CONCISE REPORT

Effect of different imputation approaches on the evaluation of radiographic progression in patients with psoriatic arthritis: results of the RAPID-PsA 24-week phase III double-blind randomised placebo-controlled study of certolizumab pegol

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ABSTRACT

Objectives To report the effect of different imputation methodologies on the assessment of radiographic progression in clinical trials.

Methods The 216-week RAPID-psoriatic arthritis (PsA) (NCT01087788) trial of certolizumab pegol (CZP) in patients with active PsA was double-blind and placebo-controlled until week 24. A primary endpoint was change from baseline in modified Total Sharp Score(s) (mTSS). Prespecified imputation methodology in patients with fewer than two analysable mTSS used minimum observed baseline score for missing baseline values and maximum observed week 24 score for missing week 24 values. Post hoc analyses used alternative methods of imputation in patients with fewer than two analysable mTSS. mTSS non-progressors were defined as patients with ≤ 0 ( predefined) or ≤ 0.5 (post hoc) change in mTSS from baseline to week 24. Baseline mTSS and C-reactive protein levels as predictors of radiographic progression were investigated.

Results 409 patients were randomised. Baseline demographics were similar between groups. Prespecified imputation analysis inaccurately overestimated radiographic progression (least squares mean placebo, 28.9; CZP, 18.3; p > 0.05). Multiple post hoc analyses demonstrated that CZP inhibited radiographic progression compared with placebo, particularly in patients with high baseline mTSS and C-reactive protein levels. mTSS non-progression rate was higher in CZP than placebo groups in all analyses.

Conclusions Inappropriate prespecified imputation methodology resulted in an unrealistic assessment of progression in all arms. Methodologies for imputing missing radiographic data can be used to estimate progression in patients with missing radiographic data; however, the impact of these different assumptions on population outcomes has not been published.

In this article, results from the multinational phase III RAPID-PsA study of certolizumab pegol (CZP) treatment in patients with PsA are presented in order to discuss the effect of different imputation methodologies on the evaluation of radiographic progression.

METHODS

Patients Full details of the ongoing 216-week RAPID-PsA study design (NCT01087788), including the patient population, are reported elsewhere. Briefly, 409 adult patients with PsA were recruited. Patients were required to
have active musculoskeletal disease, an inadequate response to one or more disease-modifying antirheumatic drug, and active psoriatic skin lesions or a documented history of psoriasis.

**Study design**
RAPID-PsA was double-blind, placebo-controlled to week 24. Patients were randomised 1:1:1 to placebo or 400 mg CZP at week 0, 2 and 4 followed by 200 mg CZP every 2 weeks (Q2W) or 400 mg CZP every 4 weeks (Q4W). Placebo patients who did not achieve a predefined minimal response at week 14 and week 16 escaped to active treatment at week 16.

**Study procedures and evaluations**
One of the two primary end points was change from baseline to week 24 in the van der Heijde modified Total Sharp Score (mTSS), adapted for PsA. This methodology quantifies the extent of osteoarthropathy, joint space narrowing in the metacarpophalangeal, proximal interphalangeal, metatarsophalangeal, metatarsal and wrist joints. Radiographs of both hands and feet were taken at baseline, then at week 12 and week 24 or an early withdrawal visit, using standardised imaging methodology. Discrepancies between readers of the adjudicated score and the closest result, was used. The proportion of mTSS non-progressors (predefined as ≤0 mTSS change from baseline) was assessed. Post hoc non-progressor analyses used a ≤0.5 mTSS change from baseline definition, based on published guidelines relating to the use of multiple readers.

Post hoc subgroup analyses of mTSS change from baseline and mTSS non-progression rates were also evaluated in patients with a high risk of progression, defined as baseline C-reactive protein (CRP) levels >15 mg/L or mTSS higher than the population median.

**Statistical analysis**
The sample size of 130 for each treatment group was sufficient to detect statistically significant differences in the mean change from baseline in the mTSS between the combined active and placebo groups with at least 95% power, assuming a difference of ≥2.1 and a standard deviation (SD) of 2.4 points.

