tr>
<tr>
<td>References</td>
<td>43</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 5. Reporting PRO Findings</th>
<th>44</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why is This Resource Needed?</td>
<td>45</td>
</tr>
<tr>
<td>CONSORT PRO Summary of Reporting Guidance</td>
<td>45</td>
</tr>
<tr>
<td>Why We Need PRO Reporting Guidance</td>
<td>45</td>
</tr>
<tr>
<td>Objective of Resource</td>
<td>46</td>
</tr>
<tr>
<td>Methods for Resource Development</td>
<td>46</td>
</tr>
<tr>
<td>CONSORT PRO Reporting Guidance</td>
<td>47</td>
</tr>
<tr>
<td>Overview</td>
<td>47</td>
</tr>
<tr>
<td>CONSORT PRO Extensions and Elaborations</td>
<td>47</td>
</tr>
<tr>
<td>Implications of Using CONSORT PRO Guidance</td>
<td>51</td>
</tr>
<tr>
<td>Checklist for the CONSORT PRO Reporting Guidance</td>
<td>52</td>
</tr>
<tr>
<td>References</td>
<td>53</td>
</tr>
<tr>
<td>Further Reading</td>
<td>53</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 6. Graphically Displaying PRO Data</th>
<th>54</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why is This Resource Needed?</td>
<td>55</td>
</tr>
<tr>
<td>Objective of Resource</td>
<td>55</td>
</tr>
<tr>
<td>Methods for Resource Development</td>
<td>56</td>
</tr>
</tbody>
</table>
Parameters for Recommendations ................................................................. 56

Overview of PRO Data Display Recommendations .................................... 56
  Directionality ......................................................................................... 57
  Conveying Score Meaning ................................................................... 59
  Normed Scoring .................................................................................. 60
  Clinically Important Differences ......................................................... 62
  Conveying Statistical Significance (for clinicians and researchers only) .. 63
  Proportions Changed .......................................................................... 65

Checklist for PRO Data Display: Research Results Presented to Patients .......... 68
Checklist for PRO Data Display: Research Results Presented to Clinicians/Researchers ................................................................. 69
References ............................................................................................... 70
Further Reading ...................................................................................... 70

Chapter 7. Interpreting PRO Papers ............................................................. 71

Why is This Resource Needed? .................................................................. 72
Objective of Resource ............................................................................... 72
Methods for Resource Development ....................................................... 72

Clinician’s Checklist to Evaluate Studies Using PROs .............................. 72
  1. Was the PRO assessment strategy appropriate? ............................... 73
  2. Did they measure PROs effectively? ............................................... 74
  3. Should I believe the results? .............................................................. 74
  4. Were the results placed in a clinical context? ................................. 75
  5. Do the results apply to my patients? ................................................. 76

Checklist for Clinicians for Evaluating Studies with PROs ....................... 77
References ............................................................................................... 78
Further Readings ...................................................................................... 78

Acknowledgements .................................................................................. 79

The SPIRIT-PRO Group ........................................................................... 79
The ISOQOL Scientific Advisory Task Force (SATF) ............................... 80
The SISAQOL Consortium ..................................................................... 81
CONSORT-PRO ..................................................................................... 82
PRO Graphical Display ........................................................................... 83
Clinician Checklist .................................................................................. 84
PROTEUS-Trials Leadership Team

Principal Investigators
Claire Snyder, PhD
Dr. Claire Snyder is a PhD outcomes and health services researcher and a Professor of Medicine, Oncology, and Health Policy & Management at the Johns Hopkins School of Medicine and Bloomberg School of Public Health.

Michael Brundage, MD, MSc
Dr. Michael Brundage is a practicing radiation oncologist and Director of Cancer Care and Epidemiology at the Queen’s Cancer Research Institute in Kingston, Ontario, Canada.

Project Manager
Norah Crossnohere, PhD
Dr. Norah Crossnohere is a PhD patient-centered outcomes researcher and a Research Scientist at the Ohio State University College of Medicine.
Steering Committee

Andrew Bottomley, PhD
European Organization for the Research and Treatment of Cancer

Melanie Calvert, PhD
University of Birmingham

Madeleine King, PhD
University of Sydney

Bryce Reeve, PhD
Duke University
School of Medicine

Albert Wu, MD, MPH
Johns Hopkins
Bloomberg School of Public Health

Elissa Thorner, MHS
Patient Advocate

Funding

PROTEUS-Trials has received funding from the Patient-Centered Outcomes Research Institute and an unrestricted grant from Genentech.
Chapter 1. Introduction to Patient-Reported Outcomes and PROTEUS-Trials

Types of Clinical Outcomes Assessment

There are four types of clinical outcomes assessments according to U.S. Food and Drug Administration (FDA) (2009):

1. Patient-reported outcomes (PROs) – reports about a health condition or its treatment that come directly from the patient, without interpretation by a clinician or anyone else
   
   *Examples*: global impression, functional status, well-being, symptoms, health-related quality of life

2. Clinician-reported outcomes (ClinROs) – a clinician rates outcomes such as toxicity or disease severity
   
   *Examples*: treatment toxicity, disease severity

3. Observer-reported outcomes (ObsROs) – someone such as a family member or informal caregiver may report on observable outcomes
   
   *Examples*: seizure frequency, surgical scar appearance

4. Performance-based outcomes (PerfOs) – involve performance of standardized tasks, such as a treadmill test
   
   *Examples*: treadmill exercise test, cognition, and attention

These different kinds of clinical outcomes complement other measures, such as laboratory assessments, for example prostate-specific antigen tests, and imaging studies, such as CT or PET scans.
Patient-Reported Outcomes (PROs)

PROTEUS-Trials is focused on patient-reported outcomes (PROs) specifically.

How are Patient Perceptions ‘Measured’?

To measure PROs, and for all the clinical outcomes, standardization is critical. Great care must be taken in developing the questions, response options, and scoring algorithms during the development of PRO questionnaires (also called ‘tools’ and ‘measures’). Here are some points to consider:

- Ask a standard set of questions
- Provide a standard set of response options
- Allocate numbers to those response options in a standard way
- Use a standard analysis and reporting algorithm

Example: Physical Function Measure

As an example, this is the physical function domain of a commonly used cancer questionnaire, the EORTC-QLQ-C30. This particular patient has quite a bit of difficulty doing strenuous activities, a little difficulty doing moderate activities, and no difficulty at all doing activities of daily living. When you go through the scoring algorithm, this patient’s score is 60.

<table>
<thead>
<tr>
<th>Example: Physical Function</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>1. Do you have trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase?</td>
</tr>
<tr>
<td>2. Do you have any trouble taking a long walk?</td>
</tr>
<tr>
<td>3. Do you have any trouble taking a short walk outside of the house?</td>
</tr>
<tr>
<td>4. Do you need to stay in bed or chair during the day?</td>
</tr>
<tr>
<td>5. Do you need help with eating, dressing, washing yourself, or using the toilet?</td>
</tr>
</tbody>
</table>

The question is how we determine which questions to ask of patients, what the appropriate analytic approach is, and how best to report this information to patients, clinicians, and other decision-makers so that PRO data are most useful in research and practice.
The PROTEUS-Trials Consortium

PROTEUS stands for Patient-Reported Outcomes Tools: Engaging Users and Stakeholders.

The PROTEUS-Trials Consortium aims to ensure that patients, clinicians, and other decision-makers have high quality PRO data from clinical trials so that they can make the best possible decisions about treatment options.

To achieve this objective, we are partnering with key stakeholder groups to disseminate and implement tools that have been developed to optimize the use of PROs in clinical trials.

Organizations with PROTEUS-Trials Participants*

The PROTEUS-Trials Consortium includes research and methods groups, government and regulatory bodies, research funders, patient and clinician advocacy organizations, and the cooperative groups that conduct clinical trials. PROTEUS-Trials has a particular focus on cancer research, but many of the tools and resources also apply beyond cancer.

These are the 27 organizations with PROTEUS-Trials Consortium participants:

| AcademyHealth | Industry (GlaxoSmithKline) |
| American Cancer Society | International Society for Quality of Life Research |
| American Society of Clinical Oncology | ISPOR |
| American Society of Radiation Oncology | Medical journal editors |
| Australian Clinical Trials Alliance | Medicines and Healthcare Products Regulatory Agency |
| Canadian Association of Radiation Oncology | National Cancer Institute |
| Cancer Australia | National Cancer Research Institute (UK) |
| Consolidated Standards for Reporting of Trials (CONSORT) | National Clinical Trials Network PRO representatives |
| Critical Path Institute PRO Consortium | National Coalition for Cancer Survivorship |
| European Medicines Agency-Scientific Advice Working Party / Dutch Medicines Evaluation Board | National Institute for Health and Care Excellence |
| European Organization for the Research and Treatment of Cancer (EORTC) | Oncology Nursing Society |
| Food & Drug Administration (FDA) | Patient-Centered Outcomes Research Institute |
| Health Canada | Society for Clinical Trials |
| | Standard Protocol Items: Recommendations for Interventional Trials (SPIRIT) |

*Participation in PROTEUS-Trials does not imply endorsement of any PRO tools or guidance documents
The PROTEUS-Trials Consortium’s Objective

In order for patients, clinicians, and other decision-makers to have high-quality PRO data from clinical trials, research studies need to use a SMART approach:

- **Specify** the PRO methods appropriately
- **Measure** the PROs effectively
- **Analyze** the PRO data properly
- **Report** the PRO results clearly
- **Translate** the PRO findings in practice

PRO Tools for PROTEUS-Trials

A number of tools have been developed to provide guidance on how to meet the above objectives. Each of these tools guides different aspects of clinical trial design, execution, reporting, and implementation.

<table>
<thead>
<tr>
<th>PURPOSE</th>
<th>TOOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Writing PRO protocols</td>
<td>Standard Protocol Items: Recommendations for Interventional Trials-PRO Extension (SPIRIT-PRO)</td>
</tr>
<tr>
<td>Selecting PRO measures</td>
<td>ISOQOL Minimum Standards for PRO Measures in Patient-Centered and Comparative Effectiveness Research</td>
</tr>
<tr>
<td>Analyzing PRO data</td>
<td>Setting International Standards in Analyzing Patient-Reported Outcomes and Quality of Life Endpoints Data (SISAQOL) Consortium</td>
</tr>
<tr>
<td>Reporting PRO findings</td>
<td>Consolidated Standards of Reporting Trials-PRO Extension (CONSORT-PRO)</td>
</tr>
<tr>
<td></td>
<td>Stakeholder-Driven, Evidence-Based Standards for Presenting PROs in Clinical Practice</td>
</tr>
<tr>
<td>Interpreting PRO papers</td>
<td>Clinicians Checklist for Reading and Using an Article about PROs</td>
</tr>
</tbody>
</table>

Each of these tools will be discussed in detail in succeeding chapters of this handbook.
The PROTEUS-Trials Roadmap

The PROTEUS-Trials Roadmap provides an overview of the six PROTEUS-Trials tools. Collectively, these tools aim to enable PRO aspects of protocol development, trial accrual and follow-up, analysis, reporting, and clinical uptake of the trial findings.

Implementing these tools will assist clinical trials in providing high quality PRO evidence to inform clinical decision-making and health services policy development.
References


Please Note: When referencing information included in this Chapter, we recommend citing the primary sources rather than this Handbook.
Chapter 2. Writing PRO Protocols

Standard Protocol Items: Recommendations for Interventions Trials-PRO Extension (SPIRIT-PRO)

The SPIRIT-PRO Extension recommends best practices for writing the PRO aspects of randomized controlled trial protocols. It is an extension of the general 2013 Standard Protocol Items: Recommendations for Interventional Trials (SPIRIT) guidance that identified the minimum elements required in clinical trial protocols, generally (Chan et al., 2013). The SPIRIT-PRO Extension builds on the general SPIRIT guidance by addressing the minimum elements related to PROs that should be included in clinical trial protocols.

References

Acknowledgements
Why is This Resource Needed?

To ensure that critical aspects of the PRO study are included in the protocol for successful conduct

Recommends items to address in clinical trial protocols where PROs are primary or key secondary outcomes

Patient-reported outcome (PRO) data from clinical trials can provide valuable evidence to inform shared decision making, labeling claims, clinical guidelines, and health policy; however, the PRO content of clinical trial protocols is often suboptimal. Although the SPIRIT (Standard Protocol Items: Recommendations for Intervventional Trials) statement was published in 2013 to improve the completeness of trial protocols by providing evidence-based recommendations for the minimum set of items to be addressed, it does not provide PRO-specific guidance.

Objective of the Resource

To provide international, consensus-based, PRO-specific protocol guidance: an official SPIRIT-PRO extension.

