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REVIEW

Patient and Physician Global Assessments of Disease Status in Systemic Sclerosis

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Global assessments of disease by both patients and physicians are widely used in clinical studies of systemic sclerosis (SSc). They are commonly secondary end points in randomized controlled trials (RCTs) and are considered important items in composite measures of treatment response. A comprehensive literature review was conducted of the formats, wording, and clinimetric properties of the patient global assessment of disease status (PtGA) and physician global assessment of disease status (PhGA) used in RCTs of SSc. Marked heterogeneity was found in the wording and measurement scales of the global assessments applied in RCTs. These instruments were not developed using rigorous methodology and have not been fully validated. There is a pressing need for standardization and validation of patient and physician global assessment tools in SSc to enable universal application of these measures across RCTs in SSc.

Introduction

Patient assessment of disease status was first incorporated into rheumatology practice in the 1970s when a patient self-assessment of pain was used to evaluate rheumatoid arthritis (RA) (1). Over the past 50 years, the use of patient-reported assessments of overall health and disease activity and severity have become commonplace in the evaluation of disease states in most rheumatic diseases. It is unclear when or with what justification the physician global assessment of disease status (PhGA) was first used to assess patients with systemic sclerosis (SSc), but it has been included in most clinical trials since the 1990s (2–5). In contrast to multiquestion patient-reported outcomes measuring organ manifestations or health-related quality of life, the patient global assessment of disease status (PtGA) and PhGA are presented as a single question and ask respondents to rate global disease status, either via a visual analog scale (VAS), numeric rating scale, or Likert scale. For at least the past 25 years, it has been recommended that both a PtGA and a PhGA be included in clinical trials of SSc (6,7). Newer multisystem outcome measures for use in randomized controlled trials (RCTs) in SSc such as the American College of Rheumatology (ACR) Composite Response Index for Systemic Sclerosis (CRISS) include both a PtGA and a PhGA as part of a composite measure of response to treatment (8).

As the PtGA and PhGA each capture disease status from different perspectives, they have complementary roles in measuring disease response in RCTs and observational studies (9,10). Patient self-assessment of the burden of disease and change in disease status are essential aspects of the assessment of the efficacy and tolerability of novel therapies. Patient assessment may be more likely to reflect a combination of physical function, psychological well-being, pain, fatigue, and severity of organ involvement. A PtGA can be a direct measure of change in how patients feel and function, important aspects considered in the process of regulatory approval of new therapies. The physician assessment is more likely to consider poor prognostic factors and organ damage, and physicians give greater weighting to physical and laboratory findings such as the modified Rodnan skin thickness score (MRSS) and renal function when rating disease severity (9,10). However, there is no strict division between patient and physician global assessments, and these measures almost certainly assess several overlapping domains, and which factors contribute most

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highly to a response to treatment depends not only on the evaluator, but also on the nature of the trial and physiologic effects of the treatment under study.

Given the widespread use of both the PtGA and PhGA in the assessment of SSc, this study sought to assess the PtGAs and PhGAs applied in SSc research. A comprehensive literature review was performed to evaluate the clinimetric properties of existing global outcome measures with reference to the Outcome Measures in Rheumatology (OMERACT) filter of truth, discrimination, and feasibility (Figure 1) (11). To ascertain whether any limitations of the validity of global assessments in SSc are unique to the disease or more widely observed, the clinimetric properties of the PtGA in other rheumatic diseases were also reviewed.

