

When to Switch GRADE tables

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Question: Should Clinical Monitoring vs Virologic, Immunologic, and Clinical Monitoring be used for guiding when to switch first-line antiretroviral therapy in adults in low-resource settings?

Settings: Low-resource settings

Bibliography: H.B.A.C. 2008

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Clinical Monitoring	Virologic, Immunologic, and Clinical Monitoring	Relative (95% CI)	Absolute		
Mortality (follow-up median 3 years)												
1	randomised trials	serious ¹	no serious inconsistency	no serious indirectness ²	serious ³	none ⁴	?/377 ⁵	?/368 ⁵	HR 1.58 (0.97 to 2.6)	-	⊕⊕○○ LOW	CRITICAL
AIDS-defining illness - not reported												
0	-	-	-	-	-	-	-	-	-	-		CRITICAL
AIDS-defining illness or Mortality (follow-up median 3 years)												
1	randomised trials	serious ¹	no serious inconsistency	no serious indirectness ²	serious ³	none ⁴	72/377 (19.1%) ⁶	47/368 (12.8%) ⁶	HR 1.88 (1.25 to 2.84)	99 more per 1000 (from 29 more to 194 more)	⊕⊕○○ LOW	CRITICAL
Unnecessary Switch (Switch to Second-line with Undetectable Viral Load) (follow-up median 3 years)												
1	randomised trials	serious ¹	no serious inconsistency	no serious indirectness ²	serious ³	none ⁴	15/377 (4%)	0/368 (0%)	RR 30.3 (1.82 to 504)	-	⊕⊕○○ LOW	CRITICAL
Virologic Treatment Failure (follow-up median 3 years)												
1	randomised trials	serious ¹	no serious inconsistency	no serious indirectness ²	serious ³	none ⁴	19/377 (5%)	16/368 (4.3%)	RR 1.16 (0.6 to 2.19)	7 more per 1000 (from 17 fewer to 52 more)	⊕⊕○○ LOW	IMPORTANT
Switch to Second-line (follow-up median 3 years)												
1	randomised trials	serious ¹	no serious inconsistency	no serious indirectness ²	serious ³	none ⁴	17/377 (4.5%)	7/368 (1.9%)	RR 2.37 (0.99 to 5.65)	26 more per 1000 (from 0 fewer to 88 more)	⊕⊕○○ LOW	

¹ Unclear sequence generation and allocation concealment, lost-to follow-up analyses not extensively presented but absolute numbers were relatively small, and blinding was not possible.

² Patient populations pre-selected and within relatively well-resourced ART delivery programs; however, as this study was in a low-resource setting it was not downgraded.

³ Total number of events was small.

⁴ Abstract(s) only, no peer-reviewed print publication(s) of these data are available; however, as a significant amount of data was available from abstracts/conference presentations no downgrading occurred.

⁵ Number with event not reported.

⁶ In clinical arm 7.57 events/100 P-Y, in virologic + immunologic + clinical arm 4.80 events/100 P-Y.