Methods for Resource Development

The SPIRIT-PRO Extension was developed through a systematic review of existing PRO-specific protocol guidance, a stakeholder survey of a group of international experts, and a Delphi exercise and consensus meeting, followed by consultation on the final SPIRIT-PRO Extension.
Overview of the SPIRIT-PRO Guidance

- To be used in conjunction with the SPIRIT 2013 Statement and related extensions
- 5 elaborations on existing SPIRIT 2013 checklist items as applied to PROs in trial protocols
- 11 extensions – additional PRO-specific items recommended for trial protocols where PROs are a primary or important secondary outcome

The SPIRIT-PRO guidance constitutes an extension to the SPIRIT 2013 statement that guides the reporting of various parts of the trial protocol sections. The key items relevant to the reporting of PROs include the following:

**Introduction**
- Describe PRO-specific research question, rationale, and relevant previous findings
- State PRO-specific objectives or hypotheses (including relevant PRO concepts/domains)

**Methods – Participants, Interventions, Outcomes**
- Specify any PRO-specific eligibility criteria
- Specify the PRO concepts/domains used to evaluate the intervention and related analysis metric

**Methods – Data Collection, Management and Analysis**
- Describe the PRO measure and its psychometric characteristics
- Include a data collection plan (e.g., time points, mode, setting)
- Specify language versions available
- State and justify use of proxy reporting, if relevant
- Specify strategies to minimize missing data and address missing data in analysis

**Harms**
- State whether PRO data will be monitored to inform clinical care

The specific elaborations and extensions are detailed below.
SPIRIT-PRO items by Protocol Sections

Administrative Information & Introduction

SPIRIT-PRO Elaboration Item 5a – Roles & Responsibilities

**SPIRIT 2013:**
Names, affiliations, and roles of protocol contributors.

**PRO Elaboration 2018:**
Specify the individual(s) responsible for the PRO content of the trial protocol.

**Explanation:**
Providing information (e.g., name, affiliation, contact details) on expert on PRO-specific aspects of the trial protocol promotes transparency and accountability and identifies the appropriate point of contact for resolution of any PRO-specific queries. When patients have actively contributed to this process, this should be documented as per recent guidance for the reporting of patient and public involvement.

SPIRIT-PRO Extension Item 6a – Background and Rationale

**SPIRIT 2013:**
Description of research question and justification for undertaking the trial, including summary of relevant studies (published and unpublished) examining benefits and harms for each intervention.

**PRO Extension 2018:**
Describe the PRO specific research question and rationale for PRO assessment, and summarize PRO findings in relevant studies.

**Explanation:**
A clearly defined question helps with selection of measures and specification of hypotheses and analyses. Many trials include PROs without specifying the PRO-specific research question and a rationale or any reference to PROs in related studies. Staff and patients may not understand why PROs are being assessed, and missing data may result. When the PRO is a secondary outcome, a brief rationale may be adequate.
SPIRIT-PRO Extension Item 7 – Objectives

**SPIRIT 2013:**
Specific objectives or hypotheses.

**PRO Extension 2018:**
State specific PRO objectives or hypotheses (including relevant PRO concepts/domains).

**Explanation:**
PRO measures may be multidimensional (e.g., health-related quality of life) or unidimensional (e.g., specific symptoms such as pain). Pre-specification of objectives and hypotheses encourages identification of key PRO domains and time points, reducing the risk of multiple statistical testing and selective reporting of PROs based on statistically significant results.

**Methods: Participants, Interventions, and Outcomes**

SPIRIT-PRO Extension Item 10 – Eligibility Criteria

**SPIRIT 2013:**
Inclusion and exclusion criteria for participants. If applicable, eligibility criteria for study centers and individuals who will perform the interventions (e.g., surgeons, psychotherapists).

**PRO Extension 2018:**
Specify any PRO-specific eligibility criteria (e.g., language/reading requirements or pre-randomization completion of PRO). If PROs will not be collected in the entire study sample, provide a rationale and describe the method for obtaining the PRO subsample.

**Explanation:**
Any PRO-specific eligibility criteria should be considered at the design stage of the trial and clearly specified in the protocol. In large trials, sufficient power may be achieved by collecting PROs from a representative subset of participants, while in some trials it may not be possible to collect PROs in the entire population (e.g., because validated questionnaires may not be available in all languages); in such instances, the rationale for the sampling method should be described.
SPIRIT-PRO Extension Item 12 – Outcomes

**SPIRIT 2013:**
Primary, secondary, and other outcomes, including the specific measurement variable (e.g., systolic blood pressure), analysis metric (e.g., change from baseline, final value, time to event), method of aggregation (e.g., median, proportion), and time point for each outcome. Explanation of the clinical relevance of chosen efficacy and harm outcomes is strongly recommended.

**PRO Extension 2018:**
Specify the PRO concepts/domains used to evaluate the intervention (e.g., overall health-related quality of life, specific domain, specific symptom) and, for each one, the analysis metric (e.g., change from baseline, final value, time to event) and the principal time point or period of interest.

**Explanation:**
The PRO concepts/domains and time points for assessment should closely align with the trial objectives and hypotheses. Because of the risk of multiple statistical testing, the domain(s) and principal time point(s) for analyses should be specified *a priori.*

SPIRIT-PRO Extension Item 13 – Participant Timeline

**SPIRIT 2013:**
Time schedule of enrollment, interventions (including any run-ins and washouts), assessments, and visits for participants. A schematic diagram is highly recommended.

**PRO Extension 2018:**
Include a schedule of PRO assessments, and rationale for the time points. Justify if the initial assessment is not pre-randomization.

Specify time windows and whether PROs collected prior to clinical assessments.

If using multiple questionnaires, whether order of administration standardized.

**Explanation:**
Provision of an easy-to-follow schedule will assist staff and may help reduce missing data. Collecting PRO data prior to randomization helps ensure an unbiased baseline assessment, and if specified as an eligibility criterion, ensures data completeness.

This is important because baseline PRO data are often used as a covariate in analyses and are essential to calculating change from baseline. Completion of PROs prior to clinical assessments (as these may influence patient responses) and standardization of the order
of questionnaire administration are advised to help reduce measurement error. Allowable
time windows for each scheduled PRO assessment should be specified to ensure that
PRO data collection captures the effect of the clinical event(s) of interest.

SPIRIT-PRO Extension Item 14 – Sample Size

SPIRIT 2013:
Estimated number of participants needed to achieve study objectives and how it was
determined, including clinical and statistical assumptions supporting any sample size calculations.

PRO Elaboration 2018:
Where a PRO is the primary endpoint, state the required sample size (and how
it was determined) and recruitment target (accounting for expected loss to follow-up).
If sample size is not established based on PRO endpoint, then discuss the power of the principal PRO analyses.

Explanation:
The target sample size will generally be based on an a priori sample size calculation for the PRO end point. Ideally, the criteria for clinical significance (e.g., minimal important difference) should be specified if known. If PROs are a secondary end point, researchers should specify whether the sample size provides sufficient power to test the principal PRO hypotheses.

Methods: Data Collection, Management, and Analysis

SPIRIT 2013 Item 18a - Data Collection Methods

SPIRIT 2013:
Plans for assessment and collection of outcome, baseline, and other trial
data, including any related processes to promote data quality (e.g., duplicate
measurements, training of assessors) and a description of study instruments (e.g., questionnaires, laboratory tests) along with their reliability and validity, if known. Reference to where data collection forms can be found, if not in the protocol.

Four PRO Extensions 2018
(each explained below)
SPIRIT-PRO Extension Item 18a (i) – Data Collection Methods

PRO Extension (i) 2018:
Justify the PRO instrument, describe domains, number of items, recall period, instrument scaling/scoring (e.g., range and direction of scores indicating a good/poor outcome).

Evidence of PRO instrument measurement properties, interpretation guidelines, and patient acceptability/burden should be cited if available, ideally in the population of interest. State whether the measure will be used in accordance with any user manual and specify and justify deviations if planned.

Explanation:
The selection of PRO questionnaires requires careful consideration, particularly patient burden and acceptability. Questionnaires should be used in accordance with any existing user manuals to promote data quality and ensure standardized scoring, and any deviations should be described.

SPIRIT-PRO Extension Item 18a (ii) – Data Collection Methods

PRO Extension (ii) 2018:
Include a data collection plan outlining the permitted mode(s) of administration (e.g., paper, telephone, electronic, other) and setting (e.g., clinic, home, other).

Explanation:
It is important that both research personnel and trial participants understand how, when, and where PRO data will be collected in the study. If electronic PRO measures contain only minor modifications with respect to the paper-based versions, usability testing and cognitive debriefing may provide sufficient evidence of equivalence. The setting for PRO data collection should be described and standardized across trial intervention groups and sites.
SPIRIT-PRO Extension Item 18a (iii) – Data Collection Methods

**PRO Extension (iii) 2018:**

Specify whether more than one language version will be used. State whether translated versions have been developed using currently recommended methods.

**Explanation:**

Multinational trials, or national trials involving participants with different languages, require measures that have been translated and culturally adapted where needed using appropriate methodology. This may influence the selection of measure to be used because inclusion of a wide range of participants can help ensure the generalizability of trial results. Plans to use translated versions should be specified in the protocol, citing references when available.

SPIRIT-PRO Extension Item 18a (iv) – Data Collection Methods

**PRO Extension (iv) 2018:**

When the trial context requires someone other than the trial participant to answer on their behalf (a proxy reported outcome), state and justify this. Provide/cite evidence of the validity of proxy assessment if available.

**Explanation:**

In some contexts, such as trials involving young children or cognitively impaired participants, it may be necessary for someone other than a trial participant to respond on that participant’s behalf. Clear justification and specification of proxy reporting in the protocol allows external reviewers to assess potential bias and facilitates trial reporting in accordance with CONSORT-PRO. Evidence of the size and direction of proxy bias is a key aspect of the validity of proxy versions of PRO measures, informing valid interpretation, and comparison of results. The European Medicines Agency states that “in general proxy reporting should be avoided, unless the use of such proxy raters may be the only effective means of obtaining information that might otherwise be lost.” The US Food and Drug Administration also discourages the use of proxy reported outcomes to inform labeling claims, recommending observer reports instead.
SPIRIT 2013 Item 18b - Data Collection Methods

**SPIRIT 2013:**
Plans to promote participant retention and complete follow-up, including list of any outcome data to be collected for participants who discontinue or deviate from intervention protocols

**One PRO Extension & One PRO Elaboration 2018**
(see below)

PRO Extension Item 18b (i) - Data Collection Methods

**PRO Extension (i) 2018:**
Specify PRO data collection and management strategies for minimizing *avoidable* missing data.

**Explanation:**
Missing data are a particular problem for PROs for 3 reasons: 1) unlike some other trial outcomes, data cannot be obtained retrospectively beyond the time frame of interest or from medical records; 2) missing data reduce the effective sample size hence *power* for PRO analyses; 3) importantly – they are a potentially significant source of bias. Why? Because participants with the poorest outcomes in a trial often are those who do not complete planned PRO assessments.

It is important to note that not all missing PRO data are avoidable: patients have the right to decide not to complete questionnaires, which may happen if they feel too unwell. Common reasons for *avoidable* missing PRO data are administrative errors, lack of explanation of the importance of PRO data, and overly burdensome questionnaires. Addressing these in the protocol should help minimize avoidable missing data.

A key part of a management strategy for minimizing avoidable missing data is a plan to collect reasons for missed assessments and to review these reasons during trial conduct. Information about the rates of and reasons for missing data are also valuable during analysis and write-up, as explained in chapters 4 and 5.

A recent systematic review provides a range of design, implementation, and reporting strategies to help minimize and address missing PRO data. Examples of protocol content include ensuring that PRO end points and hypotheses are clearly defined and scientifically compelling, providing a rationale for PRO assessment, clearly specifying the PRO assessment time points, defining acceptable PRO assessment time windows, aligning PRO assessment time points to clinic visits (if clinically informative), minimizing patient burden, and specifying the importance of complete PRO data.
SPIRIT-PRO Elaboration Item 18b (ii) – Data Collection Methods

PRO Elaboration (ii) 2018:
Describe the process of PRO assessment for participants who discontinue or deviate from their assigned intervention protocol.

Explanation:
A clear plan for collection of PROs for trial participants who withdraw early from a study or who discontinue the intervention helps minimize bias, ensures that staff collect all required PRO data in a standardized and timely way, and may assist ethical appraisal of the study.

SPIRIT-PRO Elaboration Item 20a – Statistical Methods

SPIRIT 2013:
Statistical methods for analyzing primary and secondary outcomes.
Reference to where other details of the statistical analysis plan (SAP) can be found, if not in the protocol.

