Adaptive Clinical Trials: The Promise and the Caution

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Korn and Freidlin (2011)

Two-armed trial

Assignment probability to experimental treatment arm

$$= \frac{[P(E > C)]^a}{[P(E > C)]^a + [1 - P(E > C)]^a}$$
 (1)

- a = 0: exploration
- a = ∞: exploitation
- a = 1: Thompson sampling

Giles Phase II trial

- Acute myeloid leukemia
- Complete remission (CR) by day 50

- n=24, arm1 dropped (0/5 CRs)
- n = 34, arm2 dropped (3/11 = 27% CRs)
- Standard therapy (11/18 = 61% CRs)

Giles Phase II trial

- As opposed to equal randomization of 75 patients
 - 7 standard therapy, 20 arm1, 14 arm2 instead of
 41 standard therapy
 - Estimate extra 17.6/41 patients achieved CRs (23% incremental CR rate overall)

Strengths of Adaptive Trials

- Multiple drugs & regimens + biomarker signatures (e.g. BATTLE)
- Phase II/III trials with different doses / schedules of drugs, combination therapy, different responding subpopulations

I-SPY 2 Trial

- Phase II drug screening in neoadjuvant breast cancer
 - 6 treatment arms
 - Adaptive randomization within biomarker subsets
 - Arms replaced / dropped in Phase III
 - Better-performing drugs move faster (shortening drug development) and poorly-performing drugs waste fewer resources

Disadvantages of Adaptive Trials

- Information security
 - If probability of assigning patients to the experimental arm becomes known, relative performance of the drug can be inferred
 - Investigators who enroll a large population of patients can observe these trends and may create selection bias (particularly in Phase III trials)
 - Not a problem in randomized trials

Disadvantages of Adaptive Trials

- Complex logistics
 - Need all the data in a central location, software
- How to choose design?
 - What is a?
 - Convincing regulators
 - Population drift
- Getting pharmaceutical company funding
 - If experimental arm performs poorly, only a minority of patients may be assigned to their drug