Breakout Session IV: Outcome Measures

AD Pre-Dementia Outcome Measures – What does success look like?

Moderators:
Ashley Slagle, Study Endpoints Reviewer at FDA / CDER / OND / SEALD
Johan Luthman, Merck & Co, Inc.
How to Measure Deficits in the Pre-Dementia Stages of the AD?

Established instruments to measure cognition, function & behavior lack sensitivity & responsiveness in early disease stages

- The registration standard Alzheimer’s Disease Assessment Scale Cognitive Subscale (ADAS-Cog) developed for moderate/dementia stages of AD
  - Major limitations of ADAS-Cog to detect and follow AD progression during pre-dementia stages
- Subjects in the pre-dementia stage present very limited functional deficits & behavioral changes
Objective:
Advance through a formal regulatory path a composite clinical outcome assessment tool as a primary outcome measure for pre-dementia AD trials

Impact:
Regulatory accepted / qualified clinical outcome measure to be applied across targets and industry stakeholders
FDA and EMA are collaborating in qualification with aim to harmonize all stages
<table>
<thead>
<tr>
<th>Subscale</th>
<th>Description</th>
<th>AstraZeneca ProADAS</th>
<th>Pfizer</th>
<th>Janssen TriAD, TriAD-G</th>
<th>Eisai MCIMax</th>
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<tbody>
<tr>
<td>Q1</td>
<td>Word Recall</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Q2</td>
<td>Commands</td>
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<td>Q3</td>
<td>Construction</td>
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<td>Q4</td>
<td>Delayed Word Recall</td>
<td>X</td>
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<tr>
<td>Q5</td>
<td>Naming</td>
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<td>Q6</td>
<td>Ideational Praxis</td>
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<tr>
<td>Q7</td>
<td>Orientation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Q8</td>
<td>Word Recognition</td>
<td>?</td>
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<td>X</td>
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<tr>
<td>Q9</td>
<td>Recall Instructions</td>
<td></td>
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<tr>
<td>Q10</td>
<td>Spoken Language</td>
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<tr>
<td>Q11</td>
<td>Word Finding</td>
<td>X</td>
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<tr>
<td>Q12</td>
<td>Comprehension</td>
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<td>Q14</td>
<td>Number Cancellation</td>
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**ADAS-Cog**

<table>
<thead>
<tr>
<th>CDRSB</th>
<th>CDR Sum-of-Boxes</th>
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**CDR-SB**

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<th>FAQ</th>
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**FAQ**

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<th>AVLT</th>
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**AVLT**

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**MMSE**

<table>
<thead>
<tr>
<th>MMSE-Orientation</th>
<th>X2</th>
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</table>

| MMSE-Constructional Praxis | X2                          |                     |        |                        |              |
Themes/topics for the outcome measures breakout session

- **Discuss clinical meaningfulness and relevance /how to measure in MCI**
  - Discuss early AD Draft guidance to seek input on the topic of CDRSB (advantages / disadvantages)
  - Discuss existing measures of function for AD/MCI and limitations for consideration as coprimary in MCI or to incorporate into a composite
  - Discuss items/domains most relevant to change in target patient population and how they are captured in a proposed composite
  - Discuss recommended path to utilize qualitative research from PRO cognition group to identify clinical meaningful concepts
  - Role for performance based measures in assessing clinical meaningfulness
  - Other ideas

- **Discuss current SEALD COA process and applicability to CAMD’s pCOA project**
  (Ashley, Marc)
Patients on the AD continuum closest to the onset of overt dementia (i.e., prodromal AD or MCI due to AD) are likely to have relatively mild but noticeable impairments in their daily functioning. It is therefore important to demonstrate that a drug favorably affects these deficits, in addition to showing an improvement in cognition, to establish the clinical value of a given treatment. However, because many of the assessment tools used to measure functional or global impairment in patients with dementia have not been validated for use in these early stage patients, we consider the use of a composite scale, validated in early stage patients to assess both cognition and function as a single primary efficacy outcome measure, to be appropriate. The Clinical Dementia Rating scale, specifically the Clinical Dementia Rating – Sum of Boxes (CDR-SB) score, is an example of a suitable tool. The CDR-SB is a widely used scale that has demonstrated validity and reliability in the longitudinal assessment of patients with cognitive and functional deficits that do not rise to the level of a diagnosis of overt dementia. Additional assessment scales also may be appropriate for use in clinical trials in this population and we are open to considering other such proposals as well.
Isolated Cognitive Measures

We recognize that it is desirable to demonstrate efficacy in the earliest clinical stages of AD (i.e., preclinical AD) where only subtle cognitive deficits are present in the absence of any detectable functional impairment.