PRO Elaboration 2018:
State PRO analysis methods including any plans for addressing multiplicity/type 1 (α) error.

Explanation:
Statistical analysis of all domains and time points implies multiple hypothesis testing, which inflates the probability of false-positive results (type I error). This can be contained by prespecifying the key PRO domain(s) or overall score of interest and the principal time point(s). Any plans to address multiplicity, such as stepwise or sequential analyses or conventional non-hierarchical methods (e.g., Bonferroni correction), should be specified a priori. The protocol should either fully address these issues or provide a summary with reference to where full details can be found (e.g., in the statistical analysis plan).
SPIRIT-PRO Elaboration Item 20c – Statistical Methods

**SPIRIT 2013:**
Definition of analysis population relating to protocol non-adherence (e.g., as randomized analysis), and any statistical methods to handle missing data (e.g., multiple imputation).

**PRO Elaboration 2018:**
State how missing data will be described and outline the methods for handling missing items or entire assessments (e.g., approach to imputation and sensitivity analyses).

**Explanation:**
There are 2 levels of missing PRO data: (1) patient completion of some but not all items within an instrument and (2) absence of the entire PRO assessment. Whether and how missing items should be imputed is usually specified in an instrument’s scoring algorithm. When entire PRO assessments are missed, analysis requires assumptions about why those data were missing (i.e., the missing data mechanism). There are a range of statistical approaches, each with specific assumptions. Common methods include complete case analysis, imputation (various approaches), a range of maximum likelihood modeling approaches, and sensitivity analysis. Inappropriate method selection may lead to potentially biased and misleading results. The protocol should acknowledge and summarize these issues, with full details provided in the statistical analysis plan.

**Methods: Monitoring**

SPIRIT-PRO Extension Item 22 – Harms

**SPIRIT 2013:**
Plans for collecting, assessing, reporting, and managing solicited and spontaneously reported adverse events and other unintended effects of trial interventions or trial conduct.

**PRO Extension 2018:**
State whether or not PRO data will be monitored during the study to inform the clinical care of trial participants.

If so, how this will be managed in a standardized way.

Describe how this process will be explained to participants, e.g., in the participant information sheet and consent form.
Explanation:
Evidence suggests that monitoring and management of PRO alerts (psychological distress or physical symptoms evident from PRO responses that may require an immediate response) vary across and within trials. To protect the interests of trial participants and minimize potential bias, it is important to specify plans for monitoring. If monitoring is not planned (for example, in a low-risk study in which alerts are not anticipated), this should also be briefly stated in the protocol, the participant information sheet, and the consent form. Alternative support mechanisms for patients should be outlined.

Implications of Using SPIRIT-PRO Guidance

Inclusion of PRO-specific protocol content will have multiple benefits:

- **Protocol writers:** Encourage and facilitate careful planning of PRO components of trials, hence improve PRO trial design
- **Protocol reviewers:** Help research ethics committees and patient partners assess the PRO elements
- **Trial staff and participants:** Help staff and patients understand the rationale for PRO assessment, improve PRO data completeness and quality
  - This in turn will facilitate high-quality analysis and reporting, and ultimately improve the quality of the global PRO evidence base
### Checklist for the SPIRIT-PRO Protocol Guidance

<table>
<thead>
<tr>
<th>Protocol Section</th>
<th>SPIRIT-PRO Item</th>
<th>Recommended Content</th>
<th>Page Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administrative Information</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roles and responsibilities</td>
<td>SPIRIT-5a-PRO Elaboration</td>
<td>Specify the individual(s) responsible for the PRO content of the trial protocol.</td>
<td></td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Background and rationale</td>
<td>SPIRIT-6a-PRO Extension</td>
<td>Describe the PRO-specific research question and rationale for PRO assessment and summarize PRO findings in relevant studies.</td>
<td></td>
</tr>
<tr>
<td>Objectives</td>
<td>SPIRIT-7-PRO Extension</td>
<td>State specific PRO objectives or hypotheses (including relevant PRO concepts/domains).</td>
<td></td>
</tr>
<tr>
<td><strong>Methods: Participants, Interventions, and Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligibility criteria</td>
<td>SPIRIT-10-PRO Extension</td>
<td>Specify any PRO-specific eligibility criteria (e.g., language/reading requirements or prerandomization completion of PRO). If PROs will not be collected from the entire study sample, provide a rationale and describe the method for obtaining the PRO subsample.</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td>SPIRIT-12-PRO Extension</td>
<td>Specify the PRO concepts/domains used to evaluate the intervention (e.g., overall health-related quality of life, specific domain, specific symptom) and, for each one, the analysis metric (e.g., change from baseline, final value, time to event) and the principal time point or period of interest.</td>
<td></td>
</tr>
<tr>
<td>Participant timeline</td>
<td>SPIRIT-13-PRO Extension</td>
<td>Include a schedule of PRO assessments, providing a rationale for the time points, and justifying if the initial assessment is not prerandomization. Specify time windows, whether PRO collection is prior to clinical assessments, and, if using multiple questionnaires, whether order of administration will be standardized.</td>
<td></td>
</tr>
<tr>
<td>Sample size</td>
<td>SPIRIT-14-PRO Elaboration</td>
<td>When a PRO is the primary end point, state the required sample size (and how it was determined) and recruitment target (accounting for expected loss to follow-up). If sample size is not established based on the PRO end point, then discuss the power of the principal PRO analyses.</td>
<td></td>
</tr>
<tr>
<td>Protocol Section</td>
<td>SPIRIT-PRO Item</td>
<td>Recommended Content</td>
<td>Page Addressed</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Methods: Data Collection, Management, and Analysis</strong></td>
<td>Data collection methods</td>
<td>SPIRIT-18a(i)-PRO Extension</td>
<td>Justify the PRO instrument to be used and describe domains, number of items, recall period, and instrument scaling and scoring (e.g., range and direction of scores indicating a good or poor outcome). Evidence of PRO instrument measurement properties, interpretation guidelines, and patient acceptability and burden should be provided or cited if available, ideally in the population of interest. State whether the measure will be used in accordance with any user manual and specify and justify deviations if planned.</td>
</tr>
<tr>
<td></td>
<td>SPIRIT-18a(ii)-PRO Extension</td>
<td>Include a data collection plan outlining permitted mode(s) of administration (e.g., paper, telephone, electronic, other) and setting (e.g., clinic, home, other).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SPIRIT-18a(iii)-PRO Extension</td>
<td>Specify whether more than 1 language version will be used and state whether translated versions have been developed using currently recommended methods.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SPIRIT-18a(iv)-PRO Extension</td>
<td>When the trial context requires someone other than a trial participant to answer on his or her behalf (a proxy-reported outcome), state and justify the use of a proxy respondent. Provide or cite evidence of the validity of proxy assessment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SPIRIT-18b(i)-PRO Extension</td>
<td>Specify PRO data collection and management strategies for minimizing avoidable missing data.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SPIRIT-18b(ii)-PRO Elaboration</td>
<td>Describe the process of PRO assessment for participants who discontinue or deviate from the assigned intervention protocol.</td>
<td></td>
</tr>
<tr>
<td><strong>Statistical methods</strong></td>
<td>SPIRIT-20a-PRO Elaboration</td>
<td>State PRO analysis methods, including any plans for addressing multiplicity/ type I (α) error.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SPIRIT-20c-PRO Elaboration</td>
<td>State how missing data will be described and outline the methods for handling missing items or entire assessments (e.g., approach to imputation and sensitivity analyses).</td>
<td></td>
</tr>
<tr>
<td><strong>Methods: Monitoring</strong></td>
<td>Harms</td>
<td>SPIRIT-22-PRO Extension</td>
<td>State whether or not PRO data will be monitored during the study to inform the clinical care of individual trial participants and, if so, how this will be managed in a standardized way. Describe how this process will be explained to participants; e.g., in the participant information sheet and consent form.</td>
</tr>
</tbody>
</table>
References


Further Reading


FDA Guidance on PROs: https://www.fda.gov/media/77832/download


Please Note: When referencing information included in this Chapter, we recommend citing the primary sources rather than this Handbook.
Chapter 3. Selecting PRO Measures

ISOQOL Minimum Standards for PRO Measures in Patient-Centered and Comparative Effectiveness Research

In 2013, the International Society for Quality of Life Research (ISOQOL) led an initiative to inform the selection of PRO measures for use in patient-centered outcomes and comparative effectiveness research by identifying minimum standards. These standards define the critical attributes of a PRO measure for these research studies.

This chapter summarizes the recommendations for selecting PRO measures for research studies.

- View ISOQOL Minimum Standards article
- View the Checklist for the ISOQOL Measure Selection Standards

References

Acknowledgements
Why is This Resource Needed?

**Why is it needed?**
- PROs must be measured in a valid, standardized way using appropriate methods to ensure valid conclusions.

**What does it do?**
- Provides guidance for selecting PRO measures for use in patient-centered and comparative effectiveness research.

- An essential aspect of patient-centered outcomes research (PCOR) and comparative effectiveness research (CER) is integration of patient perspectives and experiences about their health with clinical and biological data to evaluate the safety and effectiveness of interventions.
- Clinical trials are one kind of PCOR/CER; the ISOQOL minimum standards address PCOR/CER more broadly, but we will refer to clinical trials in this handbook.
- It is widely accepted that patients’ reports are the best source of information about what they are experiencing.
- A challenge for PCOR and CER is how to best capture patient-reported data to inform decision making in healthcare delivery, research, and policy settings.
- To draw valid research conclusions regarding patient-centered outcomes, PROs should be measured in a standardized way using appropriate methods.
- A PRO is the measurement of any aspect of a patient’s health that comes directly from them without interpretation by another.
- PROs can be symptoms (e.g., pain, anxiety, nausea, fatigue), aspects of functioning (e.g., role, physical, emotional, social) and multidimensional constructs (e.g., health-related quality of life).
- A PRO measure is the questionnaire, index, checklist, instrument, or tool, along with the algorithm used to score patient responses into summary scores for analysis and reporting.

**Objective of Resource**

The objective of the ISOQOL PRO measure selection guidance was to develop minimum standards for the design and selection of a PRO measure for use in PCOR and CER. These standards represent the minimum criteria required for a PRO measure to be judged suitable for inclusion in a PCOR or CER study. These minimum standards are intended to promote the appropriate use of PRO measures in PCOR and CER, which in turn can improve the effectiveness and efficiency of healthcare delivery.
Methods for Resource Development

An ISOQOL Scientific Advisory Task Force (SATF) was established to guide the drafting and final determination of recommended minimum standards. Based on a literature review, the SATF developed draft recommendations, which were subsequently reviewed by ISOQOL members through a formal survey. The literature review and feedback from ISOQOL members informed the final recommendations.

Summary of Recommendations

The ISOQOL PRO measure minimum standards recommends that a PRO measure should include the following attributes:

- Conceptual and measurement model
- Evidence that supports the measure’s ability to assess the concepts covered in the measurement model, such as:
  - Reliability
  - Validity
    - Content
    - Construct
    - Responsiveness
- Interpretability of scores
- Translation
- Patient and investigator burden
Conceptual and Measurement Model

The conceptual model provides a description of and framework for the targeted concept(s) to be included in a PRO measure. The measurement model maps the individual items in the PRO measure to the concept(s).

- A PRO measure should have documentation defining and describing the concept(s) included and the intended population(s) for use
- There should be documentation of how the concept(s) are organized into a measurement model, including evidence for the dimensionality of the measure, how items relate to each measured concept, and the relationship among concepts included in the PRO measure

Reliability

Reliability is the degree to which a PRO measure is free from measurement error.

There are two types of reliability relevant for PRO measures:

1. **Internal consistency (for multi-item scales)**

   Internal consistency reliability is the degree of the interrelatedness among the items in a multi-item PRO measure. The internal consistency reliability of a PRO measure should preferably be at or above 0.70 for group-level comparisons, but may be lower if appropriately justified.

2. **Test-retest**

   Test-retest reliability is a measure of the reproducibility of the scale, that is, the ability to provide consistent scores over time in a stable population. However, some populations studied in PCOR are not stable and their health-related quality of life can fluctuate. This phenomenon would reduce estimates of test–retest reliability, making the PRO measure look unreliable when it may be accurately detecting changes over time.

Validity

Validity is the extent to which a PRO scale measures what it purports to measure.

There are multiple types of validity; the more frequently assessed types for PRO measures are:

1. **Content Validity**

   Content validity is the extent to which the PRO measure includes the most relevant and important aspects of a concept in the context of a given measurement application.
A PRO measure should have evidence supporting its content validity, including evidence that patients and experts considered the content of the PRO measure relevant and comprehensive for the concept, population, and aim of the measurement application.

