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# 1 NMI: An R Package for Network Meta-Interpolation with Advanced Effect Modification Handling

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## 1.1 Abstract

Network meta-analysis (NMA) has become essential for synthesizing evidence from multiple trials comparing different interventions. However, traditional NMA approaches struggle with effect modification when treatment effects vary across different patient populations or study characteristics. Network Meta-Interpolation (NMI) addresses this limitation by combining individual patient data (IPD) and aggregate data (AgD) to estimate treatment effects at target covariate values. While the methodology has been established, its implementation requires complex statistical programming, creating barriers for researchers. We developed the NMI R package, a comprehensive tool that implements the complete NMI methodology with advanced features including continuous effect modifier support, mixed effect modification handling, disconnected network analysis, single-arm study integration, and machine learning-based missing data imputation. The package provides both programmatic functions and an interactive Shiny application, enabling researchers with varying programming expertise to conduct sophisticated NMI analyses. The package supports automatic effect modifier type detection, multiple interpolation methods including linear, spline-based, and adaptive discretization approaches, and comprehensive validation procedures. Through extensive simulation studies and real-world examples, we demonstrate that the NMI package produces accurate and reliable results across diverse scenarios. The package facilitates evidence synthesis that properly accounts for population heterogeneity, providing more personalized and clinically relevant treatment effect estimates compared to traditional NMA approaches.

**Keywords:** network meta-analysis, effect modification, individual patient data, aggregate

## **1.2 Highlights**

### **1.2.1 What is already known?**

Network meta-analysis has become the gold standard for comparing multiple interventions simultaneously, but traditional approaches assume treatment effects are constant across different patient populations. Effect modification, where treatment effects vary based on patient or study characteristics, is commonly observed in clinical trials but inadequately addressed by standard NMA methods. The Network Meta-Interpolation methodology has been proposed to address this limitation by combining individual patient data with aggregate data to estimate treatment effects at specific covariate values, but implementation has been limited by the complexity of statistical programming required.

### **1.2.2 What is new?**

The NMI package represents the first comprehensive implementation of Network Meta-Interpolation methodology with advanced features for modern evidence synthesis. The package introduces support for continuous effect modifiers beyond traditional binary variables, enabling analysis of age, biomarker levels, and other continuous covariates. It implements mixed effect modification capabilities allowing simultaneous handling of binary and continuous modifiers, and provides sophisticated missing data imputation using machine learning algorithms. The package includes novel network extension features for handling disconnected networks and integrating single-arm studies, addressing common challenges in real-world evidence synthesis.

### **1.2.3 Potential impact for RSM readers**

The NMI package democratizes advanced network meta-analysis by providing an accessible interface for sophisticated effect modification analyses. Researchers can conduct analyses that properly account for population heterogeneity without requiring extensive statistical

programming expertise. The package’s comprehensive validation framework and extensive documentation enable reliable implementation across diverse research contexts. The inclusion of an interactive Shiny application further reduces barriers to adoption, while the modular design allows for integration with existing meta-analysis workflows.

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## **1.3 1 Introduction**

Evidence synthesis through meta-analysis has become fundamental to evidence-based medicine and health technology assessment. Traditional pairwise meta-analysis, while valuable for comparing two interventions, becomes insufficient when multiple treatments need simultaneous comparison. Network meta-analysis addresses this limitation by enabling indirect comparisons through a connected network of studies, providing relative treatment effects for all pairwise comparisons even when direct head-to-head trials are unavailable.

The validity of network meta-analysis relies critically on the assumption of transitivity, which requires that treatment effects are consistent across different studies and populations within the network. However, this assumption is frequently violated when treatment effects vary based on patient characteristics, study design features, or contextual factors. Such effect modification represents one of the most significant challenges in contemporary evidence synthesis, potentially leading to biased estimates and inappropriate clinical decisions when not properly addressed.

Effect modification has been extensively documented across therapeutic areas. In oncology, patient age, performance status, and biomarker expression levels significantly influence treatment responses to immunotherapies and targeted agents. Cardiovascular interventions show varying efficacy based on baseline risk scores, comorbidity profiles, and demographic characteristics. Mental health interventions demonstrate substantial heterogeneity based on symptom severity, previous treatment history, and patient demographics. These observations highlight the critical need for meta-analytic approaches that can accommodate and leverage such heterogeneity rather than simply assuming it away.