Treatment comparisons for the combined CZP dose groups versus placebo for change from baseline in mTSS were evaluated using an analysis of covariance model, with treatment, region and prior tumour necrosis factor inhibitor exposure as factors, baseline mTSS as covariate, and mTSS change from baseline as the dependent variable. Linear interpolation and extrapolation of missing data points was used in patients with two or more analysable mTSS, irrespective of time interval between the two scores. Prespecified non-progressor analysis used non-responder imputation (NRI), where placebo patients escaping to CZP and patients withdrawing early from the study were considered mTSS progressors. Post hoc non-progressor analysis used linear interpolation and extrapolation of missing data points for patients with two or more analysable mTSS.

Prespecified methodology for patients with fewer than two analysable mTSS used the minimum observed baseline mTSS for missing baseline values and the maximum observed week 24 mTSS for missing week 24 values. A number of alternative methods of imputation, defining change from baseline mTSS for patients with fewer than two analysable mTSS were assessed as part of post hoc analyses including substituting by mean or median or maximum (see table 1 for all different options). For all post hoc analyses, the mTSS had to be obtained at least 8 weeks apart.

**RESULTS**

**Patients**
The demographic and baseline characteristics of the treatment groups were generally well balanced (see online supplementary table S1). In total, 368 (90%) patients completed the 24-week, double-blind phase of the study.

| Table 1 Post hoc analyses of change from baseline at week 24 in mTSS |
|-------------------------------------------------|
| **Imputation in patients with <2 analysable mTSS** |
| **mTSS change from BL at week 24** | **CZP 200 mg** | **CZP 400 mg** | **CZP 200 mg Q2W+CZP 400 mg Q4W** |
| **Placebo (n=136)** | **Q2W (n=136)** | **Q4W (n=135)** | **Q2W (n=135)** |
| Prespecified‡ | 28.9 (7.73) | 11.5 (7.59) | 25.1 (7.92) | 18.3 (6.07) |
| p=0.071† | p=0.004† | p=0.083† | p=0.008 |
| Post hoc 1§ | 0.29 (0.08) | 0.01 (0.08) | 0.12 (0.08) | 0.06 (0.06) |
| p=0.004‡ | p=0.003‡ | p=0.007‡ | p=0.007 |
| Post hoc 2¶ | 0.28 (0.07) | 0.01 (0.07) | 0.11 (0.08) | 0.06 (0.06) |
| p=0.004‡ | p=0.003‡ | p=0.007‡ | p=0.007 |
| Post hoc 3¶ | 0.28 (0.07) | 0.01 (0.07) | 0.11 (0.08) | 0.06 (0.06) |
| p=0.004‡ | p=0.003‡ | p=0.007‡ | p=0.007 |
| Post hoc 4¶ | 0.66 (0.13) | 0.18 (0.13) | 0.52 (0.13) | 0.35 (0.10) |
| p=0.003‡ | p=0.380‡ | p=0.028‡ | p=0.028 |
| Post hoc 5¶ | 0.39 (0.11) | 0.14 (0.11) | 0.49 (0.12) | 0.31 (0.09) |
| p=0.077† | p=0.483‡ | p=0.528 |

Values are least squares mean (SE). For placebo patients who escaped early to CZP, the week 24 values were linearly extrapolated. p Values of CZP versus placebo are based on analysis of covariance.

‡121 patients had fewer than two analysable mTSS; the number of patients was not equally distributed between the treatment groups.

†The study was not powered to detect statistical significance between individual CZP dosage groups and placebo, therefore, these p values should be considered nominal.

‡28 patients had fewer than two analysable mTSS more than 8 weeks apart, including two placebo patients who escaped to CZP before their second mTSS.

BL, baseline; CZP, certolizumab pegol; mTSS, modified Total Sharp Score; Q2W, every 2 weeks; Q4W, every 4 weeks.
Overall, 21 patients had no or one available mTSS (eight placebo, four CZP 200 mg Q2W, nine CZP 400 mg Q4W) (see online supplementary figure S1). An additional five patients had two mTSS less than 8 weeks apart (range 1–6 weeks), and two placebo patients escaped to active treatment without a week 12 mTSS (see online supplementary figure S1).

**Treatment efficacy (prespecified analyses)**

Most patients experienced no change in mTSS over 24 weeks (figure 1A). Overall, 27 patients had an mTSS of 0 at baseline; none of these patients had experienced mTSS progression by week 24. One patient was scored with a −1 improvement in mTSS at week 1; linear extrapolation resulted in an unrealistic improvement of −24 points over 24 weeks (figure 1A).