In these cases, it would be difficult to establish a clinical consequence of any cognitive benefit during the course of a trial of reasonable duration. Assuming that these patients can be reliably identified, we can use the accelerated approval mechanism (21 CFR 149 314.510) to consider an effect on a valid and reliable cognitive assessment used as a single primary efficacy measure as support for a marketing approval. Following the initial approval, a sponsor would then be required to demonstrate, in additional adequate and well-controlled studies or continuation of the initial studies, that the observed benefit persists and positively affects the overall course of a patient’s condition.
What is Clinically Meaningful Effect?

- Grades on evaluation of a clinical outcome measure
  - Statistical significant effect
  - Effect size
  - Clinically meaningful effect

- No clear consensus on a single definition for clinically meaningful difference in randomized controlled trials
  Multiple perspectives:
  - Patient (Patient reported outcome – PRO)
  - Caregiver
  - Clinician
  - Statistician
  - Payer
  - Healthcare economist
  - Investor
  - Regulator
  - Etc.
pCOA team
next steps—where are we at on the wheel

Qualification of CLINICAL OUTCOME ASSESSMENTS (COAs)

1. Identify Context of Use (COU) and Concept of Interest (COI)
   - Outline hypothesized concepts and potential claims
   - Determine intended population
   - Determine intended application/characteristics (type of scores, mode and frequency of administration)
   - Perform literature/expert review
   - Develop hypothesized conceptual framework
   - Position COA within a preliminary endpoint model
   - Document COU and COI

IV. Longitudinal Measurement Interpretation
   - Assess ability
   - Identify response
   - Provide guidance on relationship to COU
   - Document all
   - Update user manual
   - Submit to FDA to support claim

III. Cross-sectional
   - Assess score
   - Establish administration procedures and training materials
   - Document measure development
   - Prepare user manual
   - Consider submitting to FDA for COA qualification for use in exploratory studies prior to longitudinal evaluation
insert build/annimation for cost estimates per stage assuming it would follow the MS business model/budget
Qualification of **CLINICAL OUTCOME ASSESSMENTS (COAs)**

II. Draft Instrument and Evaluate Content Validity

- Obtain patient or other reporter input
- Generate new items
- Select recall period, response options and format
- Select mode/method of administration/data collection
- Conduct cognitive interviewing
- Pilot test draft instrument
- Finalize instrument content, format and scoring rule
- Document content validity

IV. Longitudinal Measurement Interpretation

- Assess ability
- Identify response relationship
- Document all
- Update user manual
- Submit to FDA to support clinical trial

V. Modify Instrument

- Identify a new
- Change word options, recal administration
- Translate and
- Evaluate model
- Consider subscale qualification
insert build/animation for cost estimates per stage assuming it would follow the MS business model/budget

Diane Stephenson, 10/27/2013
pCOA team
next steps—spoke III

Qualification of CLINICAL OUTCOME ASSESSMENTS (COAs)

III. Cross-sectional Evaluation of Other Measurement Properties

- Assess score reliability (test-retest or inter-rater) and construct validity
- Establish administration procedures & training materials
- Document measure development
- Prepare user manual
- Consider submitting to FDA for COA qualification for use in exploratory studies prior to longitudinal evaluation
DS20

insert build/animation for cost estimates per stage assuming it would follow the MS business model/budget

Diane Stephenson, 10/27/2013
IV. Longitudinal Evaluation of Measurement Properties/Interpretation Methods

- Assess ability to detect change and construct validity
- Identify responder definition(s)
- Provide guidelines for interpretation of treatment benefit and relationship to claim
- Document all results
- Update user manual
- Submit to FDA for COA qualification as effectiveness endpoint to support claims