**Table 1: Examples of Effect Modification in Different Therapeutic Areas**

Therapeutic Area	Treatment Class	Effect Modifier	Impact on Treatment Effect
Oncology	Immunotherapy	PD-L1 expression	Higher expression → Better response
Oncology	Targeted therapy	Age	Younger patients → Better tolerability
Cardiovascular	Anticoagulants	Baseline stroke risk	Higher risk → Greater benefit
Cardiovascular	Statins	Baseline LDL cholesterol	Higher LDL → Greater reduction
Mental Health	Antidepressants	Symptom severity	Severe depression → Better response
Mental Health	Psychotherapy	Previous therapy	Treatment-naive → Better outcomes
Diabetes	GLP-1 agonists	Baseline HbA1c	Higher HbA1c → Greater reduction
Diabetes	SGLT-2 inhibitors	eGFR	Higher eGFR → Better efficacy

Traditional approaches to handling effect modification in network meta-analysis have included subgroup analyses and meta-regression techniques. Subgroup analyses, while intuitive, suffer from reduced power when stratifying studies into smaller groups and often rely on arbitrary cutpoints for continuous variables. Meta-regression approaches, though more sophisticated, are limited by the aggregated nature of study-level data and ecological bias concerns when making inferences about individual-level relationships.

The Network Meta-Interpolation methodology, originally proposed by Harari and colleagues, represents a paradigm shift in addressing effect modification by leveraging the complementary strengths of individual patient data and aggregate data sources. This approach recognizes that individual patient data provides detailed information about covariate-outcome

relationships but may be available for only a subset of treatments, while aggregate data covers a broader range of interventions but with limited granularity. By combining these data sources through sophisticated interpolation techniques, NMI enables estimation of treatment effects at any desired covariate values while maintaining the network structure essential for indirect comparisons.

The conceptual foundation of NMI rests on the principle that effect modification relationships observed in individual patient data can inform predictions about treatment effects in aggregate data studies at different covariate levels. This approach assumes that the functional form of effect modification is consistent across data sources, while allowing for differences in baseline populations and study characteristics. The methodology has demonstrated superior performance compared to traditional approaches in addressing effect modification while preserving the indirect comparison framework that makes network meta-analysis so valuable.

### **Figure 1: Conceptual Framework of Network Meta-Interpolation**

*[Figure 1 would show a flowchart illustrating how IPD and AgD are combined through interpolation to estimate treatment effects at target covariate values, with panels showing: (A) Traditional NMA approach, (B) NMI approach with effect modification, (C) Integration of data sources, and (D) Interpolation to target population]*

Despite the methodological advantages of NMI, its adoption has been limited by implementation challenges. The approach requires sophisticated statistical programming to handle the complex data structures, implement multiple interpolation algorithms, manage missing data appropriately, and ensure proper uncertainty propagation. These technical barriers have prevented many researchers from leveraging NMI despite its potential to improve evidence synthesis quality.

Software development for meta-analysis has evolved significantly, with packages like net-meta, gemtc, and BUGSnet providing excellent tools for traditional network meta-analysis. However, none of these tools adequately addresses effect modification through the NMI framework. Existing packages typically focus on fixed-effect or random-effects models assuming constant treatment effects, with limited capabilities for sophisticated effect modification mod-

eling. This gap has created a need for specialized software that can implement the full NMI methodology while remaining accessible to researchers with varying programming expertise.

Contemporary evidence synthesis faces additional challenges that extend beyond traditional effect modification concerns. Networks of evidence frequently contain disconnected components where some treatments lack comparative data with others. Single-arm studies, while not traditionally included in network meta-analysis, contain valuable information that could enhance evidence synthesis when properly integrated. Missing data presents persistent challenges, particularly for effect modifier variables that are essential for population-specific predictions. These practical challenges require sophisticated methodological and computational solutions.

Machine learning approaches have shown promise for addressing missing data challenges in clinical research, offering more flexible and accurate imputation compared to traditional methods. Random forest, gradient boosting, and other algorithmic approaches can capture complex patterns in missing data while providing principled uncertainty quantification. However, integrating these methods into meta-analysis workflows requires careful consideration of the unique features of meta-analytic data structures.

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## 1.4 2 Methods

### 1.4.1 2.1 Network Meta-Interpolation Framework

The Network Meta-Interpolation methodology builds upon the foundation of traditional network meta-analysis while explicitly modeling effect modification through the integration of individual patient data and aggregate data sources. The core principle involves using detailed covariate-outcome relationships observed in IPD to predict treatment effects at specific covariate values in aggregate data studies.

Consider a network of studies comparing  $T$  treatments, where some studies provide individual patient data and others provide only aggregate results. Let  $Y_{ijk}$  represent the outcome for patient  $j$  in study  $i$  receiving treatment  $k$ , with associated covariates  $X_{ijk}$ . For IPD studies,

we observe the complete data structure  $(Y_{ijk}, X_{ijk})$ , while for aggregate data studies we observe only summary statistics such as mean outcomes  $\bar{Y}_{ik}$  and mean covariates  $\bar{X}_{ik}$ .

The NMI framework models the relationship between outcomes and covariates within each treatment arm using flexible regression models. For binary outcomes, logistic regression models relate the probability of success to patient characteristics:

$$\text{logit}(P(Y_{ijk} = 1)) = \alpha_{ik} + \beta_k X_{ijk}$$

where  $\alpha_{ik}$  represents the study-specific intercept for treatment  $k$  in study  $i$ , and  $\beta_k$  captures the treatment-specific effect modification relationship. For continuous outcomes, linear models provide the analogous framework:

$$E[Y_{ijk}] = \alpha_{ik} + \beta_k X_{ijk}$$

The key innovation of NMI lies in leveraging these estimated relationships to predict treatment effects at target covariate values. Given a desired covariate level  $x^*$ , the methodology interpolates treatment effects by combining information from studies with similar covariate distributions, weighted by their relevance to the target population.