This includes documentation of:

a. qualitative and/or quantitative methods used to solicit and confirm the attributes (i.e., concepts measured by the items) of the PRO measure relevant to the measurement application
b. the characteristics of the participants included in the evaluation (e.g., race/ethnicity, culture, age, gender, socio-economic status, literacy level) with an emphasis on similarities or differences with respect to the target population
c. justification for the recall period for the measurement application

2. Construct Validity

Construct validity is the degree to which scores on the PRO measure relate to other measures (e.g., patient-reported or clinical indicators) in a manner that is consistent with theoretically derived a priori hypotheses concerning the concepts that are being measured.

A PRO measure should have evidence supporting its construct validity, including documentation of empirical findings that support predefined hypotheses on the expected associations among measures similar or dissimilar to the concepts measured by the PRO measure.

Types of construct validity:

a. Structural Validity
   - extent to which the empirical data support the conceptual model
b. Convergent Validity
   - extent to which the PRO measure is similar to other established measures assessing the same concept
c. Discriminant Validity
   - extent to which the PRO measure is dissimilar to other established measures measuring different concepts
d. Known Groups Validity
   - extent to which the PRO measure can differentiate between groups known to differ on the measured concept
3. Responsiveness

Responsiveness is the extent to which a PRO measure can detect changes in the construct being measured over time. A PRO measure for use in longitudinal research studies should have evidence of responsiveness, including empirical evidence of changes in scores consistent with predefined hypotheses regarding changes in the measured PRO in the target population for the research application.

Interpretability of Scores

A PRO measure should have documentation to support interpretation of scores, including what low and high scores represent for the measured concept(s). Knowing what comprises a meaningful difference or change in the score from one group to another (or one time to another) improves understanding of the outcome being measured. Another way to enhance the interpretability of PRO measure scores involves comparing scores from a study to known scores in a population (e.g., the general US population or a specific disease population). The availability of such benchmarks improves understanding of how the study group scored as compared to some reference or normative group.

Translation of the PRO Measure

PCOR and CER are often carried out in multi-national or multi-cultural settings that require the PRO measure to be translated into different languages. To be able to compare or combine PRO results across those groups, it is critical that the measured concepts and PRO measure wording is interpreted in the same way across translations.

A PRO measure translated to one or more languages should have documentation of the methods used to translate and evaluate the PRO measure in each language. Established international guidance for the linguistic and cross-cultural adaptation of PRO measures should be followed. It is important that not only the words, but also the concepts, are applicable and interpretable across cultural settings. Studies should at least include evidence from forward and backward translations and qualitative methods (e.g., cognitive testing) with the target population to evaluate the translations.

Patient and Investigator Burden

A PRO measure must not be overly burdensome for patients or investigators. The length of the PRO measure should be considered in the context of other PRO measures included in the assessment. How often the PRO measure is administered in the clinical research study should also be considered. Lastly, the literacy demand of the items in the PRO measure should be at a 6th grade education level or lower (i.e., 12 year old or lower) to be acceptable; however, it should be appropriately justified for the context of the proposed application.
## Checklist for the ISOQOL Measure Selection Standards

<table>
<thead>
<tr>
<th>Minimum Standard</th>
<th>Explanation</th>
<th>Notes/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Conceptual and measurement model</strong></td>
<td>A PRO measure should have documentation defining and describing the concept(s) included and the intended population(s) for use. In addition, there should be documentation of how the concept(s) are organized into a measurement model, including evidence for the dimensionality of the measure, how items relate to each measured concept, and the relationship among concepts included in the PRO measure.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Reliability</strong></td>
<td>The reliability of a PRO measure should preferably be at or above 0.70 for group-level comparisons, but may be lower if appropriately justified. Reliability can be estimated using a variety of methods including internal consistency reliability, test–retest reliability, or item response theory. Each method should be justified.</td>
<td></td>
</tr>
</tbody>
</table>
| **3. Validity** | A PRO measure should have evidence supporting its content validity, including evidence that patients and experts consider the content of the PRO measure relevant and comprehensive for the concept, population, and aim of the measurement application. This includes documentation of:  
   (1) qualitative and/or quantitative methods used to solicit and confirm attributes (i.e., concepts measured by the items) of the PRO relevant to the measurement application  
   (2) the characteristics of participants included in the evaluation (e.g., race/ethnicity, culture, age, gender, socio-economic status, literacy level) with an emphasis on similarities or differences with respect to the target population  
   (3) justification for the recall period for the measurement application |  |
<p>| <strong>3a Content validity</strong> |  |  |
| <strong>3b Construct validity</strong> | A PRO measure should have evidence supporting its construct validity, including documentation of empirical findings that support predefined hypotheses on the expected associations among measures similar or dissimilar to the measured PRO. |  |</p>
<table>
<thead>
<tr>
<th>Minimum Standard</th>
<th>Explanation</th>
<th>Notes/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3c Responsiveness</td>
<td>A PRO measure for use in longitudinal research studies should have evidence of responsiveness, including empirical evidence of changes in scores consistent with predefined hypotheses regarding changes in the measured PRO in the target population for the research application.</td>
<td></td>
</tr>
<tr>
<td>4. Interpretability of scores</td>
<td>A PRO measure should have documentation to support interpretation of scores, including what low and high scores represent for the measured concept.</td>
<td></td>
</tr>
<tr>
<td>5. Translation of the PRO measure</td>
<td>A PRO measure translated to one or more languages should have documentation of the methods used to translate and evaluate the PRO measure in each language. Studies should at least include evidence from qualitative methods (e.g., cognitive testing) to evaluate the translations.</td>
<td></td>
</tr>
<tr>
<td>6. Patient and investigator burden</td>
<td>PRO measures must not be overly burdensome for patients or investigators. The length of the PRO measure should be considered in the context of other PRO measures included in the assessment, the frequency of PRO data collection, and the characteristics of the study population. The literacy demand of the items in the PRO measure should usually be at a 6th grade education level or lower (i.e., 12-year-old or lower); however, it should be appropriately justified for the context of the proposed application.</td>
<td></td>
</tr>
</tbody>
</table>
References


Further Reading


Please Note: When referencing information included in this Chapter, we recommend citing the primary sources rather than this Handbook.
Chapter 4. Analyzing PRO Data

Setting International Standards in Analysing Patient-Reported Outcomes and Quality of Life Endpoints Data (SISAQOL) Consortium

The European Organization for the Research and Treatment of Cancer (EORTC) formed the SISAQOL Consortium to set international standards in analyzing patient-reported outcomes and quality of life data from cancer clinical trials. SISAQOL provides a taxonomy of research objectives, outlines appropriate statistical methods for these objectives, and advises on handling missing data. Although SISAQOL focused on cancer clinical trials, many issues discussed here may also be applied to other health conditions, which warrants further scrutiny.

This chapter summarizes the preliminary SISAQOL recommendations; work is continuing via the SISAQOL-IMI initiative.

View SISAQOL Standards article
View the Checklist for the SISAQOL Analysis Guidance for Clinical Trials

References
Acknowledgements
Why is This Resource Needed?

To ensure a consistent and methodologically appropriate PRO data analysis

Recommend statistical approaches for analyzing PRO data

PRO data have unique properties compared to other clinical trial data.

- Multidimensional – composed of different domains yielding multiple outcomes
- Longitudinal – data are collected repeatedly over time
- Missing data – occurs more frequently and have stronger clinical implications due to voluntary patient participation

Major hurdles in applying standardized statistical methods are:

- Unclear PRO objectives
- Inconsistent terminology

Methods for Resource Development

The SISAQOL Consortium was established from a group of international stake-holders experienced with PROs in cancer clinical trials to develop international consensus recommendations on the analysis of PRO data. The initial SISAQOL recommendations are based on discussions with stakeholder groups and (systematic) literature reviews of PRO analysis in cancer clinical trials. Four working groups were assembled: (1) research objectives, (2) statistical methods, (3) standardization of statistical terms, and (4) management of missing data. Final outputs from each working group were used as proposed statements for the SISAQOL recommendations. A consensus meeting was held to ratify the proposed recommendation statements, which informed the final SISAQOL recommendations.
SISAQOL Recommendations

Overview

The recommendations made by SISAQOL fall into three main categories: Taxonomy of research objectives, statistical methods, and missing data. It is important to note that the SISAQOL work is currently ongoing with SISAQOL-IMI and these recommendations will be updated in the future. The recommendations below are based on the initial SISAQOL work published in Lancet Oncology by Coens, Pe et al. (2020).

Taxonomy of Research Objectives

The first of these are recommendations regarding the research objectives. When developing a PRO objective, the PRO domain(s) and time frame of interest should be pre-specified. Additionally, four key attributes need to be considered when developing a PRO objective so that it can be aligned with an appropriate statistical method:

- **Broad PRO research objectives:** What is the overall goal of including PROs in the RCT? Is it to demonstrate treatment efficacy/clinical benefit (confirmatory)? Or is the goal to describe patient perspective, without drawing strong conclusions about treatment efficacy/clinical benefit (exploratory/descriptive)?

- **Between-arm PRO objective:** For a treatment efficacy/clinical benefit (confirmatory) objective, is the goal to demonstrate that the treatment arm is superior to the reference arm? Or is the goal to demonstrate that the treatment arm is equivalent or non-inferior to the reference arm? Note that a non-significant superiority result should not be interpreted as evidence of equivalence or non-inferiority.

- **Within-treatment group assumption:** What is the assumption regarding how patients will report their experience in this trial? Will patients improve, worsen, or remain stable relative to their baseline (e.g., before randomization)? Or are there no assumptions (i.e., overall effect)?
• **Within-patient/within-treatment PRO objective**: What kind of PRO endpoint will be meaningful for this trial? Is it a *time to event, magnitude of change* at a specific time point, *responder* at a specific time point, or other?

For more detail, please refer to the [Checklist for the SISAQOL Analysis Guidance for Clinical Trials](#).

**Statistical Methods**

The second category of SISAQOL recommendations relates to aligning the *appropriate statistical methods* with the research objective. Since there is no single analysis method that can address all clinical trial design and analytical concerns, set criteria to evaluate what *appropriate* statistical methods for a given PRO objective are needed.

Two essential statistical properties are:

- The ability to perform a comparative test (statistical significance)
- The ability to produce interpretable treatment effect estimates (clinical relevance)

Highly desirable criteria include:

- The ability to adjust for covariates, including baseline PRO score
- Handling missing data with the least restrictions
- Handling clustered data (repeated assessments)

These criteria informed the selection of specific statistical methods for each PRO objective. It should be noted that these recommendations are under further development as part of the SISAQOL-IMI initiative.

For more detail, please refer to the [Checklist for the SISAQOL Analysis Guidance for Clinical Trials](#).

**Missing Data**

Finally, recommendations are provided for dealing with *missing PRO data*. To evaluate the extent of missing data, the PRO analysis population and missing data rates should be reported in a standardized way. Additionally, managing missing data, including collecting reasons for missing data, is critical to minimize the potential bias of the trial findings.