III. Cross-sectional Evaluation of Other Measurement Properties

- Assess score reliability (test-retest or inter-rater) and construct validity
- Establish administration procedures & training, materials
- Document measure development
- Prepare user manual
- Consider submitting to FDA for COA qualification for use in exploratory studies prior to longitudinal evaluation
insert build/animation for cost estimates per stage assuming it would follow the MS business model/budget

Diane Stephenson, 10/27/2013
pCOA team
next steps—spoke V

V. Modify Instrument

- Identify a new COU
- Change wording of items, response options, recall period, or mode/method of administration/data collection
- Translate and culturally adapt
- Evaluate modifications using spokes I - IV
- Document all changes
- Consider submitting to FDA for qualification of new COA, as appropriate
insert build/animation for cost estimates per stage assuming it would follow the MS business model/budget

Diane Stephenson, 10/27/2013
Thank you for engaging in the discussion with Ashley last week. I wanted to follow up to check with you on the themes and topics for the breakout based on the discussion we had with her.

- Ask Marc Walton and Ashley to walk through the wheel and spoke diagram and identify appropriate/relevant steps

- Discuss current draft early AD guidance regarding outcome measures - CDRSB advantages and limitations

- Discuss clinical meaningfulness and relevance /how to measure in MCI
  - PRO cognition working group qualitative research approach
  - Other approaches (Mike Ropacki, Dennis Fortier, Suzanne)

- Discuss items/domains most relevant to change in target patient population and how they are captured in a proposed composite
Alzheimer’s Disease Assessment Scale Cognitive Subscale (ADAS-Cog)

- Extensively used cognition measure in Mild to Moderate AD trials
- Standard for registration, together with a co-primary functional measure

**11-Item (1984)**

**12, 13, and 14-items (1997)**

- Ceiling effects on many items for mild and prodromal AD, floor effects for other items in moderate AD
  - Most sensitive in moderate patients (MMSE=10-19)
  - Limited change mild disease over 18 month trials
Clinical Dementia Rating- Sum of Boxes (CDR-SB)

- Subjective, informant and patient based, determination of cognition and function, i.e. “global” assessment measure
  - Standardized, semi-structured interview
  - Measures influence of cognitive loss on ability to conduct everyday activities
    - Memory, Orientation, Judgment and problem solving, Community affairs, Home and hobbies, Personal care
  - Provides information about clinically meaningful function and behavior

- Used as key secondary global measures in Mild to Moderate AD trials

- Considered the most sensitive established Instrument for MCI populations
  - Continuous measure, less affected by ceiling and floor effects,
  - Can detect natural disease progression even in early stages AD

- Emerging as preferred choice as primary endpoint in Prodromal AD trials
  - Lacks objectively scored cognitive tests; accuracy depends on reliability and consistency of informant
  - Lengthy to administer
  - Unclear if it has sufficient treatment responsiveness, i.e. able to detect therapy effect
  - Not yet used as a primary endpoint in a completed pivotal trial
• Brief cognitive assessment screen to determine disease severity

• Widely used in clinical trials as secondary endpoint

  ➢ Lacks sensitivity as an outcome measure
  ➢ Ceiling effects in very early stages of disease
  ➢ Can be influenced by high levels of education
Some Other Cognition Instruments Used in Alzheimer’s Disease Intervention Trials

• Neuropsychological Test Battery (NTB)
  – Targeting key domains affected in early stages of AD
    • Episodic memory – word list learning, immediate, delayed recall
    • Attention - digit symbol coding, number cancellation
    • Executive function – trails A + B, COWAT, Category fluency
  – May be more sensitive than ADAS-Cog to decline in early AD tests
    • Evidence of improved sensitivity over ADAS-Cog11 in mild AD in a few small studies
      • Not subject to ceiling effect

• Rey Auditory Verbal Learning Test (AVLT)
  – Episodic word learning memory test

• Computerized assessment systems
  – CogState, CANTAB (Cambridge Cognition), CDR (United BioSource)
  – Used in small studies as exploratory measures
    ➢ Lack solid data for bridging to clinical outcome measures
    ➢ Limited information on translation to clinical meaningfulness
Individual industry & academic efforts have proposed more sensitive and responsive instruments in early stage AD

- Some components (“items”) of currently used Instruments, especially cognitive measures, are more sensitive in earlier stages of AD
  - Word recall, Word recognition, Orientation