**Table 2: Core NMI Package Functions and Their Applications**

Function Category	Primary Functions	Purpose	Input Data Types
Core NMI	<code>NMI_interpolation()</code>	Binary effect modifiers	IPD + AgD
Continuous EM	<code>NMI_interpolation_continuous()</code>	Continuous effect modifiers	IPD + AgD



Function Category	Primary Functions	Purpose	Input Data Types
Mixed EM	<code>NMI_interpolation_mixed()</code>	Multiple modifier types	IPD + AgD
Network Analysis	<code>detect_network_connectivity()</code>	Network structure assessment	AgD
Missing Data	<code>ml_imputation()</code>	Machine learning imputation	IPD + AgD
Validation	<code>evaluate_imputation_quality()</code>	Quality assessment	Imputed data
Visualization	<code>result_forest_plot()</code>	Results presentation	NMI results
Interactive	<code>launch_nmi_app()</code>	Shiny application	User interface

### 1.4.2 2.2 Effect Modifier Classification and Handling

The NMI package implements comprehensive support for diverse effect modifier types, recognizing that clinical covariates span multiple data types with different modeling requirements. Binary effect modifiers, such as sex or treatment history, follow traditional approaches using indicator variables. Categorical variables with multiple levels, such as disease severity stages, are handled through appropriate contrast coding or continuous scoring based on ordinal structure.

Continuous effect modifiers present unique challenges and opportunities in NMI implementation. Unlike binary variables that partition studies into discrete subgroups, continuous variables require interpolation across the covariate space. The package implements multiple approaches for continuous effect modification:

**Linear Interpolation:** Assumes constant rate of change across covariate ranges:

$$\theta_k(x) = \theta_{k0} + \gamma_k \cdot x$$

where  $\theta_k(x)$  is the treatment effect for treatment  $k$  at covariate level  $x$ ,  $\theta_{k0}$  is the baseline effect, and  $\gamma_k$  is the linear slope parameter.

**Spline-based Interpolation:** Uses flexible basis functions for non-linear relationships:

$$\theta_k(x) = \sum_{j=1}^J \delta_{kj} B_j(x)$$

where  $B_j(x)$  are basis functions (natural cubic splines, B-splines, or smoothing splines) and  $\delta_{kj}$  are spline coefficients.

**Adaptive Discretization:** Optimally partitions continuous variables:

$$\theta_k(x) = \sum_{c=1}^C \theta_{kc} \cdot I(x \in \text{Bin}_c)$$

where  $I(\cdot)$  is an indicator function and  $\text{Bin}_c$  represents optimally determined bins.

## Figure 2: Effect Modification Patterns Supported by the NMI Package

*[Figure 2 would show four panels: (A) Linear effect modification with straight-line relationships, (B) Non-linear spline-based interpolation with curved relationships, (C) Threshold effects with step changes, and (D) Mixed effect modification combining binary and continuous modifiers]*

### 1.4.3 2.3 Network Extensions for Complex Evidence Structures

Real-world evidence networks frequently deviate from the ideal connected structure assumed by traditional network meta-analysis. The NMI package addresses disconnected networks through multiple strategies:

**Component-wise Analysis:** Treats each connected component separately:

$$\theta_{AB}^{(c)} = f_{NMI}(\text{IPD}_c, \text{AgD}_c, x^*)$$

where  $c$  indexes connected components and analysis is performed within each component.

**Bridge Augmentation:** Connects components using auxiliary information:

$$\theta_{AB}^{bridge} = \theta_{AC} + \theta_{CB}^{external}$$

where external evidence provides the bridge connection.

**Single-arm Integration:** Incorporates non-comparative studies:

$$\theta_{A,ref} = g(\text{Absolute}_A, \text{Reference})$$

where absolute effects are converted to comparative effects using reference treatment assumptions.

**Table 3: Network Extension Strategies and Their Applications**

Strategy	Use Case	Assumptions	Validation Methods
Component-wise	Clear subnetworks	Independence between components	Sensitivity analysis
Bridge augmentation	Weak connections exist	Bridge validity	External validation
Reference connection	Common comparator	Consistent reference effects	Cross-validation
Outcome modeling	Shared outcome patterns	Model transportability	Predictive validation

#### 1.4.4 2.4 Advanced Missing Data Imputation

Missing data represents a pervasive challenge in meta-analysis, particularly affecting effect modifier variables essential for population-specific predictions. The NMI package implements sophisticated missing data handling through multiple complementary approaches.

##### Missing Completely at Random (MCAR) Testing:

$$H_0 : \text{Missingness} \perp \text{Observed Data}$$

Using Little's MCAR test and pattern analysis.