Methods

A comprehensive literature search was performed with a particular emphasis on identifying papers concerning either RCTs or observational studies that included data assessing the face, content, or construct validity and discriminant validity of the PtGA and PhGA. The nature of this review was not amenable to a systematic or standardized scoping literature search because of the need to identify a broad range of sources, including cross-sectional, observational studies, and RCTs, as well as to identify analyses within papers that included the PtGA and PhGA. A standardized search was performed using PubMed (performed March 7, 2022) with the following search criteria: ('systemic sclerosis' or scleroderma or CREST) and 'global assessment' and ('reliability' or 'validity' or 'minimal clinical important difference'). In addition, a hierarchical literature search that included hand and expert opinion searches was performed to identify key publications, a methodology previously used to explore patient-reported outcomes in RA (12). The wording and response items of global assessments used in 16 RCTs were extracted from published manuscripts, clinical trial data registered at ClinicalTrials.gov (accessed March 7, 2022), or study protocols, where available, to identify the variability in PtGA and PhGA as they are currently used in RCTs in SSc. Two authors (LR and MB)

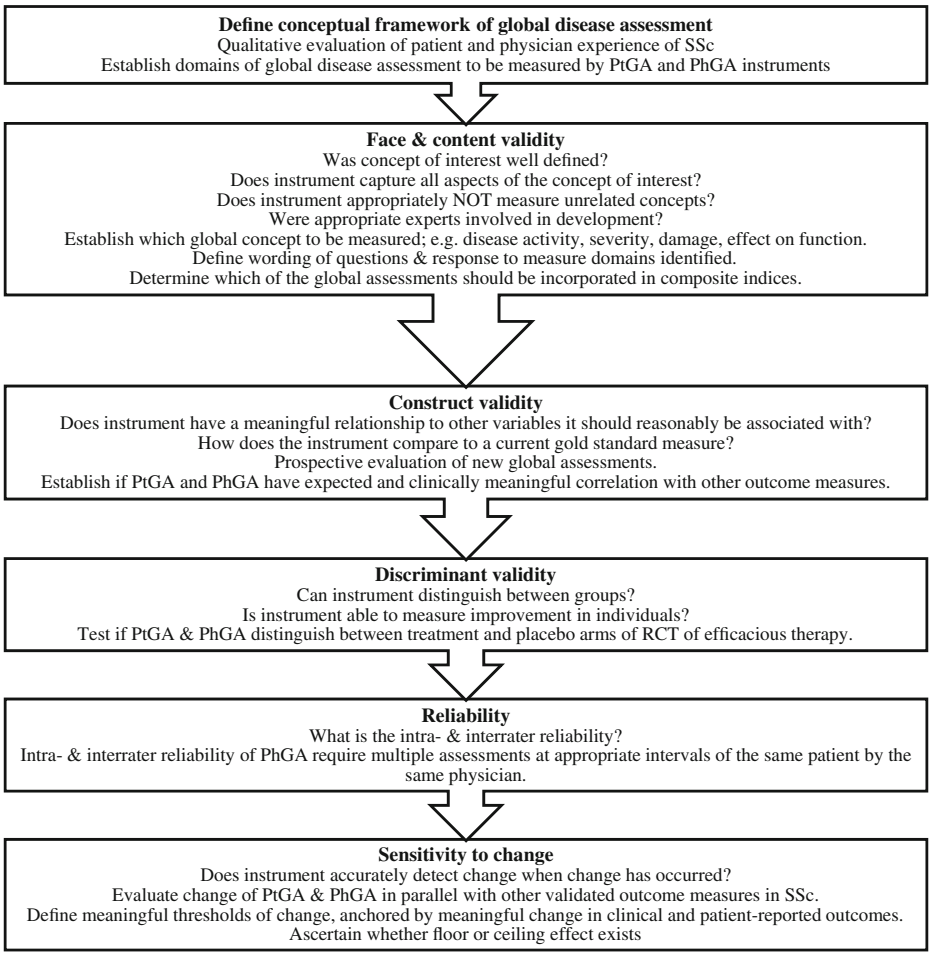

Figure 1. Proposed methodology for the development and validation of patient and physician global assessments according to Outcome Measures in Rheumatology (OMERACT) filter. PhGA = physician global assessment of disease status; PtGA = patient global assessment of disease status; RCT = randomized controlled trial; SSc = systemic sclerosis.

independently screened all titles and abstracts for relevance, with disagreements resolved by consensus. A hierarchical literature search strategy was applied to identify relevant publications assessing the clinimetric properties of the PtGA and PhGA in RA, psoriatic arthritis (PsA), antineutrophil cytoplasmic antibody–associated vasculitis (AAV), and systemic lupus erythematosus (SLE).