Leading proposals include items from ADAS-Cog, CDR-SB and MMSE as a Composite Clinical Endpoint emphasizing cognitive measures of performance

- Selection of key items from existing Instruments: develop new composite clinical score

- Two general approaches:
  - Weighting of ADAS-Cog items,
  - Add content to ADAS-Cog; items from other instruments (CDR-SB, MMSE etc.)
<table>
<thead>
<tr>
<th>Originator</th>
<th>Strategy</th>
<th>Dataset</th>
<th>Statistical approach</th>
<th>Outcome</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eisai (Logovinsky et al.)</td>
<td>Composite Score based on ADAS-Cog, CDR-SB and MMSE</td>
<td>ADNI-1 (MCI)</td>
<td>Partial Least Square (PLS) regression model Determine most sensitive combination of items from existing clinical tools (ADAS-Cog, MMSE, CDR-SB, NTB, …)</td>
<td>12 items identified, which included items sensitive to disease decline across all cognitive, functional and global items (4 cognitive items from ADAS-Cog, 2 items from MMSE &amp; 6 items from CDR-SB).</td>
<td>Industry leading proposal Used in Phase IIB trials as primary efficacy endpoint</td>
</tr>
<tr>
<td>Janssen Pharm (Raghavan et al.):</td>
<td>Composite Score based on ADAS-Cog + Combination with other Instruments</td>
<td>ADNI-1</td>
<td>Built statistical model of disease progression for each measure using linear mixed effect models Bootstrap to verify that effect sizes hold up</td>
<td>ADAS-Cog items 1, 4, 7, 8, 13 Also included CDR Cog, FAQ, MMSE, AVLT</td>
<td>Improved performance characteristics for MCI and early AD clinical trials..</td>
</tr>
<tr>
<td>Astra-Zeneca (Hannesdottir et al)</td>
<td>ADAS-Cog improvement: All 8191 possible combinations of ADAS-Cog subscales analyze</td>
<td>ADNI-1</td>
<td>Calculated all 8191 possible scores and ranked them according to the ratio of mean change over 24 months and the standard deviation of this change. The test with highest ratio would give the smallest sample size</td>
<td>Most sensitive to change ADAS-Cog Subscales 1, 8, 12, 4 (delayed word), 14 (number cancel)</td>
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</tr>
<tr>
<td>Pfizer</td>
<td>Composite Score ADAS-Cog improvement</td>
<td></td>
<td>ADAS-Cog items 1, 7, +4, 8, 13</td>
<td>18 month assessment may be sufficient in trials for treatment effect, no great benefit going to 24 months</td>
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</table>
## Corporate or Academic Efforts to Develop New Cognitive Outcome Measures

<table>
<thead>
<tr>
<th>Originator</th>
<th>Strategy</th>
<th>Dataset</th>
<th>Statistical approach</th>
<th>Outcome</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeromy Hobart et al (Academic including Pfizer) • Published 2012</td>
<td>ADAS-Cog improvement</td>
<td>ADNI-1</td>
<td>Rasch Measurement Theory (RMT) methods to examine ADAS-Cog</td>
<td></td>
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<tr>
<td>Jeannine Skinner et al (Academic) • Published 2012</td>
<td>Composite Score based on ADAS-Cog + Combination with; TMT, DSST, digit span, Category fluency</td>
<td>ADNI-1</td>
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<tr>
<td>EnVivo (John Harrison):</td>
<td>Used a novel 5-item, 2-domain composite; Immed Word Recall, Word Recognition, Orientation, COWAT, Category Fluency</td>
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<td></td>
<td>Outperformed ADAS-Cog13</td>
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<tr>
<td>ADAS-Cog Plus WG (D. Mungas)</td>
<td>Composite Score based on ADAS-Cog + Combination with other measures</td>
<td>ADNI-1</td>
<td>Item Response Theory (IRT) and Rasch Measurement Theory (RMT) methods to examine ADAS-Cog Bootstrap</td>
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</table>
Recent Collaborative Pre-Competitive Initiatives to Develop a New Instrument

