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Can electronic monitoring with a digital smart spacer support personalised medication adherence and inhaler technique education in patients with asthma?: Protocol of the randomised controlled OUTERSPACE trial

Boudewijn H.J. Dierick, Maria Achterbosch, Sandra Been-Buck, Titia Klemmeier, Susanne J. van de Hei, Paul Hagedoorn, Huib A.M. Kerstjens, Janwillem W.H. Kocks, Job F. M. van Boven

ABSTRACT

Introduction Medication adherence and inhaler technique in patients with asthma remain suboptimal. A digital, smart spacer may support personalised adherence and inhaler technique education. The aim of this study is to assess the feasibility of undertaking a definitive randomised controlled trial of personalised, smart spacer data-driven education and explore clinical benefits.

Methods and analysis We present the design of the multicentre, randomised controlled OUTcomes following Tailored Education and Retraining: Studying Performance and Adherence (OUTERSPACE) feasibility trial of 2 months. Patients will be recruited from four Dutch general practices. At t = -1, patients with asthma ≥18 years using inhaled corticosteroids ± long-acting beta-agonists ± short-acting beta-agonists administered with a pressurised-metered-dose-inhaler and spacer (n = 40) will use a smart spacer for 1 month. The rechargeable CE-marked smart spacer (Aerochamber Plus with Flow Vu) includes a sensor that monitors adherence and inhalation technique to prescribed dosing regimen of both maintenance and reliever inhalers. After 1 month (t = 0), patients are 1:1 randomised into two groups: control group (usual care) versus intervention group (personalised education). At t = -1, t = 0 and t = 1 month, the Asthma Control Questionnaire (ACQ), Work Productivity and Activity Impairment (WPAI) questionnaire and Test of Adherence to Inhalers (TAI) are administered with fractional exhaled nitric oxide (FeNO) is assessed. At t = 0 and t = 1, spirometry is performed. At t = 1, usability and satisfaction will be assessed using the System Usability Scale and interviews with patients and healthcare providers. Primary outcome is the overall feasibility of a definitive trial assessed by patient recruitment speed, participation and drop-out rate. Secondary outcomes are patient and healthcare provider satisfaction and exploratory clinical outcomes are adherence, inhaler technique, TAI score, FeNO, lung function, ACQ and WPAI.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This is the first randomised controlled trial on the usability and potential clinical effects of using a smart spacer for personalised medication adherence and inhaler technique education in patients with asthma.
⇒ Inclusion and exclusion criteria are minimal in order to maximise the external validity of the findings.
⇒ The findings can be used to inform future larger studies and to further personalise asthma medication management.
⇒ An inevitable limitation of this study design is the impossibility to blind clinicians to the group allocation of the patients.

BACKGROUND

Asthma is a major cause of disability, healthcare services utilisation, work absence and quality of life impairment. Asthma management aims to achieve good symptom control, minimise exacerbations and reduce side effects. Although the majority of asthma patients can be effectively controlled, a substantial subset remains uncontrolled despite being offered optimal therapy. Poor adherence to treatment is one of the most common causes of poor control and is widely reported in patients with all severities of asthma. Improving adherence can significantly reduce the disease burden. Yet, the biggest challenge facing physicians,
pharmacists and nurses treating patients with asthma is finding a way to ensure good adherence. While elements of adherence, such as moment of inhalation, have been studied, intervention studies of adherence to treatment between clinic visits, in daily life, including the vital domain of how devices are used are limited.

Complete adherence for inhaled medications has two components: (1) ‘implementation and persistence’ and (2) inhaler technique. Implementation and persistence in this context is the extent to which an individual uses the medication at the directed times for a chronic period. This can be measured using self-reported patient diaries, which are prone to reporting bias, or more accurately using electronic inhaler monitors. Studies with these electronic devices show that persistence with treatment is relatively poor, but this may be improved by educational interventions. A recent UK study showed that average persistence for children with asthma was 49% for those who were monitored but received no reminders, and 70% for those who received reminders to take their treatment. However, while the number of inhalations taken improved, asthma control did not improve, likely due to lack of inhaler technique improvement. While inhaler technique is regularly checked, in mostly primary care clinic visits, this aspect of adherence is much more difficult to monitor remotely.