Results

The search strategy for SSc-related publications identified 75 citations, of which 27 articles, 16 RCTs, and 11 observational studies were included in the final review of the clinimetric properties of the PtGA and PhGA, with results summarized in Table 1. The wording of the global assessment and response anchors for the PtGA and PhGA were extracted from the 16 RCT publications or study protocols and are summarized in Table 2.

Face and content validity. Expert consensus has concluded that both the PtGA and PhGA should be included as part of the core set of outcome measures for use in RCTs of SSc (7). No formal evaluation of the patient opinion of global assessments has been performed, so no assessment could be made regarding the appropriateness and relevance of the instruments to assess their measurement of overall or global status in SSc. Indeed, any assessment of content validity is challenging, as a conceptual framework for either instrument has never been established and defined. Poorly measured variables and inconsistently defined measures make it extremely difficult, if not impossible, to evaluate the properties of clinical outcomes (13).

Many studies included the PtGA and PhGA either alone as secondary outcomes or as part of a composite measure to improve the content validity of the overall instrument (8). However, the methods for the derivation of the questions and anchors used in the global assessments were not documented in any of the studies found, and thus it was not possible to ascertain the content validity of these specific measures. There was also no evidence that patient representatives were involved in the development of any PtGA or that physicians beyond the core investigator group for a specific RCT were involved in developing any global assessment (14). One of the few studies that did employ specific methodology to develop global assessments was that of Steen and Medsger in the development of the modified Health Assessment Questionnaire (HAQ) for SSc (15). After generating the patient global assessment, they asked 11 patients how they would describe the features and impact of SSc on their daily lives and found that the question, "In the past week how much have your overall scleroderma problems interfered with your activities?" incorporated the language that patients used to assess their SSc (15). Significant heterogeneity exists in the types of global assessments, the wording of the questions, and the Likert items or VAS anchors used in RCTs (Table 2). Unlike in the work of Steen and Medsger (15), no such exercise was performed to ascertain the most appropriate wording of any global assessment of disease activity, damage, overall health, or other global domains. It is not known which global assessment may best reflect patients' assessment of their own health or disease status.

Construct validity. Recently used global assessments measure a variety of constructs, including disease activity, severity, overall health, and overall SSc health across RCTs (Table 2). Only low interrater agreement between expert-rated disease activity has been observed, and there is significant within-physician correlation between assessments of disease activity, severity, and damage (16,17). This suggests that physicians incorporate an assessment of multiple disease constructs when asked to evaluate global disease status and inclusion of multiple constructs into 1 measure. Patients and physicians likely have difficulty distinguishing disease activity from damage, and it has been suggested that patient assessments more strongly correlate with particular organ manifestations rather than overall disease (9,10,15,17,18).

There is poor-to-moderate correlation between a PhGA of activity and SSc-specific disease activity indices (17,19); however, the PhGA of global health has been shown to correlate with the MRSS, a commonly used surrogate measure of overall disease burden (10). Both the PtGA and PhGA of disease severity have been strongly associated with physician-rated improvement over a 12-month period (8). Observational data have shown associations between PtGA and health-related quality of life and overall disease severity (15,20); however, there are inconsistent reports about the association of PtGA and function as measured by the HAQ (20,21).

The lack of independent gold-standard measures of either activity, damage, or disease severity in SSc limits any evaluation of the criterion validity of both the PtGA and PhGA, and as such it remains unproven. Somewhat paradoxically, despite the

Table 1. Clinimetric properties of patient and physician global assessment in systemic sclerosis*

		Truth			Discrimination			
	Feasibility	Face validity	Content validity	Construct validity	Discriminant validity	Sensitivity to change	MCID	Reliability
PtGA	Yes	Not done	No	No	No	No	Partial	No
PhGA	Yes	Not done	No	No	Partial	No	Partial	No

* MCID = minimum clinically important difference; PhGA = physician global assessment of disease status; PtGA = patient global assessment of disease status.