At baseline, the lowest observed mTSS was 0. At 24 weeks, the largest was 356.5. Consequently, four patients without mTSS were assigned a progression of 356.5. In addition, 16 patients with only analysable baseline mTSS were assigned mTSS progressions ranging from 287.5 to 356.5 (figure 1A). The imputation methodology led to an estimated mean mTSS change from baseline of 11.5 (CZP 200 mg Q2W) and 25.1 (CZP 400 mg Q4W) vs 28.9 (placebo) (table 1). This result was considered an unrealistic overestimation given that the largest observed change in mTSS in any group was 9, and most patients experienced no change in mTSS over 24 weeks and this amount of progression has never been observed in any other study.

Using the prespecified mTSS non-progression rate definition (≤0 cut-off, NRI), we found that mTSS non-progression was more common in the CZP arms than the placebo arms (83.3% (CZP 200 mg Q2W) and 76.3% (CZP 400 mg Q4W) vs 34.6% (placebo), p<0.001).

**Treatment efficacy (post hoc analyses)**

Post hoc analysis using the median mTSS of the entire population to impute missing values in patients with fewer than two analysable mTSS suggested that patients treated with CZP 200 mg Q2W and CZP 400 mg Q4W had reduced radiographic progression compared with placebo patients (0.01 (p=0.004) and 0.11 (p=0.072) vs 0.28) (figure 1C). Additional, more conservative post hoc analyses using alternative imputation methods confirmed the inhibition of radiographic progression by CZP (table 1, figure 1).

Baseline CRP and mTSS have previously been demonstrated to influence radiographic progression. Placebo patients with CRP>15 mg/L and those with mTSS >6 (median population baseline score) experienced greater mTSS progression than those with CRP levels ≤15 mg/L (0.51 vs 0.12) and mTSS ≤6 (0.54 vs 0.06). In comparison, CZP-treated patients experienced low mTSS progression irrespective of baseline CRP (0.08 vs 0.03) or mTSS at baseline (0.08 vs 0.04, see online supplementary table S2).

The proportion of mTSS non-progressors (≤0.5 points cut-off, linear extrapolation) remained significantly higher in the CZP group (93.5% (CZP 200 mg Q2W) and 90.4% (CZP 400 mg Q4W) vs 80.1% (placebo), p<0.05) and was not sensitive to the imputation methodology used for patients with fewer than two analysable mTSS (table 2). Subgroup analysis of mTSS non-progression demonstrated a similar pattern to that observed for mTSS change from baseline (see online supplementary table S2).

**DISCUSSION**

Linear interpolation and extrapolation of imaging data is a well-established imputation method in both rheumatoid arthritis and...
PsA clinical trials. However, it requires the availability of two or more mTSS. Furthermore, it has limitations when available mTSS are recorded very close together, demonstrated by the prespecified mTSS analysis of the RAPID-PsA trial. Excluding mTSS recorded <8 weeks apart resulted in a more realistic estimate of progression in this population.

Analyses that include patients regardless of radiograph availability require additional imputation assumptions. These additional imputation methodologies can have a substantial impact on the assessment of mTSS progression. In this study, the assessment of CZP efficacy was confounded by an inappropriate imputation approach. The prespecified methodology imputed a change variable (mTSS progression) in a patient by replacing status variables (mTSS) across patients. Since the variation in mTSS between patients was many orders of magnitude greater than the average progression, assignment of mTSS progression in patients with fewer than two available mTSS was unrealistic and resulted in an overestimation of mTSS progression in all study arms, preventing the detection of treatment efficacy.

Post hoc analyses demonstrated that imputation methodologies that use the mTSS progression of a population, as has been used in other recent PsA trials, resulted in a more realistic estimate of whole population progression. However, a limitation of the RAPID-PsA post hoc analysis is that only a subset of possible imputation rules has been explored.

The rate of mTSS non-progression demonstrated a statistically significant difference between the CZP treatment arms and the placebo arm regardless of imputation approach. However, the prespecified imputation methodology, which considered all patients who withdrew or escaped to active treatment as mTSS progressors, is likely to overestimate the progression seen in placebo patients.