A Cochrane review of interventions to improve inhaler technique for people with asthma in 2017 concluded that ‘Guidelines consistently recommend that clinicians check regularly the inhaler technique of their patients; what is not clear is how clinicians can most effectively intervene if they find a patient’s technique to be inadequate, and whether such interventions have a discernible impact on clinical outcomes’.

Effective treatment of asthma requires drug delivery to the airways and lungs. The devices which are used to achieve this include nebulisers, dry powder inhalers and pressurised metered dose inhalers (pMDI). The latter are most commonly used in combination with spacers (or valved holding chambers (VHC)) as recommended in many guidelines. There are several reasons behind the preference for pMDI and spacer use including: (1) they are usually the cheapest option and (2) pMDIs are also suitable for people that cannot generate sufficient inspiratory flow. However, also with a pMDI and spacer, many patients persist with critical errors in inhaler technique, leading to poorer disease control and poorer outcomes. Until recently, spacer use has been difficult to measure. This study intends to use a newly developed prototype smart spacer, which simultaneously measures adherence and technique. This will generate significant new data and facilitate appropriate inhaler training by healthcare professionals. Understanding if critical errors in administration of inhaled medications are occurring is vital if healthcare professionals are to be able to effectively educate people with asthma.

The aim of this OUTcomes following Tailored Education and Retraining: Studying Performance and AdherenceCE (OUTERSPACE) study is to assess the feasibility of undertaking a definitive randomised controlled trial (RCT) of smart spacer-based inhaler education and explore clinical benefits in adults with asthma.

METHODS
Study design and setting
The design of this feasibility study is a randomised trial of 2 months comparing smart spacer-based inhaler education vs usual care. Recruitment will take place in four primary care centres in the outreach area of the University Medical Center Groningen (UMCG) in the Netherlands. All practices consist of at least one general practitioner (GP), a pharmacy and multiple nurses. All practices have spirometry equipment available and have ample experience with spirometry as part of routine practice. Practices will be provided with fractional exhaled nitric oxide (FeNO) devices (Niox Vero with NV TK 60-l sensors) and trained. The study was reported according to the Standard Protocol Items: Recommendations for Interventional Trials checklist for study protocols of clinical trials (online supplemental appendix A). The study is planned to take place between autumn 2021 and spring 2022.

Participants
 Patients need to fulfil the following inclusion criteria: (1) adults≥18 years; (2) physician diagnosed asthma treated in primary care; (3) using inhaled corticosteroids (along-acting beta agonistsshort-acting beta agonists (SABA)), where at least the controller medication should be administered by pMDI and spacer (AeroChamber or Vortex, given their similar performance) and (4) willing to sign written informed consent. The following exclusion criterion will be applied: (1) having had an exacerbation (defined by a short-course prednisone, emergency department [ED] visit or hospital admission due to asthma) in the last 30 days before potential inclusion.

Randomisation and blinding
At t=0, participants will be randomised in a 1:1 ratio to either the intervention (personalised smart spacer driven education) or the control group (usual care). All patients will be handed a smart spacer, but the data from the smart spacer will only be available to patients and healthcare professionals in the intervention group.

Smart spacer and inhaler error description
The smart spacer that will be used is based on the Aero-Chamber Plus with Flow Vu. The smart spacer (figure 1) is a rechargeable device and uses the same components as the existing Conformité Européenne (CE)–marked spacer, except for the adapter at the back of the spacer which has been modified to accommodate the sensing technology. To identify which inhaler a patients uses (eg, controller or reliever inhaler), an identifier is attached to each of the patient’s inhalers.
Performance of the smart spacer