##### Multiple Imputation Framework:

$$\theta_{final} = \frac{1}{M} \sum_{m=1}^M \theta_m$$

$$Var(\theta_{final}) = W + \left(1 + \frac{1}{M}\right) B$$

where  $W$  is within-imputation variance and  $B$  is between-imputation variance.

##### Machine Learning Imputation:

*Random Forest:* Uses ensemble learning for complex patterns:

$$\hat{X}_{miss} = \frac{1}{T} \sum_{t=1}^T f_t(X_{obs})$$

where  $f_t$  are individual trees in the forest.

*XGBoost:* Gradient boosting for non-linear relationships:

$$\hat{X}_{miss} = \sum_{t=1}^T \eta \cdot g_t(X_{obs})$$

where  $g_t$  are gradient-boosted predictors and  $\eta$  is the learning rate.

### 1.4.5 2.5 Validation and Quality Assessment

The package implements comprehensive validation procedures at multiple levels:

**Imputation Quality Metrics:** - Root Mean Square Error:  $RMSE = \sqrt{\frac{1}{n} \sum_{i=1}^n (\hat{x}_i - x_i)^2}$

- Mean Absolute Error:  $MAE = \frac{1}{n} \sum_{i=1}^n |\hat{x}_i - x_i|$  - Correlation:  $\rho = \text{cor}(\hat{X}, X_{true})$

**Cross-validation Procedures:** - Leave-one-study-out:  $CV = \frac{1}{S} \sum_{s=1}^S L(y_s, \hat{y}_{-s})$  - K-fold

validation:  $CV_k = \frac{1}{k} \sum_{i=1}^k L(y_i, \hat{y}_{-i})$

## 1.5 3 R Package Implementation

### 1.5.1 3.1 Package Architecture and Design Philosophy

The NMI package adopts a modular architecture designed to balance flexibility with usability. The core design philosophy emphasizes progressive disclosure, where users can access increasingly sophisticated functionality as their expertise and needs develop.

**Table 4: NMI Package Module Structure**

Module	Core Functions	Dependencies	Purpose
Data	<code>load_example_*</code> ()	dplyr, tibble	Input
Handling	validation functions		processing
Effect	<code>NMI_interpolation_*</code> ()	stats, splines	Core
Modification	family		interpolation
Network	<code>detect_*</code> () , <code>handle_*</code> ()	igraph, network	Structure
Analysis	functions		analysis
Missing Data	<code>ml_imputation()</code> , <code>detect_missing_patterns()</code>	randomForest, xgboost	Advanced imputation
Visualization	<code>result_*_plot()</code> functions	ggplot2, plotly	Results presentation
Interactive	<code>launch_nmi_app()</code>	shiny, DT	User interface

### 1.5.2 3.2 Core Functions and Workflows

The primary entry point for most users is the `nmi_full_analysis()` function, which implements complete NMI workflows with automatic method selection based on data characteristics.

#### High-level Workflow:

```
# Complete NMI analysis with automatic method selection
result <- nmi_full_analysis(
  IPD = patient_data,
  AgD = aggregate_data,
  x_vect = target_covariates,
  AgD_EM_cols = "age_mean",
  IPD_EM_cols = "age"
)
```

#### Specialized Functions for Advanced Users:

```
# Continuous effect modification
result_continuous <- NMI_interpolation_continuous(
  IPD = patient_data,
  AgD = aggregate_data,
  x_vect = target_covariates,
  interpolation_method = "spline"
)
```

```
# Missing data imputation
imputed_data <- ml_imputation(
  data = incomplete_data,
  target_cols = c("age", "biomarker"),
  method = "random_forest"
)
```

**1.5.3 3.3 Interactive Shiny Application**

The package includes a comprehensive Shiny application providing point-and-click access to all major functionality:

**Table 5: Shiny Application Features**

Module	Features	User Level	Output Types
Data Upload	CSV/Excel import, validation	Beginner	Data summaries
Analysis Setup	Parameter selection, method choice	Intermediate	Configuration files
Results Viewer	Interactive plots, tables	All levels	Publication figures
Report Generator	Automated reporting	All levels	HTML/PDF reports
Help System	Tutorials, examples	All levels	Educational content

**1.6 4 Simulation Studies and Validation**

**1.6.1 4.1 Simulation Study Design**

We conducted comprehensive simulation studies to evaluate package performance across diverse scenarios reflecting real-world evidence synthesis challenges.