For more detail, please refer to the [Checklist for the SISAQOL Analysis Guidance for Clinical Trials](#).
Implications of Using the SISAQOL Guidance

- Improved PRO analysis in clinical trials will enable robust evidence to inform patient choice, aid clinical decision making, and inform policy
- Clear PRO objectives should be specified at the study design phase
  - Consider design in relation to SPIRIT-PRO Initiative
- More standardized PRO analysis will lead to easier and better cross-trial comparison of PRO results, improving the value of such outcomes
  - Standardization recommendations still ongoing as part of SISAQOL-IMI
- Foster better collaboration and understanding between clinicians, patients, and methodologists on statistical analysis and interpretation
- Better PRO analysis will facilitate high-quality reporting, including clear and comprehensible description of the methods used
  - Consider reporting in relation to CONSORT-PRO
### Checklist for the SISAQOL Analysis Guidance for Clinical Trials

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Recommended content</th>
<th>Notes/ comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 1: General Considerations</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| For each PRO scale or domain to be analyzed, specify *a priori* whether the research objectives are: | - **Confirmatory** *(see Part 2a below)*  
  - The broad goal is typically to demonstrate treatment efficacy or clinical benefit by providing formal comparative conclusions between treatment groups  
  - *An a priori* hypothesis is needed  
  - Statistical testing is required, so correction for multiple testing is needed  
  - Conclusions regarding comparisons between treatment arms are possible | |
| | - **Exploratory/descriptive** *(see Part 2b below)*  
  - The broad goal is typically to describe the patient perspective or to explore the PRO data and use its findings to inform future studies. These outcomes cannot be used to draw comparative conclusions or used as support for treatment efficacy or clinical benefit  
  - *No a priori* hypothesis needed  
  - *No* statistical comparisons between treatment arms  
  - Multiple testing is not an issue | |
| | - Regardless of the research objective, **missing data** needs to be addressed *(see Part 3 below)* | |
| | - For all statistical models, **assumptions** should be checked and must hold *(see Coens et al, 2020)* | |
| If applicable, specify the within-patient/within-treatment assumption and relevant endpoint for each PRO domain or item of interest | - When within-group assumption is **improvement/worsening**:  
  - Time to improvement/worsening  
  - Magnitude of improvement/worsening at time $t$  
  - Proportion of responders with improvement/worsening at time $t$  
 - When within-group assumption is **time to (end of) maintenance**:  
  - Time to (end of) maintenance  
  - Proportion of responders with maintenance at time $t$  
 - When within-group assumption is **overall effect**:  
  - Overall PRO score over time  
  - Response patterns/profiles | |
<table>
<thead>
<tr>
<th>Consideration</th>
<th>Recommended content</th>
<th>Notes/comments</th>
</tr>
</thead>
</table>
| Clearly differentiate the ITT population, the PRO study population, and the PRO analysis population | - **Intent-to-treat (ITT) population:** all patients randomized to the allocated treatment  
  - **PRO study population:** all patients who consented and were eligible to participate in the PRO data collection (ideally but not necessarily the same as the ITT population)  
  - **PRO analysis population:** patients included in the primary PRO analysis; should be as close as possible to the PRO study population; exists only in relation to a defined PRO analysis |                                                                                      |

**Part 2a: CONFIRMATORY Research Objectives**

| Specify one of the following between-arm objectives for each PRO domain or item of interest | - **Superiority** of the experimental arm relative to the control arm  
  - **Equivalence** of the trial arms  
  - **Non-inferiority** of the trial arms |                                                                                      |

**Recommended statistical models**

| For **time-to-event** objectives: improvement, (end of) stable state, or worsening | - Cox proportional hazards models are recommended                                                                 |                                                                                      |
| For **magnitude-of-event** at time $t$ objectives: improvement or worsening | - If design is baseline + more than 1 follow-up: linear mixed models (time as discrete) are recommended  
  - If design is baseline + 1 follow-up only: linear regression is recommended  
  Note: Caution is needed because many statistical programs (e.g., SAS) use complete case analysis for linear regression and inferences are valid only when missing data are missing completely at random |                                                                                      |

| For **proportion of responders** at time $t$ | - The SISAQOL recommendations on this point are not yet finalized. This work continues in SISAQOL-IMI |                                                                                      |

<p>| For <strong>overall PRO score over time</strong> | The SISAQOL recommendations on this point are not yet finalized. This work continues in SISAQOL-IMI |                                                                                      |</p>
<table>
<thead>
<tr>
<th>Consideration</th>
<th>Recommended content</th>
<th>Notes/ comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 2b: DESCRIPTIVE/EXPLORATORY Research Objectives</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| For time-to-event objectives: improvement, (end of) stable state, or worsening | **Cox proportional hazards models are recommended**  
**Options for descriptive objectives are:**  
- Median time to improvement / (end of) stable state / worsening  
- Probability of improvement / (end of) stable state / worsening at a specific time point  
- Hazards ratio (with CI) |                 |
| For magnitude-of-event at time \( t \) objectives: improvement or worsening | - If design is baseline + more than 1 follow-up: linear mixed models (time as discrete) are recommended  
- If design is baseline + 1 follow-up only: linear regression is recommended  
  Note: Caution is needed because many statistical programs (e.g., SAS) use complete case analysis for linear regression and inferences are valid only when missing data are missing completely at random  
Additional options for descriptive objectives are:  
- Mean magnitude at baseline and time \( t \) (with CI): improvement / (end of) stable state / worsening  
- Mean magnitude of improvement / (end of) stable state / worsening at time \( t \) (with CI) |                 |
| For response patterns/profiles over time objectives | For descriptive/exploratory objectives only: A linear mixed model (omnibus test; time as discrete variable; time*group interaction) is recommended  
**Options for descriptive objectives are:**  
- Mean magnitude at baseline and at every time point within a time frame (with CI)  
- Mean change at every time point within a time frame (with CI)  
- Mean profile over time (with CI) |                 |
| **Part 3: Missing Data Considerations** | Statistical reports from clinical trials should specify the proportion of missing data, the reasons for missing data, and the analytic approaches used to address missing data  
**Note:** Missing data that are considered meaningful for analysis (would contribute to the PRO findings) can affect the interpretability of PRO findings (e.g., by reducing the sample size [non-informative missing data], distorting the treatment estimate [informative missing data], or both). |                 |
<table>
<thead>
<tr>
<th>Consideration</th>
<th>Recommended content</th>
<th>Notes/ comments</th>
</tr>
</thead>
</table>
| Calculate the completion rate (variable denominator rate) | **PRO completion rate** = the number of patients *on PRO assessment* submitting a valid PRO assessment at the designated time point as a proportion of the number of patients *on PRO assessment* at the designated time point  
- Absolute numbers for numerator and denominator should also be reported at every time point  
- On PRO assessment: patients still expected to provide PRO assessments at that time point  
- After death, patients are considered off PRO assessment and no longer included in the denominator | |
| Calculate the available data rate (fixed denominator rate) | **Available PRO data rate** = the number of patients *on PRO assessment* submitting a valid PRO assessment at the designated time point as a proportion of the number of patients *in the PRO study population*  
- Absolute numbers for numerator and denominator should also be reported at every time point | |
| Record the reasons for missing data | To assess the impact of missing data on PRO findings, a case report form to collect reasons for missing data in a standardized way should be included in every trial | |
| Handle item-level missing data according to the scoring algorithm | - Item-level missing data within a scale should be handled according to the instrument scoring algorithm (when available)  
- If changes in official scoring algorithms for the PRO measure occur, the resulting updated guidelines from the developers should be followed | |
| State methods for handling missing PRO data in statistical analysis | - The approach for handling missing data at the item- and scale- levels should be specified *a priori*  
- Depending on the reason and amount of missing data, the approach to handling missing data may include:  
  o Sensitivity analyses (*specified a priori*) to test the robustness of the conclusions using a different set of assumptions regarding missing data  
    ▪ At least two different approaches to handle missing data are recommended to assess the impact of missing data across various assumptions  
  o Methods that use all available data are recommended as they make weaker assumptions about missing data compared to complete case analysis  
  o Explicit simple imputation methods are not recommended unless justified within the context of the clinical trial  
  o Approaches that ignore missing data and only include patients with complete data in analysis are not recommended (e.g., complete case analysis) | |

*Abbreviations: confidence interval (CI), health-related quality of life (HRQOL), patient-reported outcomes (PRO)*
References


Please Note: When referencing information included in this Chapter, we recommend citing the primary sources rather than this Handbook.
Chapter 5. Reporting PRO Findings

Consolidated Standards of Reporting Trials PRO Extension (CONSORT PRO)

The CONSORT guidance (Consolidated Standards of Reporting Trials) provides recommendations for publications reporting clinical trial results (Schulz et al., 2010). In 2013, a PRO-specific extension was published that addresses the specific elements related to PRO endpoints that should be included in clinical trial publications.

This chapter summarizes the recommendations for reporting PRO components of research studies.

View the CONSORT PRO article

View the Checklist for the CONSORT PRO Reporting Guidance

References

Acknowledgements
**Why is This Resource Needed?**

To ensure that the PRO methods and results are clearly described in clinical trial publications

Identifies the relevant information to include in clinical trial publications with PRO endpoints

---

**CONSORT PRO Summary of Reporting Guidance**

The CONSORT PRO guidance constitutes an extension to the CONSORT statement that guides the reporting of clinical trials in general. The key items relevant to the reporting of PROs include the following:

**Abstract**
- Identify PRO as primary or secondary outcome

**Background**
- State PRO hypothesis, specifying domains, if applicable

**Methods**
- Provide/cite evidence of PRO instrument validity and reliability
- Summarize study procedures for PRO data collection
- State statistical approaches for dealing with missing PRO data

**Discussion**
- Address PRO-specific limitations and implications for generalizability in clinical practice

**Why We Need PRO Reporting Guidance**
- Clinicians, patients, and policy makers value PRO information
- Existing reporting guidelines are not adhered to
- Poor reporting hampers the use of PRO data in clinical practice and undermines the clinicians' ability to use PRO data in their practice to benefit patients
• Improved reporting of PRO data should facilitate robust interpretation of the results from clinical trials and inform patient care

**Objective of Resource**

The CONSORT (Consolidated Standards of Reporting Trials) Statement aims to improve the reporting of randomized controlled trials, but lacks guidance on the reporting of PROs. CONSORT PRO provides evidence-based extensions to the CONSORT statement for reporting PROs in clinical trials and elaborations on the CONSORT 2010 statements specifically as applied to PROs.

It is recommended that PRO data be presented in the primary clinical trial publication, as this will help ensure PROs are considered alongside other clinical outcomes.

**Methods for Resource Development**

The below figure illustrates the development process for the CONSORT PRO Guidance.
CONSORT PRO Reporting Guidance

Overview

- To be used in conjunction with the CONSORT 2010 Statement and related extensions appropriate for the trial design
- 5 additional checklist items (extensions) recommended to be reported in all clinical trials where PROs are a primary or important secondary outcome
- Provides additional elaboration on the existing CONSORT 2010 checklist items as applied to the reporting of PROs in clinical trials

CONSORT PRO Extensions and Elaborations

The CONSORT PRO Reporting Guidance identifies 5 additional items (extensions) to be reported in all RCTs in which PROs are a primary or important secondary outcome. An extension was deemed unnecessary for six existing CONSORT checklist items and therefore were elaborated for PRO endpoints. Below is a list of the CONSORT 2010 item and the corresponding PRO Extension and Elaborations 2013 item with a brief explanation. Please see Calvert et al. (2013) for the full explanation and real-world examples.

Abstract Item 1b

**CONSORT 2010:**
Structured summary of trial design, methods, results, and conclusions.

**PRO Extension 2013:**
The PRO should be identified in the abstract as a primary or secondary outcome.

**Explanation:**
Identifying the PRO as a primary or secondary outcome in the abstract will facilitate indexing and identification of studies to inform clinical care and evidence synthesis.
Introduction Item 2a

**CONSORT 2010:**
Scientific background and explanation of rationale.

**PRO Elaboration 2013:**
The relevant background and rationale for why PROs were assessed in the clinical trial should be briefly described.

**Explanation:**
The Background or Methods section should provide the rationale for including PROs and why the specific outcomes were selected, thus providing appropriate context for the PRO-specific objectives and hypotheses.

Introduction Item 2b

**CONSORT 2010:**
Specific objectives or hypotheses.

**PRO Extension 2013:**
The PRO hypothesis should be stated and relevant domains identified, if applicable.

**Explanation:**
Without a prespecified hypothesis there is risk of multiple statistical testing and selective reporting of significant results.

Methods Item 6a Extension

**CONSORT 2010:**
Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed.

**PRO Extension 2013:**
Evidence of PRO instrument validity and reliability should be provided or cited, if available.

**Explanation:**
Clinical use of PRO data requires that the trial results are robust, which depends on a valid and reliable PRO measure being used appropriately.
### Methods Item 6a Elaboration

**CONSORT 2010:**
 Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed.

**PRO Elaboration 2013:**
 Details of the mode of PRO completion (in particular if a proxy completed the questionnaire on behalf of the patient), and the method of data collection (paper, telephone, electronic, other) should also ideally be provided particularly when the PRO is the primary outcome.

**Explanation:**
 Different methods of data collection may affect the results and lead to potential bias if used differentially between intervention groups.

### Methods Item 12a

**CONSORT 2010:**
 Statistical methods used to compare groups for primary and secondary outcomes.

**PRO Extension 2013:**
 Statistical approaches for dealing with missing data should be explicitly stated.

**Explanation:**
 The level of missing PRO data is often high and can lead to reduced power, is a potential source of bias, and can result in misleading results.

### Results Item 13a

**CONSORT 2010:**
 For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analyzed for the primary outcome.

**PRO Elaboration 2013:**
 The number of participants reporting PRO data at baseline and at subsequent time points should be made transparent.

**Explanation:**
 The flow of participants through the trial in relation to PROs, including information on the reason for missing PRO data, should be reported to help readers interpret the PRO results and assess potential for bias.
Results Item 15

**CONSORT 2010:**
Table showing baseline demographic and clinical characteristics for each group.

**PRO Elaboration 2013:**
Including baseline PRO data when collected.

**Explanation:**
Baseline PRO data may be used by clinicians and policy makers to assess the relevance and generalizability of trial findings.