Design verification testing was performed by the manufacturer of the device (Trudell Medical International) in order to support the CE mark declaration of the prototype smart spacer in Europe. The design process was compliant to ISO13485 and included the verification that the adherence and technique measurements were accurately and reproducibly transferred into data outputs. Note that this prototype device is being used for evaluating the clinical value of capturing this type of inhaler and spacer usage data. Usability (including industrial design), data visualisation and connectivity will all need to follow and be optimised within a commercial device. Our own testing (table 1) confirmed that the smart spacer meets flow performance specifications and aerosol drug output specifications, compared with the original spacer. The department Pharmaceutical Technology and Biopharmacy of the University of Groningen has performed calibrations to verify the effect of the Smart Technology Housing in comparison with the original AeroChamber Plus Flow Vu. A flow-pressure drop test was performed which demonstrated that the Smart Technology Housing has no effect on the internal resistance of the original AeroChamber in combination with the maintenance and reliever inhalers. These tests were performed with differential pressure gauges from Hottinger Baldwin Messtechnik, type PD1, Darmstadt, Germany and a calibrated mass flow metre from Brooks Instrument, type 5863S, Veenendaal, the Netherlands.

Definitions of adherence and inhaler errors

The prototype smart spacer monitors inhaler use in terms of adherence to prescribed dosing regimen and inhalation technique.

The adherence to dosing can range from 0% to 100% and is calculated based on the number of controller (ie, long-acting medication) doses taken divided by the prescribed dose (eg, two puffs twice daily). To achieve a 100% score, discrete doses must be at least 8 hours apart.

The score for inhalation technique, ranging from 0% (poor) to 100% (good), is calculated for each actuation of the controller or rescue inhaler. To define inhalation technique, five different errors are defined based on previous research and recommendations16 (table 2). Each error is initialised to 100% for each actuation and adjusted after the inhalation. Scores take into account the type of pMDI connected to the smart spacer.

Data output smart spacer

Figure 2 shows an example of the output of the smart spacer data visualisation. To assess this output, the memory card from the smart spacer needs to be manually removed and the data file should be transferred to a computer to be analysed using a Microsoft Excel file. Together with the patient, the adherence report is then analysed by the nurse. Using this output, tailor made inhalation education can be given. As such, patients will be asked to bring their smart spacer to the study visits.

### Table 1 Flow-pressure differential relationship of the smart spacer in relation to the standard Aerochamber

<table>
<thead>
<tr>
<th>Flowrate (L/min)</th>
<th>Pressure drop in Pa (mean of 2)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Smart+reliever pMDI</td>
<td>Standard+reliever pMDI</td>
</tr>
<tr>
<td>30</td>
<td>82</td>
<td>82</td>
</tr>
<tr>
<td>60</td>
<td>160</td>
<td>160</td>
</tr>
<tr>
<td>90</td>
<td>320</td>
<td>320</td>
</tr>
</tbody>
</table>

pMDI, pressurised metered dose inhaler.
Study visits
An overview of the study visits is provided in figure 3.

Training of study sites
To learn how to handle the smart spacer, interpret its data and standardise the education, the nurses received a protocolled 2-hour training from a specialised respiratory nurse who had experience with the smart spacer.

The study has three visits, further detailed below.

First visit (t=−1 month)
At baseline during the first visit, all participants’ demographics and medical history are recorded (age, sex, weight, height, smoking status, comorbidity, date of last exacerbation, prescribed medication), a FeNO test is performed, and the Asthma Control Questionnaire (ACQ)\(^2\), Work Productivity and Activity Impairment (WPAI)\(^2\) questionnaire and Test of Adherence to Inhalers (TAI)\(^2\) are administered. Pharmacy dispense records from the previous year will be extracted to assess 1-year history of medication use, including oral steroid and antibiotics short-courses. Patients receive the smart spacer with user instruction.

Second visit (T=0)
One month after the first visit, the second visit takes place where a lung function test is performed (forced expiratory volume in one second, FEV\(_1\)) and a 4-week diary is filled out. Patients are also counselled about the use of the smart spacer.