Table 2. Summary of types of patient and physician global scores and frequency of application in randomized controlled trials (RCTs) of systemic sclerosis (SSc)*

Feature	Frequency of use in RCTs	References
Features of patient global assessments (n = 16)		
RCTs using VAS	7/16 (43.8)	5,26,28,29,31,60,61
100-mm VAS	5/7 (71.4)	5,26,28,29,60
RCTs using NRS	5/16 (31.3)	62–66
11-point NRS	5/5 (100)	62–66
RCTs using Likert scale	4/16 (25)	25,60,65,67
11-point Likert scale	2/4 (50)	25,67
7-point Likert scale	0/4 (0)	–
5-point Likert scale	2/4 (50)	60,65
Assessment of disease activity	3/16 (18.8)	61,62,64
Assessment of disease severity or overall impact of disease	2/16 (12.5)	31,63
Assessment of current SSc status/overall disease	4/16 (25)	25,28,29,67
Overall health/general well-being	3/16 (18.8)	5,66,68
Health transition question	2/16 (12.5)	60,65
Global assessment not otherwise specified	2/16 (12.5)	26,60
Assessment of activity or severity	1/16 (6.3)	65
Pain and disability	1/16 (6.3)	69
Features of physician global assessments (n = 16)		
RCTs using VAS	6/16 (37.5)	26,28,29,31,60,61
100-mm VAS	4/6 (66.7)	26,28,29,60
RCTs using NRS	5/16 (31.3)	62–66
11-point NRS	5/5 (100)	62–66
RCTs using Likert scale	4/16 (25)	2,25,65,67
11-point Likert scale	2 /4 (50)	25,67
7-point Likert scale	1/4 (25)	2
5-point Likert scale	1/4 (25)	65
Assessment of disease activity	4/16 (25)	61,63,64,67
Assessment of disease severity/overall impact of disease	3/16 (18.8)	28,31,62
Assessment of current SSc status/overall disease	2/16 (12.5)	25,29
Global health assessment	3/16 (18.8)	2,66,68
Health transition question	1/16 (6.3)	65
Global assessment not otherwise specified	2 /16 (12.5)	26,60
Assessment of activity or severity	1/16 (6.3)	65
Pain and disability	1/16 (6.3)	69

* Values are the no./total no. (%) unless indicated otherwise. NRS = numerical rating scale; VAS = visual analog scale.

unproven content and construct validity of the PtGA and PhGA, it is often these global assessments that are used to anchor and validate other new outcome measures, such as the European Scleroderma Trials and Research (EUSTAR) Activity Index and the ACR CRISS (8,22).

Discriminant validity. Review of the performance of the PhGA in RCTs in SSc has shown that the PhGA can identify a net treatment benefit in active treatment arms in some studies despite the failure of many RCTs to reach their primary end point (23–26). Repeated PhGAs were shown to be a useful measure of disease status in the D-penicillamine RCT, correlating with MRSS and HAQ scores (27). Notably, the PtGA did not distinguish between treatment and placebo groups in any recent randomized trial with published results; however, these were clinical trials that did not reach their primary end point. The phase 2 and 3 trials of tocilizumab in SSc (28,29) did not find a meaningful change in the PtGA or PhGA or between-group differences between the treatment and placebo study arms, despite meaningful improvement in other secondary outcomes.

Sensitivity to change and minimum clinically important difference (MCID). The sensitivity to change of global assessments in SSc remains unknown, and clinically meaningful thresholds of change (the MCID) are yet to be defined. Observational cohort data used to identify items that predict overall improvement over a 12-month period defined a standard error measure of 0.26 and 1.75 for the PtGA and PhGA, respectively (8). Attempts have been made to define the MCID of the global VAS score using observational data (21) and a Delphi exercise of experts (30), but no data from prospective randomized trials have been used to define these thresholds.