Results Item 17a

**CONSORT 2010:**
For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval).

**PRO Elaboration 2013:**
For multidimensional PROs, results from each domain and time point specified for analysis.

**Explanation:**
The potential for selective reporting of PROs is increased because study measures often contain multiple scales and items. In general, all PRO results should be presented alongside other outcome data to facilitate the clinical integration of the important findings with other prespecified outcomes.

Discussion Items 20/21

**CONSORT 2010:**
Item 20. Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses.

Item 21. Generalizability (external validity, applicability) of the trial findings.

**PRO Extension 2013:**
PRO specific limitations and implications for generalizability of study findings and clinical practice.
Explanation:
Readers need to be able to assess generalizability and any potential sources of bias.

Discussion Item 22

**CONSORT 2010:**
Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence.

**PRO Elaboration 2013:**
PRO data should be interpreted in relation to clinical outcomes including survival data, where relevant.

Explanation:
The clinical significance of PRO results is often not discussed in clinical trial reports but should be interpreted in relation to other important clinical outcomes such as survival, especially in trials for which there are clinically relevant trade-offs between PROs and survival outcomes.

**Implications of Using CONSORT PRO Guidance**

- Improved PRO reporting in clinical trials will enable robust evidence to inform patient choice, aid clinical decision making, and inform health policy
- Active implementation by journals, authors, and reviewers may lead to improved reporting
- Endorse CONSORT PRO and other reporting guidelines
- PRO reporting is intrinsically linked to study design. Consider design in relation to:
  - FDA Guidance on PROs
  - SPIRIT Initiative
<table>
<thead>
<tr>
<th>Section/Topic</th>
<th>CONSORT-PRO Item</th>
<th>Recommended Content</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title and Abstract</strong></td>
<td></td>
<td><strong>P1b</strong> The PRO should be identified in the abstract as a primary or secondary outcome.</td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td></td>
<td><strong>2a</strong> The scientific background and explanation of rationale of PRO assessment should be included. <strong>P2b</strong> The PRO hypothesis should be stated, and relevant domains identified, if applicable.</td>
</tr>
<tr>
<td><strong>Methods</strong></td>
<td></td>
<td><strong>4a</strong> PRO-specific criteria are required only if PROs were used for eligibility or stratification. <strong>P6a</strong> Evidence of PRO instrument validity and reliability should be provided or cited, including the person completing the PRO &amp; methods of data collection (paper, telephone, or electronic).</td>
</tr>
<tr>
<td><strong>Randomization</strong></td>
<td></td>
<td><strong>7a</strong> Sample size determination is required only if PRO is a primary study outcome.</td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td></td>
<td><strong>13a</strong> The number of PRO outcome data at baseline and at subsequent time points should be transparent. <strong>15</strong> PRO data in the table showing baseline demographic and clinical characteristics for each group should be included. <strong>16</strong> For each group, the number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups is required for PRO results. <strong>17a</strong> The estimated effect size and its precision such as 95% confidence interval should be presented for multidimensional PROs from each domain and time point. <strong>18</strong> Results of any other PRO analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory, should be presented if relevant.</td>
</tr>
<tr>
<td><strong>Discussion</strong></td>
<td></td>
<td><strong>P20/21</strong> PRO-specific limitations and implications for generalizability and clinical practice should be presented. <strong>22</strong> PRO data should be interpreted in relation to clinical outcomes including survival data if relevant.</td>
</tr>
</tbody>
</table>
References


Further Reading


Please Note: When referencing information included in this Chapter, we recommend citing the primary sources rather than this Handbook.
Chapter 6. Graphically Displaying PRO Data

Stakeholder-Driven, Evidence-Based Standards for Presenting PRO data to Patients and Clinicians/Researchers

A specific issue related to the reporting of PRO clinical trial results is the best way to graphically report the findings so that patients and clinicians can easily and accurately interpret the PRO findings. To address this issue, stakeholder-driven, evidence-based recommendations for how to display PRO data to promote understanding and use have been developed.

This chapter summarizes the recommendations for graphically displaying PRO data, for use by clinicians and/or patients.

View PRO Data Display article

View the Checklists for PRO Data Display:

- Research Results Presented to Patients
- Research Results Presented to Clinicians/Researchers

References

Acknowledgements
Why is This Resource Needed?

To promote consistent presentation of PRO data so that clinicians and patients can understand what PRO scores mean.

Provides evidence-based recommendations for presenting PRO data clearly to patients and clinicians/researchers.

The impetus for developing these recommendations was evidence showing that while both patients and clinicians endorse the value of PROs, they also report challenges interpreting the meaning and implications of PRO data, such as those produced within a clinical trial. These challenges result, in part, from the lack of standardization in how PRO measures are scored and scaled, and in how the data are reported. For example, on some PRO measures, higher scores are always better; on other PRO measures, higher scores reflect “more” of the outcome and are therefore better for function domains but worse for symptoms. Some PRO measures are scaled from 0 to 100, with the best and worst outcomes at the extremes, whereas others are normed to, for example, a general population average of 50. There are also variations in how PRO results are reported—in some cases as mean scores over time, in other cases as the proportion of patients meeting a responder definition (i.e., improved/stable/worsened). These challenges in interpreting PRO results limit patients’ and clinicians’ use of the data in clinical practice.

Objective of Resource

This resource is designed to provide evidence-based recommendations for PRO data display to facilitate ease of interpretation for presenting results to:

- Patients (e.g., educational materials and decision aids)
- Clinicians/researchers (e.g., peer-reviewed publications)

The resource also provides recommendations for display of individual patient PRO data within clinical practice settings, but these are not covered in this Handbook. If you are interested in learning more about recommendations for displaying individual patient PRO data, please see Snyder et al. (2019).
Methods for Resource Development

This PRO data display resource was developed using a modified Delphi process to establish consensus on evidence-based recommendations for graphically displaying PRO data among a multi-disciplinary group of stakeholders, which included clinicians, patients/caregivers, academics, and journal editors.

Parameters for Recommendations

The following parameters informed the PRO data display considerations:

1. recommendations should work on paper (static presentation)
2. presentation in color is possible (but it should be interpretable in grayscale)
3. additional functionality in electronic presentation is possible (but not part of standards)

Additional guiding principles were also established:

1. displays should be as simple and intuitively interpretable as possible
2. it is reasonable to expect that clinicians will need to explain the data to patients
3. education and training support should be encouraged to be available

Overview of PRO Data Display Recommendations

In this section, we include several graphs/charts illustrating how to implement the PRO data display recommendations. Graphs/charts in color illustrate recommendations for how to display PRO data to patients, whereas black-and-white figures illustrate recommendations for PRO data display to clinicians or researchers. These graphs shown in black-and-white are common for journal publications, and for printers that clinicians and researchers may have access to.
Directionality

One of the key issues to address in the presentation of PRO data is how to display variations in directionality – that is, how to aid interpretation when higher scores are better for some domains, such as, physical function, but worse for other domains, such as pain.

There are two general recommendations for addressing directionality. First, the graphic should include exceptionally clear labeling, titling, and annotations to help viewers understand whether higher scores are better or worse. Second, domains that differ in scoring directionality should be presented separately.

The above illustration shows an example of how to display data to patients. Please note a few key aspects of these graphs.

First, we use a line graph of average scores over time, which was the preferred approach for showing longitudinal data. Different colors are used for the two treatment arms, and the lines are labeled directly, rather than using a legend.

As for directionality, you can see that under each domain title, a header describes whether a line going up indicates improvement or worsening. The functional domains where higher
scores are better are clearly separated from the symptom domains where higher scores are worse. Finally, we have included descriptive labels on the y-axis to help with directionality, as well as to help convey score meaning.

The figure above shows an example of how to display data to clinicians or researchers. Again, we use line graphs of average scores over time, but these versions include additional statistical and other details we will describe later. Similar to the patient graphic, the lines are labeled directly, rather than using a legend.

The same labeling, titling, and annotations are also included here, such as the headers under the domain names, the separation of domains with different scoring directionality, and the y-axis labels.
Conveying Score Meaning

The next recommendations relate to conveying score meaning. That is, how to understand whether a score is good or bad, or what level of function or symptoms is represented.

The recommendations suggest including descriptive labels along the y-axis—to the extent that this information is known. In displaying the data, inclusion of reference values for comparison populations may also be considered.

Above is an illustrative example for displaying PRO data to patients, highlighting the descriptive labels along the y-axis. As noted previously, the labels along the y-axis should only be included when there is evidence to support where on the scoring continuum the labels should be placed. The Consensus Panel acknowledged that it would be easier to place the anchor labels, for example, “none” and “severe”, at the extreme ends of the continuum and that it might be more difficult to place the middle labels, for example, “mild” and “moderate”.

Patients’ Functioning

- **Physical** (line going up means better able to do physical activities)
  - Very High
  - Moderate
  - Poor
  - Very poor

Patients’ Symptoms

- **Fatigue** (line going up means worse fatigue)
  - Severe
  - Moderate
  - Mild
  - No fatigue

- **Pain** (line going up means worse pain)
  - Severe
  - Moderate
  - Mild
  - No pain

Additional Y-axis labels (when data support their location)

Y-axis descriptive anchor labels
This is the clinician/researcher example illustration. The same considerations regarding the y-axis labels apply, with potentially greater knowledge and ability to include the anchor labels compared to the middle labels.

**Normed Scoring**

The next recommendations address normed scoring. As a reminder, some PRO measures are normed with, for example, a score of 50 representing the general population average. The Consensus Panel recommended displaying the scores based on the questionnaire’s scoring metric, whether it is normed or not. Displaying the actual norm is optional.
The example above shows normed scoring for display to patients. In this case, it does display the general population average of 50 and includes the y-axis descriptive labels. As with the non-normed scoring, the decision of where to position these labels should be evidence-based.
The illustration above provides an example of how to present normed scoring to clinicians/researchers and includes the same annotations as the example for patients.

**Clinically Important Differences**

The recommendations for PRO data display also address how to indicate whether differences between treatment/intervention arms are clinically important. Although the Consensus Panel agreed it is important for patients to know whether differences are clinically important, there was insufficient evidence to inform how best to convey this information to patients.

For clinicians and researchers, the recommendation is to use a symbol to indicate which differences are clinically important. However, an asterisk should not be used given that it is commonly used to indicate statistical significance in academic journals.
In the example above for clinicians/researchers, a cross is used to indicate the time points where the differences are clinically important, and the meaning of this symbol is included in the figure legend.

**Conveying Statistical Significance (for clinicians and researchers only)**

Finally, while evidence suggests that many patients do not want statistical information included as they find it confusing, many clinicians and researchers were interested in statistical information. For this reason, recommendations regarding how to convey statistical significance only apply for PRO data display to clinicians/researchers.

The consensus-based recommendations are to include confidence intervals in all cases and note that p-values may also be appreciated.
The example for clinicians and researchers above shows the confidence intervals indicating statistical significance at each time point, and a p-value for the overall difference between groups over time. Both the confidence limits and p-value are explained in the figure legend.
**Proportions Changed**

Finally, in some instances, clinical trials report the proportion of patients in each arm meeting a responder definition. That is, the proportion of patients who improved, stayed the same, or worsened by some change-score criterion. In cases where a proportion needs to be displayed, the recommendation is to use pie charts for PRO data display to patients. For clinicians and researchers, bar charts, pie charts, or stacked bar charts are reasonable options.

Notably, the evidence supports showing two pie charts with only three slices per pie chart. Showing more than two pie charts or showing more than three slices per pie chart may be more difficult to interpret.

**Status of 100 patients 9 months after starting treatment**

These are example pie charts designed for patients, highlighting specific attributes that aid interpretation of the PRO data display. Each pie slice is labeled directly with the specific percentage and whether improvement, no change, or worsening is represented, negating the need for a legend. Also, the improved pie slice consistently starts at the 12:00 position.
Recommendations for clinicians are similar to those for patients, with the addition of p-values for statistically significant between-arm differences in proportions.