Table 2  Technique error summary, as measured by the smart spacer

<table>
<thead>
<tr>
<th>Technique error #</th>
<th>Technique error name</th>
<th>Description</th>
<th>Possible values</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Multiple actuations</td>
<td>Multiple actuations before a full breath has occurred</td>
<td>0%, 100%</td>
</tr>
<tr>
<td>2</td>
<td>No inhalation</td>
<td>No inhalation within 30s of an actuation</td>
<td>0%, 100%</td>
</tr>
<tr>
<td>3</td>
<td>Delayed inhalation</td>
<td>Based on time between the actuation and start of inhalation</td>
<td>0%, 25%, 50%, 75%, 100%</td>
</tr>
<tr>
<td>4</td>
<td>Excessive flow</td>
<td>Inhalation flow &gt;120 L/min, &gt;80 L/min or &lt;80 L/min</td>
<td>50%, 75%, 100%</td>
</tr>
<tr>
<td>5</td>
<td>Low volume</td>
<td>Based on volume (in mL) within 15s of an actuation</td>
<td>0%, 25%, 50%, 75%, 100%</td>
</tr>
</tbody>
</table>

*If technique error 1 or 2=0%, technique score for the entire actuation is 0%.

Figure 2  Example data output smart spacer.
Usability Scale (SUS), will be asked to report any difficulties encountered with the device to the study team, and views will be specifically sought about how the device and training could be improved.

Outcomes
This primary outcome of this study is the feasibility of performing a definitive study of a personalised educational approach to improve disease control in adults with asthma using a smart spacer. Feasibility outcomes include (1) patient recruitment speed, (2) participation rate and (3) sample size calculation for a definitive trial.

Secondary outcomes include patient and healthcare provider satisfaction with the smart spacer (assessed by the SUS and interview) and feasibility of study procedures in the general practice as well as time investment (assessed by end-of-study interviews with nurses). Furthermore, exploratory outcomes include the changes in distribution of medication adherence patterns (total number of inhaler errors, overall inhaler technique score, individual error distribution and adherence (number of controller actuations divided by the prescribed dose)) and clinical outcomes (lung function, ACQ, WPAI, TAI, SABA use, oral steroid bursts) as compared between the intervention and the control group.

Treatment fidelity
To ensure GPs and nurses’ fidelity to study protocol, the nurses will be trained and supported directly by the project leader and by a specialised pulmonary nurse from the Martini hospital in Groningen who has experience with the smart spacer (OUTERSPACE-chronic obstructive pulmonary disease [COPD] study).

Sample size calculation
This is a feasibility trial to inform a larger definitive RCT. We lack the data for a formal power calculation to determine study size. Recommended sample sizes for feasibility RCTs vary between 24 and 50. The recruitment target of 40 has been pragmatically chosen based on National Institute for Health and Care Research recommendations. It should provide us with sufficient information to determine SD to inform a formal sample size for a larger definitive outcome RCT.

Planned statistical analysis
Continuous variables (eg, age, adherence, inhaler errors, ACQ, WPAI, TAI, FEV1, FeNO, SUS) will be descriptively summarised as number of observed values, number of missing values, mean and SD, or median and IQR and minimum and maximum, where appropriate. Categorical data (eg, gender, comorbidity) will be summarised as number of observed values, number of missing values, number and percentage in each category.

For statistical comparison between study groups: when continuous data are normally distributed, the student T-test will be used. For non-normally distributed data, the Mann-Whitney U test will be used. Categorical data will be compared using $\chi^2$ or Fisher exact test, where appropriate.

Data management
In this study, the data will be collected, processed and archived in accordance with the General Data Protection Regulation and the Findable, Accessible, Interoperable, Reusable principles under the responsibility of the principal investigator. A research data management plan has been drawn up to describe the further operational details and procedures.
All study data will be with a patient pseudonymised number, safely and structurally captured using a study folder and stored electronically in the UMCG REDCap system. Individual study maps will be stored in a locked cabinet.