Reliability. Reliability has yet to be established for the patient and physician global assessments in SSc. Data collected from the post-procedure observation phase of an RCT for Raynaud's phenomenon found that both the PtGA and PhGA of disease severity were unreliable measures, with an SD of difference between 18–25% (31). Increased variability of the PtGA and PhGA scores compared to other measures of disease status was also observed in observational cohort data, and significant interrater variability of the PtGA has been described (16,32).

Feasibility. Both the PtGA and PhGA are quick and simple to perform without any great burden to either the patient or physician in studies of SSc. Both assessments are well accepted by both patients and physicians (12,31,33). Feasibility was formally assessed during the development of the ACR CRISS, and global assessments were found to be feasible measures of disease both in the derivation study, where they achieved a prespecified threshold of feasibility, and by subjective evaluation by the ACR CRISS steering committee (8).

Measurement of global assessments in other rheumatic diseases. Assessment of both the PtGA and PhGA in other rheumatic diseases shows similar limitations to those revealed by our evaluation of global assessments in SSc. Global assessments are used widely across many multisystem autoimmune diseases, with the derivation of each global assessment largely undocumented and highly variable application of both the PtGA

and PhGA across studies. The PtGA has been incorporated into many of the major disease activity indices to measure disease status in RA, such as the Disease Activity Score in 28 joints (34), the Simplified Disease Activity Index (35), the Clinical Disease Activity Index (36), and the Routine Assessment of Patient Index Data 3 (37). The PtGA is reported in almost one-half of all RA clinical trials (1). However, the scales used to rate the PtGA are often not specified, and the RA PtGA has poor content validity due to the lack of patient involvement via focus groups, qualitative studies, or evaluation of the meaning of a given PtGA (1). There is heterogeneity of concepts measured by different PtGAs and variation in the specificity of PtGAs to RA, as some are measures of global health status, meaning that patient responses may not be comparable between studies (1). A PtGA is one of the domains of the PsA core domain set and defined as a patient global assessment of disease-related health status (38). Similar to SSc, little is understood about what a PtGA should look like, and there remains no standardized application of PtGA across PsA clinical trials (39–41). However, meaningful improvements in the PtGA are frequently observed in PsA RCTs of effective therapies (39–41). The PsA PtGA is considered a reliable measure of changes in disease status; however, it is influenced by the presence of comorbidities and overall pain (42,43). There are no studies that detail the development of the PtGA, so it is therefore not possible to assess the face and content validity of any of the PsA PtGAs. A recent systematic review of the global assessments used in clinical trials of psoriasis found significant heterogeneity of the implementation of these instruments and concluded that all psoriasis PtGAs and PhGAs as they are currently used are lacking in content validity and feasibility (44).

AAV is another complex multisystem disease with multiple outcome measures used across clinical trials. The clinimetric properties of the PhGA in AAV remain unassessed (45), but interestingly, as we observed in SSc, it has been used to validate other composite outcome measures, such as the Birmingham Vasculitis Activity Score (BVAS) (45) and the Patient-Reported Outcomes Measurement Information System (PROMIS) instruments (46). The PtGA is considered to lack validity and reliability in AAV and has untested responsiveness to change (45). The PtGA in AAV has only poor-to-moderate correlation with BVAS scores and other measures of health-related quality of life (45). No standardized measures of patient or physician global assessment exist for large vessel vasculitis (47).

It is notable that in SLE a PtGA is not used to assess disease status in clinical trials. In contrast, a PhGA is widely used as part of composite outcome measures such as the Lupus Activity Index (48), the Systemic Lupus Erythematosus Disease Activity Index (49), and the British Isles Lupus Assessment Group index (50). Similar to SSc, there is no consistent application of the PhGA across SLE trials, including discrepancies in the application of the types of VAS applied, time frames of assessment, and whether the PhGA should incorporate investigation findings (51). There are currently significant international efforts underway to standardize the application of the SLE PhGA in recognition that the reliability of the instrument can only be truly established when it is consistently applied across studies (52).