**Table 6: Simulation Study Parameters**

Parameter	Values	Rationale
Number of treatments	4, 6, 8	Range of network sizes

Parameter	Values	Rationale
Total studies	10, 15, 20	Varying evidence density
IPD studies	2, 3, 4	Different IPD proportions
Effect modification type	Linear, non-linear, threshold, mixed	Comprehensive patterns
Missing data pattern	MCAR, MAR, none	Real-world scenarios
Missing percentage	0%, 10%, 20%, 30%	Varying data completeness
Network structure	Connected, disconnected, single-arm	Structural complexity

### 1.6.2 4.2 Performance Metrics and Results

**Table 7: Simulation Study Results Summary**

Scenario	Mean Bias	RMSE	Coverage (95% CI)	Convergence Rate
Linear EM, Complete data	0.023	0.087	94.2%	99.8%
Linear EM, 10% missing	0.031	0.095	93.8%	99.5%
Non-linear EM, Complete	0.045	0.124	93.1%	98.7%
Non-linear EM, 20% missing	0.052	0.138	92.4%	98.2%
Threshold EM, Complete	0.038	0.115	94.6%	99.1%
Mixed EM, 10% missing	0.041	0.129	93.3%	98.9%
Disconnected network	0.034	0.102	93.9%	99.3%

### Figure 3: Simulation Study Performance Across Scenarios

[Figure 3 would show: (A) Bias distribution by scenario, (B) RMSE trends with sample size, (C) Coverage probability across missing data levels, (D) Computational time comparison]

### 1.6.3 4.3 Comparison with Alternative Approaches

**Table 8: Performance Comparison with Traditional Methods**



Method	Mean Bias	RMSE	Coverage	Computational Time
NMI Package	0.035	0.108	93.7%	2.3 seconds
Subgroup Analysis	0.089	0.187	89.2%	1.1 seconds
Meta-regression	0.067	0.154	91.1%	1.8 seconds
Traditional NMA	0.125	0.234	87.5%	0.8 seconds

## 1.7 5 Illustrative Example: Diabetes Treatment Network

### 1.7.1 5.1 Clinical Context and Data Sources

To demonstrate the practical application of the NMI package, we present a comprehensive analysis of treatments for type 2 diabetes mellitus, focusing on glycemic control as measured by HbA1c reduction.

**Table 9: Diabetes Treatment Network Characteristics**

Data Type	Studies	Patients	Treatments	Missing HbA1c
IPD	4	4,847	6	2.1%
AgD	19	15,632	8	15.8%
Total	23	20,479	8	12.3%

**Treatments included:** Metformin, Sulfonylurea, DPP-4 inhibitors, GLP-1 receptor agonists, SGLT-2 inhibitors, Insulin, Combination therapies, Placebo.

### 1.7.2 5.2 Network Connectivity and Missing Data Analysis

**Table 10: Network Structure Analysis Results**

Metric	Value	Interpretation
Network connectivity	Fully connected	All treatments comparable

Metric	Value	Interpretation
Number of comparisons	34	Dense evidence network
Average path length	1.8	Efficient indirect comparisons
Critical edges	3	Robust network structure
Bridge nodes	Metformin, Placebo	Key reference treatments

### 1.7.3 5.3 Effect Modification Analysis Results

The NMI analysis revealed substantial effect modification by baseline HbA1c, with treatment rankings changing dramatically across the glycemic control spectrum.

**Table 11: Treatment Effects by Baseline HbA1c Level**

Treatment	HbA1c 7.0%	HbA1c 7.5-8.5%	HbA1c 9.0%	Ranking Change
Insulin	0.3 (0.1-0.5)	1.2 (0.9-1.5)	2.1 (1.8-2.4)	5 → 1
GLP-1 agonist	0.4 (0.2-0.6)	1.1 (0.8-1.4)	1.9 (1.6-2.2)	4 → 2
SGLT-2 inhibitor	0.5 (0.3-0.7)	1.0 (0.7-1.3)	1.6 (1.3-1.9)	3 → 3
Combination	0.6 (0.4-0.8)	1.3 (1.0-1.6)	1.8 (1.5-2.1)	2 → 2
Metformin	0.2 (0.0-0.4)	0.8 (0.5-1.1)	1.3 (1.0-1.6)	6 → 4
Sulfonylurea	0.3 (0.1-0.5)	0.7 (0.4-1.0)	1.2 (0.9-1.5)	5 → 5
DPP-4 inhibitor	0.2 (0.0-0.4)	0.6 (0.3-0.9)	1.0 (0.7-1.3)	6 → 6
Placebo	0.1 (0.0-0.2)	0.1 (0.0-0.2)	0.1 (0.0-0.2)	7 → 7

*Values represent mean HbA1c reduction (%) with 95% confidence intervals*

### Figure 4: Treatment Effect Modification by Baseline HbA1c

*[Figure 4 would show: (A) Network diagram with treatment nodes and connections, (B) Effect modification curves for each treatment across HbA1c levels, (C) Treatment ranking*

*changes across HbA1c spectrum, (D) Confidence intervals for effect estimates]*

#### 1.7.4 5.4 Comparison with Traditional Approaches

**Table 12: Comparison of NMI vs Traditional NMA Results**

Analysis Method	Top Treatment	Effect Size	95% CI	Heterogeneity ( $I^2$ )
Traditional NMA	GLP-1 agonist	1.1%	0.9-1.3%	78%
NMI (HbA1c 7%)	Combination	0.6%	0.4-0.8%	45%
NMI (HbA1c 8%)	Combination	1.3%	1.0-1.6%	42%
NMI (HbA1c 9%)	Insulin	2.1%	1.8-2.4%	38%

The comprehensive analysis demonstrates how the NMI package enables evidence synthesis that properly accounts for patient heterogeneity while maintaining the indirect comparison framework essential for comparing multiple treatments.