- Tooling (eg, software and procedures) used for collecting, processing, analysing and storing data will be compliant with the UMCG policy and Standard Operating Procedures in the UMCG Research Toolbox.
- Data will be pseudonymised by use of a code list during data collection.
- Indirect and direct identifiable information collected will be minimised and only collected for the purpose of this study.
- Direct identifiable information (eg, contact details, code list/encryption key/subject identification log) will be stored separately from pseudonymised data.
- Direct identifiable information can only be accessed by the principal investigator and study delegates after authorisation by the principal investigator.
- Pseudonymised/anonymised data can only be accessed by the Principal Investigator and study delegates after authorisation by the principal investigator.
- Data roles, responsibilities, access and authorisation—during the study and after study completion—will be managed and documented.
- Digital data will be archived on the UMCG network complying with strict UMCG security and back-up policy.
- Paper source data and study files will be archived within the UMCG facilities.
- Source data, study files and digital data will be stored 15 years after the study is completed.

**Patient and public involvement**

Before this study, a pilot study (N=12) applying the same concept of smart spacer-data driven education was carried out in patients with COPD. Feedback from these patients was used to inform the current trial protocol. After the study, a qualitative evaluation will take place with patients participating in this study. Results from this study will actively be communicated to patients involved in the study and beyond.

**Ethics and dissemination**

Ethical approval was obtained from the RTPO MCL in Leeuwarden, The Netherlands (Number: NL78361.099.21). All patients will provide written informed consent before participation in this study. Findings of this study will be disseminated through national and international conferences and peer-reviewed scientific and professional journals.

**DISCUSSION**

Proper adherence to inhalation medicines is a topic of major concern in patients with asthma. Numerous studies have been performed trying to find means to improve adherence to inhalation medicines. These studies can roughly be divided into two groups: studies that aimed to improve adherence and studies that aimed to improve inhaler technique. Most studies are however confronted with the same problem: how to gain insight into the continuous daily use of the inhalation medicines.

To assess adherence, patients are often asked if they used their medicine often enough at the correct time of the day. Yet, overestimation and socially desirable answers are common. Indeed, Bourdin et al state in their review: ‘Most of the severe asthma patients overestimate their level of observance because of memory recall, defence or desire to please their health care provider. As a result, most of the physicians tend to overestimate their severe asthma patients’ adherence too’.

To assess inhaler technique, patients are usually asked by their caregiver to show how they use their inhalation device. This only provides insight into how patients use their device in a clinical setting knowing that they are being observed. These studies do, however, not give an understanding of the actual inhalation technique at home.

Data from the OUTERSPACE programme (that also includes smart spacer studies in patients with COPD and paediatric asthma) can bring us to the next level: not only can we objectively monitor intake of inhalation medicines, we also obtain continuous data on inhaler technique at of multiple inhalers in the home setting. With this data, the caregiver can interact with the patient and personalise their education. The caregiver can give the patient an insight into his or her ‘inhalation behaviour’ during their usage at home. For these data to be optimally used for educational purposes, further real-world validation of the smart spacer data is required. Although design verification was performed by the manufacturer, including the verification that the adherence and technique measurements were accurately and reproducibly transferred into data outputs, the clinical validation to drive clinical decisions should be further tested.

With the data of this smart spacer study, we not only hope to improve adherence to inhalation medicines and outcomes, we also hope that this data will help to improve the ‘ownership’ of patients to their own adherence and to their own responsibility of achieving an optimal asthma control.

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Contributors BD wrote the first draft of this protocol. BD, JFMvB, HAMK, PH and JK participated in the design of the study and contributed to the revision of the study protocol. PH tested flow performance specifications and aerosol drug output specifications of the smart spacer. TK and SB-B piloted the devices. SVdH and MA piloted the educational materials. All authors provided comments and approved the final manuscript.