In conclusion, RAPID-PsA trial results demonstrate how significantly imputation methodology can influence the interpretation of radiographic outcomes in clinical trials. The ‘no imputation’ approach for patients with no or only one film, or two films less than 8 weeks apart and linear extrapolation for patients with two films at least 8 weeks apart seems to be the most appropriate primary analysis. The other imputation methods should be used as sensitivity analyses.

Correction notice This article has been corrected twice since it was published Online First. The length of the study has been amended from 158 weeks to 216 weeks, and the value for the pre-specified mTSS non-responder cut-off should read ’<2’ in the Treatment efficacy (prespecified analysis) section of the paper.

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Table 2 mTSS non-progression analysis

| Non-progression cut-off (mTSS) | Imputation of missing values | mTSS non-progression rate (%) |
|-------------------------------|-----------------------------|------------------------------|
|                               |                             | Placebo (n=136) | CZP 200 mg Q2W (n=138) | CZP 400 mg Q4W (n=135) |
| 0†                            | ≥2 mTSS: NRI‡§               | 34.6           | 83.3*                       | 76.3*                        |
|                               | <2 mTSS: considered progressors‡ | 81.9           | 91.7*                       | 87.8                          |
| ≤0.5                          | ≥2 mTSS: linear imputation   | 86.6           | 96.2*                       | 96.7*                        |
|                               | <2 mTSS: no imputation       | 87.5           | 96.4*                       | 97.0*                        |
| ≤0.5                          | ≥2 mTSS: linear imputation   | 87.5           | 96.4*                       | 97.0*                        |
|                               | <2 mTSS: mean mTSS change from BL of all patients observed | 79.4           | 92.8*                       | 88.1                          |

For placebo patients who escaped early to CZP, the week 24 values were linearly extrapolated.
*p<0.05 versus placebo.
†Prespecified non-progression cut-off mTSS.
‡Prespecified imputation.
§Patients with missing values considered progressors.
BL, baseline; CZP, certolizumab pegol; mTSS, modified Total Sharp Score; NRI, non-responder imputation; Q2W, every 2 weeks; Q4W, every 4 weeks.

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### Table S1: Baseline demographics

| Demographic characteristics | Placebo (n=136) | CZP 200 mg Q2W (n=138) | CZP 400 mg Q4W (n=135) |
|-----------------------------|-----------------|------------------------|------------------------|
| **Age, years**              | 47.3 ± 11.1     | 48.2 (12.3)            | 47.1 (10.8)            |
| **Sex, % female**           | 58.1            | 53.6                   | 54.1                   |
| **Race, % white**           | 97.1            | 97.8                   | 98.5                   |
| **Weight, kg**              | 82.6 ± 19.9††   | 85.8 ± 17.7            | 84.8 ± 18.7            |
| **BMI, kg/m²**              | 29.2 ± 6.7††    | 30.5 ± 6.2             | 29.6 ± 6.6             |

| Arthritis characteristics   |                 |                        |                        |
|-----------------------------|-----------------|------------------------|------------------------|
| **Psoriatic arthritis duration, years** | 18.0 ± 12.3 | 17.3 ± 12.3 | 16.8 ± 13.4 |
| **CRP** (mg/L), median (min-max) | 9.0 (0.2 – 131.0) | 7.0 (0.2 – 238.0) | 8.7 (0.1 – 87.0) |
| **ESR** (mm/h), median (min-max) | 34.0 (6.0 – 125.0) | 35.0 (5.0 – 125.0) | 33.0 (4.0 – 120.0) |
| **Tender joint count (0-68 joints)** | 19.9 ± 14.7 | 21.5 ± 15.3 | 19.6 ± 14.8 |
| **Swollen joint count (0-66 joints)** | 10.4 ± 7.6 | 11.0 ± 8.8 | 10.5 ± 7.5 |
| **HAQ-DI** (range 0-3) | 1.3 ± 0.7 | 1.3 ± 0.7 | 1.3 ± 0.6 |
| **Modified total Sharp score** | 24.4 ± 46.5 | 18.0 ± 30.6 | 22.8 ± 46.5 |
| **Joint space narrowing score** | 14.0 ± 27.0 | 10.3 ± 17.3 | 13.4 ± 25.2 |

