Table 6. Strength of evidence for adherence (KQ3)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Drug Comparison****Number of Studies** **# of Subjects** | **Risk of Bias****Design/ Quality** | **Consistency** | **Directness** | **Precision** | **Results** | **Strength of Evidence** |
| **Oral DMARD vs. Oral DMARD**5 RCT N = 1,924 | HighRCT/5 fair | Inconsistent | Direct | Imprecise  | No apparent differences in adherence among oral DMARDs | Low |
| **Biologic DMARD vs. Biologic DMARD**5 observational N = 14,250 | Highcohort/5 fair | Inconsistent | Direct | Imprecise  | Better adherence for INF than ETN in 1 study, similar adherence for INF and ETN in a second study, worse adherence for INF than ETN in a third study  | Insufficient |
| **Biologic DMARD vs. Oral DMARD**1 observational N = 6,018 | HighCohort/1 fair | Unknown | Direct  | Imprecise  | Better adherence for LEF, ADA, ETN, and INF monotherapy compared with MTX | Low |
| **Biologic DMARD vs. placebo**2 RCT N = 2,066 | MediumRCT/1 good, 1 fair | Consistent | Indirect  | Imprecise  | No apparent differences in adherence | Insufficient |

ADA, adalimumab; DMARD, disease modifying antirheumatic drug; ETN, etanercept; INF, infliximab; leflunomide, LEF; MTX, methotrexate; N, number; RCT, randomized controlled trial; vs., versus.