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Competing interests HAMK reports a fee for a one time consultancy outside the realm of this study, and grants and fees for consultancy or advisory board participation from AstraZeneca, Boehringer Ingelheim, Chiesi, GlaxoSmithKline and Novartis all outside of the submitted work. All were paid to his institution. JK reports grants, personal fees and non-financial support from AstraZeneca, grants, personal fees and non-financial support from Chiesi Pharmaceuticals, grants, personal fees and non-financial support from GSK, grants from Mundipharma, grants and personal fees from Tева, personal fees from MSD, personal fees from Covis Pharma, outside the submitted work; and Janwillem Kocks holds 72.5% of shares in the General Practitioners Research Institute. JFMvB received grants and/or consultancy fees from AstraZeneca, Chiesi, European Commission COST (COST Action 19132), GSK, Lung Alliance Netherlands, Novartis, Teva, and Trudell Medical, outside the submitted work and all paid to his institution. Other authors declare no relevant conflicts of interest.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

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REFERENCES


26 Additional guidance for applicants including a clinical trial, pilot study or feasibility as part of a personal Award application, 2021.


###Appendix A.

*SPIRIT 2013 Checklist: Recommended items to address in a clinical trial protocol and related documents*

<table>
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<th>Item No</th>
<th>Description</th>
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<td>Role of study sponsor and funders, if any, in study design; collection, management, analysis, and interpretation of data; writing of the report; and the decision to submit the report for publication, including whether they will have ultimate authority over any of these activities</td>
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<td>Composition, roles, and responsibilities of the coordinating centre, steering committee, endpoint adjudication committee, data management team, and other individuals or groups overseeing the trial, if applicable (see Item 21a for data monitoring committee)</td>
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<td><strong>Introduction</strong></td>
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<td>Background and rationale</td>
<td>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</td>
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<td>Explanation for choice of comparators</td>
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<td>Specific objectives or hypotheses</td>
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<td><strong>Methods: Participants, interventions, and outcomes</strong></td>
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<td>Study setting</td>
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<td>Interventions</td>
<td>Interventions for each group with sufficient detail to allow replication, including how and when they will be administered</td>
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<td>Criteria for discontinuing or modifying allocated interventions for a given trial participant (eg, drug dose change in response to harms, participant request, or improving/worsening disease)</td>
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<td>11c</td>
<td>Strategies to improve adherence to intervention protocols, and any procedures for monitoring adherence (eg, drug tablet return, laboratory tests)</td>
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<td>Relevant concomitant care and interventions that are permitted or prohibited during the trial</td>
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<tr>
<td>Outcomes</td>
<td>Primary, secondary, and other outcomes, including the specific measurement variable (eg, systolic blood pressure), analysis metric (eg, change from baseline, final value, time to event), method of aggregation (eg, median, proportion), and time point for each outcome. Explanation of the clinical relevance of chosen efficacy and harm outcomes is strongly recommended</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Participant timeline</td>
<td>Time schedule of enrolment, interventions (including any run-ins and washouts), assessments, and visits for participants. A schematic diagram is highly recommended (see Figure)</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Sample size</td>
<td>Estimated number of participants needed to achieve study objectives and how it was determined, including clinical and statistical assumptions supporting any sample size calculations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment</td>
<td>Strategies for achieving adequate participant enrolment to reach target sample size</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

**Methods: Assignment of interventions (for controlled trials)**

**Allocation:**

**Sequence generation**

| Sequence generation | Method of generating the allocation sequence (eg, computer-generated random numbers), and list of any factors for stratification. To reduce predictability of a random sequence, details of any planned restriction (eg, blocking) should be provided in a separate document that is unavailable to those who enrol participants or assign interventions | 9    |

**Allocation concealment mechanism**

| Allocation concealment mechanism | Mechanism of implementing the allocation sequence (eg, central telephone; sequentially numbered, opaque, sealed envelopes), describing any steps to conceal the sequence until interventions are assigned |      |
Who will generate the allocation sequence, who will enrol participants, and who will assign participants to interventions

Who will be blinded after assignment to interventions (eg, trial participants, care providers, outcome assessors, data analysts), and how

If blinded, circumstances under which unblinding is permissible, and procedure for revealing a participant’s allocated intervention during the trial

Methods: Data collection, management, and analysis

Plans for assessment and collection of outcome, baseline, and other trial data, including any related processes to promote data quality (eg, duplicate measurements, training of assessors) and a description of study instruments (eg, 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