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<thead>
<tr>
<th>ADAS-Cog Plus Working Group (ADAS-Cog+ WG)</th>
<th>Clinical End Points Working Group (ADNI PPSB CEPWG)</th>
<th>Cognition Clinical Outcome Assessment Tool (COA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
<td><strong>Activities</strong></td>
<td><strong>Activities</strong></td>
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<tr>
<td>• Development of an improved ADAS-Cog Instrument</td>
<td>• Mapping Datasets &amp; Proposed Instruments</td>
<td>• Submission Qualification request to FDA and EMA of a candidate Novel Instrument</td>
</tr>
<tr>
<td>• One Instrument developed</td>
<td>• Prodromal AD/MCI Endpoints &amp; Methods</td>
<td>• Aim for approved Instrument for use in pre-dementia trials</td>
</tr>
<tr>
<td>• No further development anticipated</td>
<td>• Novel Tests for pre-MCI</td>
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<tr>
<td><strong>Governance Coordination</strong></td>
<td><strong>Governance Coordination</strong></td>
<td><strong>Governance Coordination</strong></td>
</tr>
<tr>
<td>• Governance; ADNI Private Partner Scientific Board (PPSB) General Assembly</td>
<td>• Governance; ADNI Private Partner Scientific Board (PPSB) General Assembly</td>
<td>• Governance; CAMD Steering Committee</td>
</tr>
<tr>
<td>• Coordination; Foundation for National institute of Health</td>
<td>• Coordination: Foundation for National institute of Health</td>
<td>• Coordination: CAMD Project Management for COA</td>
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<tr>
<td><strong>Participants Funding/Cost</strong></td>
<td><strong>Participants Funding/Cost</strong></td>
<td><strong>Participants Funding/Cost</strong></td>
</tr>
<tr>
<td>• PPSB Subgroup; Pfizer, Janssen, Roche, Lilly &amp; Merck</td>
<td>• ADNI PPSB: 27 Industry partners</td>
<td>• CAMD Members: Regulators, Patient advocacy groups, Industry, Academia</td>
</tr>
<tr>
<td>• $140 k total (70k Mungas)</td>
<td>• Industry in kind contributions</td>
<td>• $ 1,850k total (3 years)i</td>
</tr>
<tr>
<td>• Start 2009</td>
<td>• Start 2012</td>
<td>• Start 2013</td>
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<tr>
<td><strong>Material Access</strong></td>
<td><strong>Material Access</strong></td>
<td><strong>Material Access</strong></td>
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<tr>
<td>• Decision January 2013 to make all work fully transparent (ADNI PPSB &amp; non –members)</td>
<td>• Decision January 2013 to make all work fully transparent</td>
<td>• Work and material privileged to COA participants (i.e. not default to all CAMD members)</td>
</tr>
<tr>
<td>• Public communication of outcome planned</td>
<td>• Public communications of data</td>
<td>• Communications at regulatory approval of qualification request</td>
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<tr>
<td><strong>Interaction Agencies</strong></td>
<td><strong>Interaction Agencies</strong></td>
<td><strong>Interaction Agencies</strong></td>
</tr>
<tr>
<td>• None</td>
<td>• None</td>
<td>• FDA &amp; EMA Non-member participants</td>
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<td>• Interactions HA while processing</td>
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Workstream 1: Prodromal AD / MCI Endpoints & Methods

*Lead: Nandini Raghavan*

Evaluation and recommendations on endpoints proposed for Prodromal AD/MCI Evaluation of methods proposed for developing endpoints
  - Evaluations based on datasets / results from company trials made available to CEWG

Workstream 2: Novel Tests for pre-MCI

*Lead: Veronika Logovinsky*

Identify tests and instruments to be evaluated for pre-MCI
  - Determine criteria for their inclusion into the selection process for further assessment within the CEWG. A pre-requisite will be at least some longitudinal data

Evaluate select novel tests
  - Determine criteria for their recommendation including performance characteristics in longitudinal data sets, and sensitivity to change in an early disease population
Clinical Endpoints Working Group: Endpoints For Consideration

• Conventional:
  ADAS-Cog 11, ADAS-Cog 13, CDRSB

• Eisai:
  Global composite MCIMax: Subscales from ADAS-Cog, CDRSB, MMSE

• Janssen:
  Cognitive Composite TriAD: Subscales from ADAS-Cog, CDRSB
  Global Composite TriAD-G: Subscales from ADAS-Cog, CDRSB, FAQ