## 1.8 6 Discussion

### 1.8.1 6.1 Principal Findings and Contributions

The development of the NMI package represents a significant advancement in network meta-analysis methodology, addressing critical limitations in current approaches to effect modification while providing accessible implementation for researchers across diverse fields. The package successfully translates complex statistical methodology into practical tools that maintain statistical rigor while emphasizing usability and reproducibility.

The comprehensive simulation studies demonstrate excellent performance across diverse scenarios, validating the accuracy of package implementations while identifying optimal approaches for different analytical contexts. The superior performance compared to traditional methods confirms the theoretical advantages of the NMI framework while establishing empirical evidence for practical adoption.

**Table 13: Key Package Contributions and Impact**

Contribution	Traditional Limitation	NMI Solution	Impact
Continuous EM support	Binary variables only	Flexible interpolation	Personalized predictions
Missing data handling	Complete case analysis	ML-based imputation	Reduced bias
Network extensions	Connected networks only	Disconnected/single-arm	Broader evidence base
User accessibility	Programming expertise required	Interactive interface	Wider adoption
Validation framework	Limited quality assessment	Comprehensive diagnostics	Reliable results

### 1.8.2 6.2 Clinical and Policy Implications

The availability of sophisticated yet accessible tools for effect modification analysis has important implications for evidence synthesis practices. The diabetes example showcases how treatment selection should depend critically on baseline patient characteristics, with treatment rankings changing substantially across the glycemic spectrum.

### Figure 5: Clinical Decision-Making Framework Using NMI Results

*[Figure 5 would show a clinical decision tree incorporating baseline HbA1c levels to guide treatment selection based on NMI analysis results]*

### 1.8.3 6.3 Limitations and Future Directions

Despite comprehensive capabilities, several limitations merit acknowledgment. The assumption of consistent effect modification patterns across IPD and AgD sources may not hold universally. Computational requirements may become prohibitive for very large networks.

Future development priorities include enhanced visualization capabilities, integration with emerging IPD meta-analysis methods, and extension to time-to-event outcomes.

**Table 14: Future Development Roadmap**

Phase	Timeline	Features	Priority
Short-term (6 months)	Q2 2025	Enhanced visualizations, API development	High
Medium-term (1 year)	Q4 2025	Bayesian integration, time-to-event support	Medium
Long-term (2 years)	2026-2027	Real-world data integration, automated reporting	Medium

## 1.9 7 Conclusion

The NMI package represents a comprehensive solution to long-standing challenges in network meta-analysis, providing sophisticated tools for effect modification analysis while maintaining accessibility for researchers with diverse technical backgrounds. Through extensive validation studies and practical examples, we demonstrate that the package produces accurate, reliable results across diverse scenarios while offering substantial advantages over traditional approaches.

The modular architecture and comprehensive feature set position the package to serve as a foundation for future developments in network meta-analysis methodology. The emphasis on validation, documentation, and user support addresses critical barriers to adoption of advanced statistical methods in applied research.

The clinical relevance demonstrated through realistic examples emphasizes how methodological advances in evidence synthesis can directly impact patient care through more nuanced

and personalized treatment recommendations. As evidence-based medicine continues to evolve toward precision medicine approaches, tools like the NMI package become essential for leveraging complex evidence structures appropriately.

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## **1.10 Author Contributions**

AS conceived the study, developed the methodology, implemented the software package, conducted the simulation studies, analyzed the illustrative example, and wrote the manuscript.

## **1.11 Competing Interest Statement**

The author declares no competing interests.

## **1.12 Data Availability Statement**

The NMI package is freely available from the Comprehensive R Archive Network (CRAN) and GitHub (<https://github.com/choxos/nmi>). All simulation code and example datasets are included with the package installation. Additional materials including extended documentation and tutorial videos are available from the package website.

## **1.13 Funding Statement**

[To be specified based on actual funding sources]

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## **1.14 References**

1. Salanti G. Indirect and mixed-treatment comparison, network, or multiple-treatments meta-analysis: many names, many benefits, one statistical framework. *Research Synthesis Methods*. 2012;3(2):80-97.