The patient experience of using a PtGA has been explored in individuals diagnosed with RA. Three overarching problems have been identified: difficulty understanding the meaning and purpose of the PtGA and measurement difficulties (53). Wording of global assessments and the phrasing of response anchors requires consistency, as changes to the wording of either outcome anchors or item responses alters the construct measured by a particular global assessment tool (1,54). In RA, up to one-half of patients can be confused by the PtGA (55). A potential floor effect exists when asking patients to rate disease activity or the impact of disease. Patients with RA will rarely score 0 on a PtGA, commenting that activity or impact of RA "can't be zero" given the persistent impact of disease damage and comorbidities, wanting to encompass the varying nature of chronic illness in any self-assessment, and patient concern about withdrawal of treatment if disease is reported to be under excellent control (53). It has been identified that in RA there is a pressing need to reckon with these limitations of the content validity of PtGA (56). Patient-reported outcome assessments should permit accurate documentation of patients' disease status, and the current PtGAs used in RA do not seem to adequately give voice to patients' experiences of their disease (56). The inclusion of the PtGA in many measures of disease remission risks overtreatment because of the floor effect of the PtGA and therefore risks incorporating this same effect into composite measures of low disease activity and/or remission.

Conclusions

There is a lack of consensus as to what concept of disease the PtGA and PhGA should be measuring in clinical trials of SSc. Disease constructs such as activity, damage, and severity, as well as overall health, are not directly interchangeable, and it is unknown which construct best measures patient's disease status; this issue applies to both the patient and physician global assessment. Furthermore, the heterogeneity in what 'global' or 'disease' means to individuals may reduce the precision of any global assessment tool and therefore any composite outcome measure that includes a global assessment. Global constructs of disease status are open to interpretation by both the patient and physician, and responses are highly dependent on the respondent's comprehension of the underlying construct being measured. An example of this is the absence of meaningful change of the PhGA and PtGA in the RCTs of tocilizumab (28,29), despite important changes in pulmonary domains of disease. It also illustrates an inherent limitation of both the PtGA and PhGA, in that positive effects of therapy on an individual domain may by diluted in a global assessment because of the absence of treatment

efficacy on other domains of disease. Demonstrating an absence of statistical difference of an unclear end point, such as the PtGA and PhGA as they are currently used, does not rule out a meaningful effect size in favor of either the test or the control intervention or an absence of a clinically meaningful difference to patients (13). Therefore, it seems reasonable to question whether several domains should be included in a global assessment instrument, such as the accepted patient-reported assessment for cryopyrin-associated periodic syndromes that incorporates a severity rating of individual disease-related symptoms (57).

The authors of this manuscript have been involved in a task force assessing various measures that assess the global aspects of SSc. The concept of measuring a global disease was defined by consensus as measuring the effect of the disease on >1 organ or body system, and it should reflect how a patient feels or functions without reference to 1 specific body system. The focus of legacy global measures can be classified into several domains: health-related quality of life, function, psychosocial, pain, fatigue, disease activity, disease severity, disease damage, frailty, and composite indices, any of which likely cross multiple disease domains. It is thus not surprising that there are many different patient and physician global assessments that ask different questions. No PtGA or PhGA has been systematically designed for use in SSc or has undergone full validation according to the OMERACT filter of truth, discrimination, and feasibility (11). No study has attempted to identify which global disease construct should be assessed by either the PtGA or PhGA nor ascertain which of the commonly used constructs of disease activity, severity, damage, or overall health is the most informative when measuring response to therapy. None of the global assessments currently used in research in SSc include patients in the development of the question asked or design of item responses.

Review of the performance of global assessments in clinical studies of SSc has not shown substantial sensitivity to change of either the PtGA or PhGA. This has implications for the use of global assessments in clinical trials where responsiveness to change is key to being able to identify therapeutic benefit. However, the majority of RCTs in SSc have failed to reach their primary end point, thus the lack of difference between study arms may speak to a failure of therapy rather than the insensitivity of an outcome measure to detect change in health status. In a condition such as SSc, effect sizes and MCIDs are influenced by burden of disease as well as disease duration (9,58). Potential floor and ceiling effects are influenced by the wording of both the question anchors and potential item responses. Changes in any of these elements of a global assessment tool affects the sensitivity to change of the item in use (54).