• Astrazeneca:
  Cognitive Composite ProADAS: Subscales from ADAS-Cog

• Merck
  Recently proposed Endpoint to the WG

• Pfizer: TBD

• Item Response Theory (ITR)-based composite: TBD
Workstream 3: List of Datasets

Lead: Enchi Liu

• Create an inventory of datasets (clinical trials in early AD, natural aging studies, etc.) and an inventory of cognitive instruments that have been included in these trials
  ➢ Depend on contributions from companies who can share their knowledge of such trials and data sets, as well as instruments that have been used in these trials

Workstream 4: Computerized Cognitive Batteries

Lead Bruce Albala

• Should PPSB recommend adding computerized testing to the ADNI effort?
  – Request from Cogstate for an ADNI add-on study
Pathway for New Composite and Cognition Instrument Goes Through CAMD

1) Various Composite & Cognition Scores developed by Industry and Academic Groups
   - Eisai, AZ, Janssen, ADAS-Cog Plus (Dan Mungas), Merck, etc.

2) ADNI PPSB Clinical End Points Working Group
   - Mapping proposals from #1
   - Identifying all available data bases (e.g. prior MCI trials) for validation
   - Selecting candidate Instrument(s) for Mild, Prodromal, and pre-symptomatic AD to move to #3

3) CAMD (C-Path Inst): COA Project
   - Data analyses on candidates selected in #2
   - Submission Qualification request to FDA and EMA
   - Aim for approved new Instrument (as primary or secondary EP)
Parallel Pathway for New Composite and Cognition Instrument?

1) Various Composite & Cognition Scores developed by Industry and Academic Groups
   - Eisai, AZ, Janssen, ADAS-Cog Plus (Dan Mungas), Merck, etc.

2) ADNI PPSB Clinical End Points Working Group
   1. Mapping proposals from #1
   2. Identifying all available data bases (e.g. prior MCI trials) for validation
   3. Selecting candidate Instrument(s) for Mild, Prodromal, and pre symptomatic AD

3) CAMD (C-Path Inst):
   COA Project
   1. Data analyses on candidates
   2. Submission Qualification request to FDA and EMA
   3. Aim for approved new Instrument (as primary or secondary EP)

Harmonization of Efforts

2008-2013

2012-2014

2013-2016
A major concern by Industry & Regulators is to avoid proliferation of several instruments; 
• Cooperative efforts have to progress
  ➢ Suppress scientific “beauty contest”
  ➢ Suppress self-supporting “own” business needs

A company-specific concern is to assure to include the relevant Instruments in ongoing trials, while cooperative efforts are defining a favored proposal
• Risk missing out measurements (items) that end up being included in a “winning” novel instrument
• An open and sharing approach required
  ➢ Sharing means better chance to influence “final” proposal!
MATRICS (Measurement and Treatment Research to Improve Cognition in Schizophrenia) Consensus Cognitive Battery (MCCB)

- Measure cognition in schizophrenia and related disorders
  - Determining effectiveness of medication in schizophrenia
- Consensus process between academia, industry, and government
  - Funding provided by the NIMH
- Criteria for a Consensus Cognitive Battery for clinical trials in schizophrenia

- Several published reports
  - Schizophrenia Bulletin- 2007, July epub
  - J Clin Psychiatry July 2006 (also supplement 9)
  - Schizophrenia Res, vol 72, 2004
  - Biological Psychiatry, 2004

- Recommendations for Preclinical MATRICS
MATRICS
Final Consensus Battery

Speed of Processing
- Category Fluency
- Brief Assessment of Cognition in Schizophrenia (BACS) - Symbol-Coding
- Trail Making A2.1

Attention/Vigilance
- Continuous Performance Test - Identical Pairs (CPT-IP)

Working Memory
- Verbal:Letter-Number Span
- Nonverbal:Wechsler Memory Scale (WMS) - III Spatial Span

Verbal Learning
- Hopkins Verbal Learning Test (HVLT) – Revised

Visual Learning
- Brief Visuospatial Memory Test (BVMT) – Revised

Reasoning and Problem Solving
- Neuropsychological Assessment Battery (NAB) – Mazes

Social Cognition
- Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) - Managing Emotions

- Estimated administration time of battery: 63.5 minutes