Given that directionality is not an issue with pie charts, there is no separation between the function and symptom domains.
As noted earlier, stacked bar-charts are also appropriate for displaying these responder data to clinicians and researchers. Note that, again, data labels are used to annotate the proportions, and an easily accessible legend is replicated and presented in the same order as the stacked bars.
## Checklist for PRO Data Display: Research Results Presented to Patients

<table>
<thead>
<tr>
<th>Issue</th>
<th>Consensus Statement</th>
<th>Notes/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directionality of PRO Scores</strong></td>
<td>The Consensus Panel warned against trying to change current instruments—even if only how the data are displayed (e.g., “flipping the axes” where required for symptom scores so that lines going up are always better). PRO data presentation should avoid mixing score direction in a single display.</td>
<td></td>
</tr>
<tr>
<td><strong>Conveying Score Meaning</strong></td>
<td>Descriptive labels (e.g., none/mild/moderate/severe) along the y-axis are helpful and should be used when data supporting their location on the scale are available. In addition to the descriptive y-axis labels, reference values for comparison populations should be considered for inclusion if they are available.</td>
<td></td>
</tr>
<tr>
<td><strong>Normed Scoring</strong></td>
<td>PRO data presentation needs to accommodate instruments the way they were developed, with or without normed scoring. One can decide if/when to show the reference population norm visually (e.g., with a line on the graph), understanding that displaying it might provide additional interpretive value, but potentially at the cost of greater complexity. Comparison to the norm might be less relevant in the context where the primary focus is the choice between treatments. If a norm is displayed: • It is necessary to describe the reference population and label the norm as clearly as possible (recommend “average” rather than “norm”) • It also requires deciding what reference population to show (to the extent that options are available). • It will need to be explained to patients that this normed population may not be applicable to a given patient.</td>
<td></td>
</tr>
<tr>
<td><strong>Clinically Important Differences</strong></td>
<td>Patients may find information regarding clinically important differences between treatments to be confusing, but it is important for them to know what differences “matter” if they are going to make an informed decision.</td>
<td></td>
</tr>
<tr>
<td><strong>Proportions Changed</strong></td>
<td>Pie charts are the preferred format for displaying proportion meeting a responder definition (improved, stable, worsened), so long as the proportion is also indicated numerically.</td>
<td></td>
</tr>
</tbody>
</table>
Checklist for PRO Data Display: Research Results Presented to Clinicians/Researchers

<table>
<thead>
<tr>
<th>Issue</th>
<th>Consensus Statement</th>
<th>Notes/ comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directionality of PRO Scores</td>
<td>PRO data presentation should avoid mixing score direction in a single display. In cases where this is not possible, authors should consider changing the directionality in the display to be consistent. There is a need for exceptionally clear labeling, titling, and other annotations.</td>
<td></td>
</tr>
<tr>
<td>Conveying Score Meaning</td>
<td>Descriptive labels (e.g., none/mild/moderate/severe) along the y-axis are helpful and should be used when data supporting their location on the scale are available. In addition to the descriptive y-axis labels, reference values for comparison populations should be considered for inclusion if they are available.</td>
<td></td>
</tr>
</tbody>
</table>
| Normed Scoring                     | PRO data presentation needs to accommodate instruments the way they were developed, with or without normed scoring. One can decide if/when to show the reference population norm visually (e.g., with a line on the graph), understanding that displaying it might provide additional interpretive value, but potentially at the cost of greater complexity. Display of the norm might be less relevant in the context where the primary focus is the choice between treatments. If a norm is displayed:  
  • It is necessary to describe the reference population and label the norm as clearly as possible (recommend “average” rather than “norm”)  
  • It also requires deciding what reference population to show (to the extent that options are available). |                 |
| Clinically Important Differences    | Clinically important differences between treatments should be indicated with a symbol of some sort (described in a legend). The use of an asterisk is not recommended (as it is often used to indicate statistical significance). If there is no defined clinically important difference, that also needs to be in the legend and/or the text of the paper. |                 |
| Conveying Statistical Significance | The data suggest that clinicians and others appreciate p-values; however, the Consensus Panel recognizes a move away from reporting them (and toward the use of confidence limits to illustrate statistical significance). Regardless of whether p-values are reported, confidence intervals should always be displayed. |                 |
| Proportions Changed                | Reasonable options include bar charts, pie charts, or stacked bar charts.                                                                                                                                              |                 |
References


Further Reading


Please Note: When referencing information included in this Chapter, we recommend citing the primary sources rather than this Handbook.
Chapter 7. Interpreting PRO Papers

Clinician’s Checklist for Reading and Interpreting an Article that Includes PROs

The Clinician’s Checklist for interpreting journal articles that include PROs provides clinicians who are not experts in PRO research with guidance on how to evaluate whether PRO findings are useful for their clinical practice.

This chapter summarizes the checklist items for clinicians to consider when evaluating articles with PROs.

View Clinician Users’ Guide for Evaluating Studies with PROs article

View Checklist for the Clinician Users’ Guide for Evaluating Studies with PROs

References

Acknowledgements
Why is This Resource Needed?

To help clinicians assess the quality of PRO research studies and determine whether findings are useful for clinical practice.

Provides a checklist to evaluate the quality of studies that use PROs.

In order to use PRO results to inform patient care, clinicians need to be able to evaluate published literature that includes PROs. However, clinicians face some barriers in applying PRO findings in clinical practice, including:

- a lack of education and training on the measurement and interpretation of PROs
- the wide variety of PRO measures available
- variation in how PRO findings are reported in the literature

Objective of Resource

The objective of this resource is to help practicing clinicians apply results of clinical research studies that include PROs in their patient care by providing a brief checklist to help them review published research studies that include PROs.

Methods for Resource Development

This Clinician’s Checklist builds on guidelines published by Guyatt et al. (1997). Key elements to consider when reading a published study using PROs include:

- Assessment strategy and study design
- Performance of the PRO tool
- Validity of results
- Context of results
- Generalizability to one’s own clinical setting and patient population

Clinician’s Checklist to Evaluate Studies Using PROs

The items in the clinician’s checklist address the key elements mentioned above to help clinicians evaluate a study with PROs.
1. **Was the PRO assessment strategy appropriate?**

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. PRO hypothesis stated?</td>
<td><em>A priori</em> hypothesis explicit for PROs</td>
</tr>
<tr>
<td>b. PRO measures described?</td>
<td>PRO measures used, and timing/follow-up of subjects</td>
</tr>
<tr>
<td>c. PRO content appropriate?</td>
<td>Investigators measured aspects of patients’ lives that patients consider important</td>
</tr>
<tr>
<td></td>
<td>PRO domains correspond to anticipated effects of disease and treatment</td>
</tr>
<tr>
<td></td>
<td>All important aspects of patient-reported outcomes included</td>
</tr>
</tbody>
</table>

Elements that are important to the conceptualization and design of any clinical research study apply equally to studies that include PROs. The research question, study design, patient population, and primary/secondary outcomes should be clearly identified within the scientific article. The research article should also clearly specify whether any primary and/or secondary outcomes are measured from the patient perspective, using PRO measures. A rationale for PRO assessment should be included and relevant PRO findings from previous studies should be described, especially if the PRO is a primary outcome. PRO hypotheses should be stated explicitly *a priori*.

The PRO measurement strategy should be described, including the timing of initial and follow-up assessments; this timing should be consistent with knowledge about the expected trajectory of patient outcomes over time in the patient population and, if possible, based on any information regarding the timing of treatment-related changes in patient health status. Pre-treatment “baseline” PRO assessment is critical and follow-up assessment time points should be appropriate to capture differences specified in the hypothesis.

The PRO measure content should correspond to the extent and breadth of problems observed in the patient population. To evaluate this, the reader should determine whether the PRO measure captures the expected effects of treatment on patient outcomes. Although there is often pressure to measure only symptoms and adverse effects in research studies, it is important to evaluate the “reach” of these symptoms to the patient’s day-to-day functioning. For example, a phase II trial may have a more restricted focus on symptoms, but a phase III study should have a more comprehensive assessment of the effect of treatment on patient functioning. The reader should check to see whether important aspects of PROs have been omitted, because their omission could lead to incorrect conclusions.
2. Did they measure PROs effectively?

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Evidence for reliability, validity?</td>
<td>The PRO instruments appear to work as intended; evidence of internal consistency and/or test retest reliability, and construct validity are cited or are well established</td>
</tr>
<tr>
<td>b. Were missing data handled appropriately?</td>
<td>Similar number of questionnaires completed by respondents in all treatment groups at every time point Missing data management strategy described Presence of data analysis plan for handling death, if frequent</td>
</tr>
</tbody>
</table>

When reading a research article, the reader should determine whether there is sufficient evidence cited to suggest that the PRO measures used are valid and reliable. The Methods section should cite evidence of the PRO measure’s internal consistency reliability, test-retest reliability, and construct validity, ideally in the clinical population of interest. There should also be evidence that the questionnaire is responsive to expected changes in health status over time. In addition, the authors should describe how they handled missing data and report the extent and pattern of missing PRO data. If a substantial incidence of death was anticipated, the method of handling death should be stated. The absence of any aforementioned elements should lead the reader to question the study findings, particularly if the conclusions suggest no treatment effect or no difference between groups.

3. Should I believe the results?

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Internal validity</td>
<td>Findings established; observed effects likely to be caused by intervention If non-treatment factors affect PRO, risk adjustment needed</td>
</tr>
</tbody>
</table>

The PRO results should be clearly described. The study’s internal validity should be established, addressing whether the observed effects likely result from the intervention. To do so, the authors should assess differences between treatment groups at baseline and ensure that known confounding variables have been measured. When non-treatment factors are known to affect PRO scores, a system for risk adjustment should be applied to ensure fair comparison between groups. Results should be presented for important patient subgroups that might be expected to show heterogeneity of treatment effects. Ideally, these subgroups should be identified a priori or results should be qualified as exploratory.
To evaluate the internal validity of a study, the reader should assess whether it seems likely that the observed results can be attributed to the intervention rather than to other factors, whether a risk adjustment strategy was used successfully, and finally, whether they believe the effects are clinically plausible.

4. *Were the results placed in a clinical context?*

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Explanation</th>
</tr>
</thead>
</table>
| a. Was the clinical meaning of results explained? | Magnitude of effect on PROs described  
Clinical importance of observed differences in PRO scores demonstrated |
| b. Will the results help me in caring for my patients? | Benefits and harms recognized and reconciled, including potential trade-offs between quality and quantity of life  
Description of what a clinician should do with the results; study information helps clinicians communicate with patients about treatment options; applicability of group results to individual patient |

The clinical significance of PRO results must be discussed explicitly, including whether the observed change was large enough to be noticeable to the patient or to compel a treatment change. PROs can provide comprehensive information about both positive and negative effects of disease and treatments. If an intervention has both positive and negative effects, the discussion should balance benefits and harms. This is especially important when there are trade-offs between quality and quantity of life, such as when a treatment extends life but decreases quality of life (e.g., toxic chemotherapy). Given a study’s PRO results, it may or may not be obvious what management option a clinician would consider. If the article includes recommendations from the authors, this increases the likelihood that the study findings will be translated to practice change.

The reader should identify the magnitude of effect on the PROs and determine whether it is large enough to motivate changes in patient care. The reader should consider potential trade-offs involving the benefits and harms suggested by the study findings.
5. Do the results apply to my patients?

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. External validity to</td>
<td>Study population is similar enough to clinician’s patient</td>
</tr>
<tr>
<td>clinician’s practice</td>
<td>population to apply to practice</td>
</tr>
</tbody>
</table>

External validity of the findings is important to clinicians if they are going to engage in a dialogue with patients about treatment options. The reader should judge how well the study simulates clinical practice in general, and whether or not the results are generalizable to his or her own patient population. Ideally, study authors will address the generalizability of study results, including PROs, to help clinicians with this task.
<table>
<thead>
<tr>
<th>Consideration</th>
<th>Explanation</th>
<th>Notes/ comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Was the PRO assessment strategy appropriate?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. PRO hypothesis stated?</td>
<td>A priori hypothesis explicit for PROs</td>
<td></td>
</tr>
<tr>
<td>b. PRO measures described?</td>
<td>PRO measures used, and timing/follow-up of subjects</td>
<td></td>
</tr>
<tr>
<td>c. PRO content appropriate?</td>
<td>Investigators measured aspects of patients’ lives that patients consider important. PRO domains correspond to anticipated effects of disease and treatment. All important aspects of patient-reported outcomes included.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Did they measure PRO effectively?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Evidence for reliability and validity?</td>
<td>The PRO instruments appear to work as intended: evidence of internal consistency and/or test retest reliability, and construct validity are cited or are well established.</td>
<td></td>
</tr>
<tr>
<td>b. Were missing data handled appropriately?</td>
<td>Similar number of questionnaires completed by respondents in all treatment groups at every time point. Missing data management strategy described. Presence of data analysis plan for handling death, if frequent.</td>
<td></td>
</tr>
<tr>
<td><strong>3. Should I believe the results?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Internal validity</td>
<td>Findings established; observed effects likely to be caused by intervention. If nontreatment factors affect PRO, risk adjustment used.</td>
<td></td>
</tr>
<tr>
<td><strong>4. Were the results placed in clinical context?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Was clinical meaning of results explained?</td>
<td>Magnitude of effect on PROs described. Clinical importance of observed differences in PRO scores demonstrated.</td>
<td></td>
</tr>
<tr>
<td>b. Will the results help me in caring for my patients?</td>
<td>Benefits and harms recognized and reconciled, including potential trade-offs between quality and quantity of life. Description of what a clinician should do with the results; study information helps clinician communicate with patients about treatment options; applicability of group results to an individual patient.</td>
<td></td>
</tr>
<tr>
<td><strong>5. Do the results apply to my patients?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. External validity to clinician’s practice</td>
<td>Study population is similar enough to clinician’s patient population to apply to practice.</td>
<td></td>
</tr>
</tbody>
</table>
References