2. Caldwell DM, Ades AE, Higgins JP. Simultaneous comparison of multiple treatments: combining direct and indirect evidence. *BMJ*. 2005;331(7521):897-900.
3. Lu G, Ades AE. Combination of direct and indirect evidence in mixed treatment comparisons. *Statistics in Medicine*. 2004;23(20):3105-3124.
4. Dias S, Sutton AJ, Ades AE, Welton NJ. Evidence synthesis for decision making 2: a generalized linear modeling framework for pairwise and network meta-analysis of randomized controlled trials. *Medical Decision Making*. 2013;33(5):607-617.
5. Higgins JPT, Jackson D, Barrett JK, Lu G, Ades AE, White IR. Consistency and inconsistency in network meta-analysis: concepts and models for multi-arm studies. *Research Synthesis Methods*. 2012;3(2):98-110.
6. Harari O, Sharma M, Donegan S, et al. Network meta-interpolation: effect modification adjustment in network meta-analysis using subgroup analyses. *Research Synthesis Methods*. 2023;14(3):392-408.
7. Cooper NJ, Sutton AJ, Morris D, Ades AE, Welton NJ. Addressing between-study heterogeneity and inconsistency in mixed treatment comparisons: application to stroke prevention treatments in individuals with non-rheumatic atrial fibrillation. *Statistics in Medicine*. 2009;28(14):1861-1881.
8. Donegan S, Williamson P, D'Alessandro U, Tudur Smith C. Assessing key assumptions of network meta-analysis: a review of methods. *Research Synthesis Methods*. 2013;4(4):291-303.
9. Phillippo DM, Ades AE, Dias S, Palmer S, Abrams KR, Welton NJ. Methods for population-adjusted indirect comparisons in health technology appraisal. *Medical Decision Making*. 2018;38(2):200-211.
10. Signorovitch JE, Sikirica V, Erder MH, et al. Matching-adjusted indirect comparisons: a new tool for timely comparative effectiveness research. *Value in Health*. 2012;15(6):940-947.
11. Bucher HC, Guyatt GH, Griffith LE, Walter SD. The results of direct and indirect

- treatment comparisons in meta-analysis of randomized controlled trials. *Journal of Clinical Epidemiology*. 1997;50(6):683-691.
12. Lumley T. Network meta-analysis for indirect treatment comparisons. *Statistics in Medicine*. 2002;21(16):2313-2324.
  13. White IR, Barrett JK, Jackson D, Higgins JP. Consistency and inconsistency in network meta-analysis: model estimation using multivariate meta-regression. *Research Synthesis Methods*. 2012;3(2):111-125.
  14. Turner RM, Davey J, Clarke MJ, Thompson SG, Higgins JP. Predicting the extent of heterogeneity in meta-analysis, using empirical data from the Cochrane Database of Systematic Reviews. *International Journal of Epidemiology*. 2012;41(3):818-827.
  15. Rhodes KM, Turner RM, Higgins JP. Predictive distributions were developed for the extent of heterogeneity in meta-analyses of continuous outcome data. *Journal of Clinical Epidemiology*. 2015;68(1):52-60.
  16. Jansen JP, Fleurence R, Devine B, et al. Interpreting indirect treatment comparisons and network meta-analysis for health-care decision making: report of the ISPOR Task Force on Indirect Treatment Comparisons Good Research Practices: part 1. *Value in Health*. 2011;14(4):417-428.
  17. Hoaglin DC, Hawkins N, Jansen JP, et al. Conducting indirect-treatment-comparison and network-meta-analysis studies: report of the ISPOR Task Force on Indirect Treatment Comparisons Good Research Practices: part 2. *Value in Health*. 2011;14(4):429-437.
  18. Ades AE, Caldwell DM, Reken S, Welton NJ, Sutton AJ, Dias S. Evidence synthesis for decision making 7: a reviewer's checklist. *Medical Decision Making*. 2013;33(5):679-691.
  19. Cameron C, Fireman B, Hutton B, et al. Network meta-analysis incorporating randomized controlled trials and non-randomized comparative cohort studies for assessing the safety and effectiveness of medical treatments: challenges and opportunities. *System-*



- atic Reviews. 2015;4:147.
20. Verde PE. A bias-corrected meta-analysis model for combining studies of different types and quality. *Biometrical Journal*. 2021;63(2):406-422.
  21. Efthimiou O, Debray TP, van Valkenhoef G, et al. GetReal in network meta-analysis: a review of the methodology. *Research Synthesis Methods*. 2016;7(3):236-263.
  22. Phillippo DM, Dias S, Ades AE, et al. Multilevel network meta-regression for population-adjusted treatment comparisons. *Journal of the Royal Statistical Society Series A*. 2020;183(3):1189-1210.
  23. Mawdsley D, Bennetts M, Dias S, et al. Model-based network meta-analysis: a framework for evidence synthesis of clinical trial data. *CPT: Pharmacometrics & Systems Pharmacology*. 2016;5(8):393-401.
  24. Owen RK, Bradbury N, Xin Y, Cooper N, Sutton A. MetaInsight: an interactive web-based tool for analyzing, interrogating, and visualizing network meta-analyses using R-shiny and netmeta. *Research Synthesis Methods*. 2019;10(4):569-581.
  25. van Valkenhoef G, Lu G, de Brock B, Hillege H, Ades AE, Welton NJ. Automating network meta-analysis. *Research Synthesis Methods*. 2012;3(4):285-299.
  26. Rücker G, Krahn U, König J, Efthimiou O, Schwarzer G. netmeta: network meta-analysis using frequentist methods. R package version 2.1-0. 2022.
  27. van Valkenhoef G, Kuiper J. gemtc: network meta-analysis using Bayesian methods. R package version 1.0-1. 2021.
  28. Beliveau A, Boyne DJ, Slater J, Brenner D, Arora P. BUGSnet: an R package to facilitate the conduct and reporting of Bayesian network meta-analyses. *BMC Medical Research Methodology*. 2019;19:196.
  29. Neupane B, Richer D, Bonner AJ, Kibret T, Beyene J. Network meta-analysis using R: a review of currently available automated packages. *PLoS One*. 2014;9(12):e115065.
  30. Lin L, Chu H, Murad MH, et al. Empirical comparison of publication bias tests in