| Prior use of synthetic DMARDs, % | Placebo (n=90) | CZP (n=194) | 0.12 92.2 |
|----------------------------------|----------------|-------------|-----------|
|                                  | 1              | 44.1        | 44.4      |
|                                  | ≥ 2             | 52.9        | 44.4      |

| Prior use of NSAIDs, % | Placebo (n=46) | CZP (n=79) | 0.03 96.9 |
|------------------------|----------------|-------------|-----------|
|                        | 83.8           | 81.9        | 91.1      |

| Prior TNF inhibitor exposure, % | Placebo (n=78) | CZP (n=130) | 0.40 96.2* |
|---------------------------------|----------------|-------------|-----------|
|                                 | 19.1           | 22.5        | 17.0      |

| Concomitant MTX at baseline, % | 61.8           | 63.8        | 65.2      |

* Except where indicated otherwise, values are the mean ± SD. There were no significant differences between treatment groups at baseline. BMI: Body mass index; CRP: C-reactive protein; CZP: Certolizumab pegol; DI: Disability index; DMARDs: Disease-modifying antirheumatic drugs; ESR: Erythrocyte sedimentation rate HAQ: Health Assessment Questionnaire; NSAIDs: Nonsteroidal antiinflammatory drugs; MTX: Methotrexate; Q2W: Every 2 weeks; Q4W: Every 4 weeks; TNF: Tumor necrosis factor

** Normal range of CRP < 8.0 mg/L

†† n=135

### Table S2: Change from baseline in mTSS and mTSS nonprogressor rates by baseline risk factors

| Baseline risk factor | Treatment | Mean mTSS change from baseline | mTSS nonprogressor rate (%) |
|----------------------|-----------|--------------------------------|-----------------------------|
| CRP ≤15 mg/L         | Placebo (n=90) | 0.12                          | 92.2                        |
|                      | CZP (n=194)   | 0.03                          | 96.9                        |
| CRP >15 mg/L         | Placebo (n=46) | 0.51                          | 78.3                        |
|                      | CZP (n=79)    | 0.08*                         | 96.2*                       |
| mTSS ≤ median (6)    | Placebo (n=78) | 0.06                          | 97.4                        |
|                      | CZP (n=130)   | 0.04                          | 98.4                        |
| mTSS > median (6)    | Placebo (n=58) | 0.54                          | 74.1                        |
|                      | CZP (n=143)   | 0.08*                         | 95.1*                       |

* p<0.05; CRP: C-reactive protein; CZP: Certolizumab pegol; mTSS: modified total Sharp score. mTSS nonprogressor defined as mean mTSS change from baseline ≤0.5. Median mTSS change from baseline imputation was used in patients with <2 analyzable mTSS scores.
Figure S1: Patient disposition and availability of radiographs

409 patients randomized
- 136 PBO
- 138 CZP 200 mg Q2W
- 135 CZP 400 mg Q4W

388 patients with ≥2 mTSS scores
- 128 PBO
- 134 CZP 200 mg Q2W
- 126 CZP 400 mg Q4W

383 patients with ≥2 mTSS scores ≥8 weeks apart
- 127 PBO
- 133 CZP 200 mg Q2W
- 123 CZP 400 mg Q4W

21 patients <2 mTSS scores
- 8 PBO
- 4 CZP 200 mg Q2W
- 9 CZP 400 mg Q4W

5 patients 2 mTSS scores ≤8 weeks apart
- 1 PBO
- 1 CZP 200 mg Q2W
- 3 CZP 400 mg Q4W

2 PBO patients who escaped to CZP before their second radiograph

302 patients with BL and Wk24 data
- 58 PBO
- 126 CZP 200 mg Q2W
- 118 CZP 400 mg Q4W

16 patients mTSS score at BL only
- 1 patient mTSS score at Wk12 only
- 0 patients mTSS score at Wk24 only
- 4 patients 0 mTSS scores

79 patients with no BL or no Wk24 data
- 67 PBO
- 7 CZP 200 mg Q2W
- 5 CZP 400 mg Q4W

4 patients no mTSS score at BL

75 patients no mTSS score at Wk24
(59 PBO patients escaping to CZP)

BL: Baseline; CZP: Certolizumab pegol; LD: Loading dose; mTSS: modified total Sharp score; PBO: Placebo; Q2W: Every 2 weeks; Q4W: Every 4 weeks; Wk: Week.