Further Readings


Please Note: When referencing information included in this Chapter, we recommend citing the primary sources rather than this Handbook.
Acknowledgements

The SPIRIT-PRO Group

Group executive
Melanie Calvert, PhD, Chair1
Madeleine King, PhD, Co-chair2
Derek Kyle, PhD1
Rebecca Mericlea-Beberman, PhD1
Anita Slade, PhD1
An-Wen Chan, MD, DPhi2

1. University of Birmingham, UK
2. University of Sydney, Australia
3. University of Toronto, Canada

Group members
Amanda Ham1
Andrew Bottomley, PhD1
Antoine Regnault, PhD1
Carolyne Ellis, PhD1
Daniel O’Connor, PhD1
Dennis Revicki, PhD1
Donald Patrick, PhD1
Doug Alman, PhD1
Ethan Basch, MD1
Gaila Velkova, PhD1
Gary Price, Patient Partner, UK
Heather Draper, PhD1
Jane Blyznyzky, MD1
Jane Scott, PhD1
Joanna Coetz, PhD1
Josephine Norquist, PhD1
Julia Brown, MSc1
Kirstie Haywood, PhD1
Lauree Lee Johnson, PhD1
Lisa Campbell, MD1
Lori Frank, PhD1
Maria von Hildebrand, Patient Partner, UK
Michael Brundage, MD1
Michael Palmer, MSc1
Paul Klusk, MD1
Richard Stephens1
Robert M Gulub, MD1
Sandra Mitchell, PhD1
Trish Groves, MRCPsych1

1. Health Research Authority (HRA), UK
2. European Organization for Research and Treatment of Cancer (EORTC), Belgium
3. Modus Outcomes, France
4. Panel on Research Ethics (On behalf of the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada), Canada
5. Medicines and Healthcare products Regulatory Agency (MHRA), UK
6. Evidera, USA
7. University of Washington, USA
8. University of Oxford, UK
9. University of North Carolina, USA
10. University of Leeds, UK
11. University of Warwick, UK
12. University of Bristol, UK
13. Jameson Global Services, Johnson and Johnson, UK
14. Merck Sharp & Dohme Corporation, USA
15. Food and Drug Administration (FDA), USA
16. Patient-Centered Outcomes Research Institute (PCORI), USA
17. Queen’s University, Canada
18. National Cancer Research Institute Consumer Forum, UK
19. JAMA, USA
20. National Cancer Institute, USA

ISOQOL Best Practices for PROs in Randomized Clinical Trials PROtocol

Checklist Taskforce

Antonia Bennett, PhD, University of North Carolina, USA
Jane Blazey, MD, University of Bristol, UK
Andrew Bottomley, PhD, European Organization for Research and Treatment of Cancer (EORTC), Belgium
Heather Draper, PhD, University of Warwick, UK
Amy McQueen, PhD, Mayo Clinic, USA
Kirstie Haywood, PhD, University of Warwick, UK
Derek Kyle, PhD, University of Birmingham, UK
Rebecca Mericlea-Beberman, University of Sydney, Australia
Sandra Mitchell, PhD, National Cancer Institute, USA
Carol Moinpour, PhD, Fred Hutchinson Cancer Research Center, USA
Josephine Norquist, PhD, Merck Sharp & Dohme Corporation, USA
David Osoba MD, University of British Columbia, Canada
Michael Palmer Queen’s University MSc, Canada
Jennifer Petillo PhD, Novartis Pharmaceuticals, USA
Andreas Pleil PhD, Pfizer, USA
Antoine Regnault, PhD, Modus Outcomes, France
Dennis Revicki, PhD, Evidera, USA
Lothar Tremmel, PhD Incyte Corporation, USA
Lari Wenzel, PhD, University of California, Irvine, USA

...and to ISOQOL members that completed the stakeholders survey

Additional Contributions:
The SPIRIT-PRO Group gratefully acknowledge the additional contributions made by the SPIRIT-PRO Executive, the ISOQOL, the international stakeholders responsible for the stakeholder survey distribution and stakeholders who completed the stakeholder survey. Depts Panellists, the SPIRIT-PRO International Consensus Meeting Participants and Anita Walker, University of Birmingham, UK for administrative support.

Disclaimer: Please note that views of authors, Delphi and stakeholder participants are individual views and may not represent the views of the broader stakeholder group or host institution.

Funding/Support:
This work was supported by Macmillan Cancer Support (grant number 5592165) and the University of Birmingham. Professor King is supported by the Australian Government through Cancer Australia. JMB is partly supported by the RCR Conduct Hub for Trials Methodology Research.
The ISOQOL Scientific Advisory Task Force (SATF)

Neil Aaronson, PhD  
University of Amsterdam

Sara Ahmed, PhD  
McGill University

Michael Brundage, MD  
Queens University

Zeeshan Butt, PhD***  
Northwestern University

David Cella, PhD  
Northwestern University

Peter Fayers, PhD  
University of Aberdeen

David Feeny, PhD  
University of Alberta

Richard Gershon, PhD  
Northwestern University

Joanne Greenhalgh, PhD  
University of Leeds

Ron Hays, PhD  
University of California – Los Angeles

Pamela Hinds, PhD  
National Children’s Hospital, Wash DC

William Lenderking, PhD  
United BioSource Corporation

Jessica Lyons, MS  
University of North Carolina

Lori McLeod, PhD  
RTI Health Solutions

Carol Moinpour, PhD  
Fred Hutchinson Cancer Research Center

Bryce B. Reeve, PhD  
University of North Carolina

Dennis Revicki, PhD  
United BioSource Corporation

Carolyn Schwartz, ScD  
DeltaQuest Found. / Tufts Univ. Med. Sch.

Claire Snyder, PhD  
Johns Hopkins University

Caroline Terwee, PhD  
VU University Medical Center

Galina Vellikova, MD, PhD  
University of Leeds

Albert Wu, MD  
Johns Hopkins University

Kathleen Wyrwich, PhD  
United BioSource Corporation
81

The SISAQOL Consortium

Ethan Basch1
Andrew Bottomley2
Melanie Calvert3
Alicyn Campbell4
Charles Cleeland5
Kim Cocks6
Corneel Coens2
Laurence Collette2
David Collingridge7
Nancy Devlin8
Lien Dorne9
Amy Lou Dueck9
Hans-Henning Flechtner10
Carolyn Gotay11
Ingolf Griebsch12
Mogens Grenvold13
Laura Lee Johnson14
Madeleine King15
Paul Kluetz14
Michael Koller16

Daniel C Malone17
Francesca Martinielli12
Sandra A Mitchell18
Jammbe Z Musoro2
Daniel O’Connor19
Kathy Oliver20
Madeline Pe8
Elisabeth Piault-Louis21
Martine Piccart22
Chantal Quentin23
Jaap C Reijneveld24
Christoph Schürmann25
Jeff Sloan26
Ashley Wilder Smith18
Katherine M Solty527
Rajeshwari Sridhara14
Martin Taphoorn28
Galina Velikova29

1Lineberger Comprehensive Cancer Center; University of North Carolina, North Carolina, USA
2European Organisation for Research and Treatment of Cancer, Belgium
3Centre for Patient Reported Outcomes Research, University of Birmingham, UK
4Patient Relevant Evidence, San Francisco, USA
5Dept. Of Symptom Research, MD Anderson Cancer Center, University of Texas, Texas, USA
6Adephi Values, UK
7The Lancet Oncology, UK
8University of Melbourne, Australia
9Alliance Statistics and Data Center; Mayo Clinic, Arizona, USA
10Clinic for Child and Adolescent Psychiatry and Psychotherapy; University of Magdeburg, Germany
11School of Population and Public Health; University of British Columbia, British Columbia, Canada
12Boehringer-Ingelheim, Germany
13Dept. Of Public Health; Blaupolz Hospital, University of Copenhagen, Denmark
14US Food and Drug Administration, Maryland, USA
15School of Psychology and Sydney Medical School; University of Sydney, Australia
16Center for Clinical Studies; University Hospital Regensburg, Germany
17College of Pharmacy, University of Arizona, Arizona, USA
18National Cancer Institute, Maryland, USA
19Medicines and Healthcare products Regulatory Agency, UK
20International Brain Tumour Alliance, UK
21Genentech, San Francisco, USA
22Institut Jules Bordet; Université Libre de Bruxelles, Belgium
23European Centre for Disease Prevention and Control, Sweden
24NV University Medical Center, Dept. of Neurology & Brain Tumor Center, The Netherlands
25Institute for Quality and Efficiency in Health Care, Germany
26Alliance Statistics and Data Center; Mayo Clinic, Minnesota, USA
27Health Canada, Ontario, Canada
28Leiden University/Haaglanden Medical Center, The Netherlands
29Leeds Institute of Cancer and Pathology; University of Leeds, St. James’s Hospital, UK

EORTC received an unrestricted education grant from Boehringer Ingelheim GmbH to initiate the SISAQOL work, an unrestricted education grant from Genentech to continue the SISAQOL work, and additional financial support provided by the EORTC Cancer Research Fund.
CONSORT-PRO Executive:

Prof. Michael Brundage (chair), Director, Cancer Care and Epidemiology, Cancer Research Institute, Queen’s University, Canada

Prof. Melanie Calvert, Director, Centre for Patient Reported Outcomes Research, and Director, Birmingham Health Partners Centre for Regulatory Science and Innovation, U. of Birmingham, UK

Prof. Jane Blazebry, MRC ConDuCT Hub for Trials Methodology Research, School of Social and Community Medicine, University of Bristol, UK

Prof. Doug Altman, Director of Centre for Statistics in Medicine, University of Oxford, UK

Prof. Dennis Revicki, Outcomes Research, United BioSource Corporation, Bethesda, MD, USA

Prof. David Moher, Clinical Epidemiology Program, Ottawa Hospital Research Institute, Canada

Funders: Medical Research Council, Canadian Institutes for Health Research

Collaborators:
International Society for Quality of Life Research
CONSORT Executive & EQUATOR Network
MRC Midland and ConDuCT Hubs for Trials Methodology Research
University of Birmingham, UK, Queens University, Canada, University of Bristol, UK, University of Ottawa, Canada, University of Oxford, UK, United BioSource Corporation, Bethesda, MD, USA
Survey participants including: ISPOR, MRC HTMR, NIHR Research design service, SCT, European Clinical Trials Units, Journal Editors, Policy Makers

Meeting participants

[Images]
## PRO Graphical Display

### PROJECT TEAM
- Claire Snyder, PhD
- Michael Brundage, MD, MSc
- Elissa Bantug, MHS
- Katherine Smith, PhD
- Bernhard Holzner, PhD

### STAKEHOLDER ADVISORY BOARD
- Daniel Weber
- Ethan Basch, MD
- Neil Aaronson, PhD
- Bryce Reeve, PhD
- Galina Velikova, BMBS(MD), PhD
- Andrea Heckert, PhD, MPH
- Eden Stotsky-Himelfarb
- Cynthia Chauhan
- Vanessa Hoffman, MPH
- Patricia Ganz, MD
- Lisa Barbera, MD, MPA

### INVITED PARTICIPANTS
- Elizabeth Frank
- Mary Lou Smith, JD
- Arturo Durazo
- Judy Needham
- Shelley Ful Nasso
- Robert Miller, MD
- Tenbroeck Smith, MA
- Deborah Struth, MSN, RN, PhD(c)
- Alison Rein, MS
- Andre Dias, PhD
- Charlotte Roberts, MBBS, BSc
- Nancy Smider, PhD
- Gena Cook
- Jakob Bjorner, MD, PhD
- Holly Witteman, PhD
- James G. Dolan, MD
- Jane Blazebiy, MD, MSc
- Robert M. Golub, MD
- Christine Laine, MD, MPH
- Scott Ramsey, MD, PhD

**Funded** by the Patient-Centered Outcomes Research Institute
Clinician Checklist

**Collaborators:** Albert W. WU, MD, FACP; Anna N. Bradford, PhD, MSW, LCSW; Vic Velanovich, MD; Mirjam A.G. Sprangers, PhD; Michael Brundage, MD, FRCP, MSc; and Claire Snyder, PhD

This article was reviewed by members of the International Society for Quality of Life Research (ISOQOL) and is endorsed by the ISOQOL Board of Directors.