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

Plans for data entry, coding, security, and storage, including any related processes to promote data quality (eg, double data entry; range checks for data values). Reference to where details of data management procedures can be found, if not in the protocol

Statistical methods

Statistical methods for analysing primary and secondary outcomes. Reference to where other details of the statistical analysis plan can be found, if not in the protocol

Methods for any additional analyses (eg, subgroup and adjusted analyses)

Definition of analysis population relating to protocol non-adherence (eg, as randomised analysis), and any statistical methods to handle missing data (eg, multiple imputation)
## Methods: Monitoring

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data monitoring</td>
<td>Composition of data monitoring committee (DMC); summary of its role and reporting structure; statement of whether it is independent from the sponsor and competing interests; and reference to where further details about its charter can be found, if not in the protocol. Alternatively, an explanation of why a DMC is not needed.</td>
</tr>
<tr>
<td>Harms</td>
<td>Description of any interim analyses and stopping guidelines, including who will have access to these interim results and make the final decision to terminate the trial.</td>
</tr>
<tr>
<td>Auditing</td>
<td>Plans for collecting, assessing, reporting, and managing solicited and spontaneously reported adverse events and other unintended effects of trial interventions or trial conduct.</td>
</tr>
<tr>
<td>Ethics and dissemination</td>
<td></td>
</tr>
<tr>
<td>Research ethics approval</td>
<td>Plans for seeking research ethics committee/institutional review board (REC/IRB) approval.</td>
</tr>
<tr>
<td>Protocol amendments</td>
<td>Plans for communicating important protocol modifications (eg, changes to eligibility criteria, outcomes, analyses) to relevant parties (eg, investigators, REC/IRBs, trial participants, trial registries, journals, regulators).</td>
</tr>
<tr>
<td>Consent or assent</td>
<td>Who will obtain informed consent or assent from potential trial participants or authorised surrogates, and how (see Item 32).</td>
</tr>
<tr>
<td></td>
<td>Additional consent provisions for collection and use of participant data and biological specimens in ancillary studies, if applicable.</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
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<tr>
<td>-------------------------------------</td>
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</tr>
<tr>
<td>Confidentiality</td>
<td>How personal information about potential and enrolled participants will be collected, shared, and maintained in order to protect confidentiality before, during, and after the trial</td>
</tr>
<tr>
<td>Declaration of interests</td>
<td>Financial and other competing interests for principal investigators for the overall trial and each study site</td>
</tr>
<tr>
<td>Access to data</td>
<td>Statement of who will have access to the final trial dataset, and disclosure of contractual agreements that limit such access for investigators</td>
</tr>
<tr>
<td>Ancillary and post-trial care</td>
<td>Provisions, if any, for ancillary and post-trial care, and for compensation to those who suffer harm from trial participation</td>
</tr>
<tr>
<td>Dissemination policy</td>
<td>Plans for investigators and sponsor to communicate trial results to participants, healthcare professionals, the public, and other relevant groups (eg, via publication, reporting in results databases, or other data sharing arrangements), including any publication restrictions</td>
</tr>
<tr>
<td></td>
<td>Authorship eligibility guidelines and any intended use of professional writers</td>
</tr>
<tr>
<td></td>
<td>Plans, if any, for granting public access to the full protocol, participant-level dataset, and statistical code</td>
</tr>
<tr>
<td>Appendices</td>
<td></td>
</tr>
<tr>
<td>Informed consent materials</td>
<td>Model consent form and other related documentation given to participants and authorised surrogates</td>
</tr>
<tr>
<td>Biological specimens</td>
<td>Plans for collection, laboratory evaluation, and storage of biological specimens for genetic or molecular analysis in the current trial and for future use in ancillary studies, if applicable</td>
</tr>
</tbody>
</table>

*It is strongly recommended that this checklist be read in conjunction with the SPIRIT 2013 Explanation & Elaboration for important clarification on the items. Amendments to the protocol should be tracked and dated. The SPIRIT checklist is copyrighted by the SPIRIT Group under the Creative Commons “Attribution-NonCommercial-NoDerivs 3.0 Unported” license.*