The heterogeneity of SSc provides unique challenges concerning patient global health assessments. The gradual accrual of disease-related morbidity could result in shifting patient perceptions of global disease severity being influenced by recent disease events. For example, digital ulcer occurrence may lead to a patient concluding that their previous global disease severity ratings should not have been so high in the time preceding their first digital ulcer. A response shift of global assessments has been observed particularly if status is compared to a previous visit rather than a baseline study visit (13). Conversely, habituation and adaptation may favorably impact longitudinal global disease severity assessment despite the disease manifestations remaining unchanged or potentially worsening. Both the coping strategies and styles of patients can influence their global rating of disease status (59), and conceivably the concept of global disease may vary depending on the disease subtype, duration of disease, and particular organ involvement that a patient had experienced. Many of these issues could also impact physician global assessments.

There is an urgent imperative to develop fully valid and universally applied global assessments in clinical trials of SSc. A suggested research methodology to first define and then validate both the patient and physician global assessments is outlined in Figure 1. The most important phase is the initial phase to define the construct to be measured and then developing appropriate wording of the question and scale anchors to best reflect the domain under consideration and thus improve the content validity of global assessments. This step is essential to be able to demonstrate construct validity of the novel instrument. Without face and content validity, any presumed construct validity demonstrated by a correlation of the novel instrument with other outcome measures hypothesized to assess a similar disease construct may well be spurious. Perhaps multiple PtGA and PhGA assessments should be developed to measure each of several different domains of disease and that consensus methodology be used to decide which domain can be used alone and which should be included in composite indices.

Rigorous prospective studies are required to test the discriminative capacity and determine the sensitivity to change and MCID of any standardized global assessment. Successful ascertainment of these values will require testing of the novel PtGA and PhGA in groups of patients treated with efficacious therapies compared to placebo. Assessment of the test–retest reliability, particularly of the PhGA, will require major resources, including significant physician time, to have multiple physicians clinically reassess individual patients with stable disease after an appropriate interval. Careful consideration needs to be paid to varying thresholds that may need to apply according to individual patients' disease subtype, duration, baseline values, and perhaps even specific organ manifestations.

Both the patient and physician global assessment are attractive outcome measures, as they provide complimentary information that directly reflects the patient's experience of his or her disease, in the case of the patient global, and direct evaluation by the physician caring for the patient. Additionally, they can capture elements of disease that have proven elusive to measure by more objective measures of disease status through investigation

findings or biomarkers. Currently, however, this review of both the work to date in SSc as well as other rheumatic diseases suggests that the heterogeneity of the wording of global assessments, and the lack of rigorous methodology in their development, leads to an absence of content validity of these assessments and limits their validity as outcome measures for use in RCTs. The lack of content validity of these global measures across multiple rheumatic diseases suggests that this may be a global issue rather than specific to a particular disease. This raises concerns about the use of composite measures that include both patient and physician assessments to generate a final overall score. The lack of consistency of global assessments between studies undermines the results of validation studies of composite measures that include the PtGA or PhGA and risk negatively affecting these findings and spuriously limiting the use of novel composite outcomes as valid study end points.

In conclusion, future work needs to address the most valid constructs to measure using the PtGA and PhGA in RCTs in SSc. Once constructs that best capture aspects of disease important to both patients and physicians are defined, methods to define appropriate questions, anchors, and item responses must be developed and employed in creating PtGAs and PhGAs before considering the reliability, construct validity, and sensitivity to change of these global assessments. Without consistently applied, valid PtGAs and PhGAs across RCTs in SSc, there is an ongoing risk of negative trials due to a measurement failure rather than a failure of therapy.

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AUTHOR CONTRIBUTIONS

All authors drafted the article, revised it critically for important intellectual content, and approved the final version to be published.

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