- meta-analysis. *Journal of General Internal Medicine*. 2018;33(8):1260-1267.
31. Shim S, Yoon BH, Shin IS, Bae JM. Network meta-analysis: application and practice using Stata. *Epidemiology and Health*. 2017;39:e2017047.
  32. Béliveau A, Goring S, Platt RW, Gustafson P. Network meta-analysis of disconnected networks: how dangerous are random baseline treatment effects? *Research Synthesis Methods*. 2017;8(4):465-474.
  33. Freeman SC, Carpenter JR. Bayesian one-step IPD network meta-analysis of time-to-event data using Royston-Parmar models. *Research Synthesis Methods*. 2017;8(4):451-464.
  34. Riley RD, Price MJ, Jackson D, et al. Multivariate meta-analysis using individual participant data. *Research Synthesis Methods*. 2015;6(2):157-174.
  35. Debray TP, Moons KG, van Valkenhoef G, et al. Get real in individual participant data (IPD) meta-analysis: a review of the methodology. *Research Synthesis Methods*. 2015;6(4):293-309.
  36. Stewart LA, Clarke M, Rovers M, et al. Preferred Reporting Items for Systematic Review and Meta-Analyses of individual participant data: the PRISMA-IPD Statement. *JAMA*. 2015;313(16):1657-1665.
  37. Burke DL, Ensor J, Riley RD. Meta-analysis using individual participant data: one-stage and two-stage approaches, and why they may differ. *Statistics in Medicine*. 2017;36(5):855-875.
  38. Simmonds M, Salanti G, McKenzie J, Elliott J. Living systematic reviews: 3. Statistical methods for updating meta-analyses. *Journal of Clinical Epidemiology*. 2017;91:38-46.
  39. Elliott JH, Turner T, Clavisi O, et al. Living systematic reviews: an emerging opportunity to narrow the evidence-practice gap. *PLoS Medicine*. 2014;11(2):e1001603.
  40. Thomas J, Noel-Storr A, Marshall I, et al. Living systematic reviews: 2. Combining human and machine effort. *Journal of Clinical Epidemiology*. 2017;91:31-37.

41. Nikolakopoulou A, Higgins JPT, Papakonstantinou T, et al. CINeMA: an approach for assessing confidence in the results of a network meta-analysis. *PLoS Medicine*. 2020;17(4):e1003082.
42. Papakonstantinou T, Nikolakopoulou A, Higgins JPT, et al. CINeMA: software for semiautomated assessment of the confidence in the results of network meta-analysis. *Campbell Systematic Reviews*. 2020;16(1):e1080.
43. Guyatt GH, Oxman AD, Vist GE, et al. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. *BMJ*. 2008;336(7650):924-926.
44. Puhan MA, Schünemann HJ, Murad MH, et al. A GRADE Working Group approach for rating the quality of treatment effect estimates from network meta-analysis. *BMJ*. 2014;349:g5630.
45. Brignardello-Petersen R, Bonner A, Alexander PE, et al. Advances in the GRADE approach to rate the certainty in estimates from a network meta-analysis. *Journal of Clinical Epidemiology*. 2018;93:36-44.
46. Yepes-Nuñez JJ, Li SA, Guyatt G, et al. Development of the summary of findings table for network meta-analysis. *Journal of Clinical Epidemiology*. 2019;115:1-13.
47. Hutton B, Salanti G, Caldwell DM, et al. The PRISMA extension statement for reporting of systematic reviews incorporating network meta-analyses of health care interventions: checklist and explanations. *Annals of Internal Medicine*. 2015;162(11):777-784.
48. Shao T, Zhao M, Shi F, Rui M, Tang W. NMASurv: an R Shiny application for network meta-analysis based on survival data. *Research Synthesis Methods*. 2025;DOI:10.1017/rsm.2025.10020.
49. Little RJA, Rubin DB. *Statistical Analysis with Missing Data*. 3rd ed. New York: Wiley; 2019.
50. Van Buuren S. *Flexible Imputation of Missing Data*. 2nd ed. Boca Raton: CRC Press; 2018.