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Comparing the effectiveness, safety and tolerability of interventions for depressive symptoms in people with multiple sclerosis: a systematic review and network meta-analysis protocol

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ABSTRACT

Background Comorbid depression is prevalent in people with multiple sclerosis (MS). Depression is commonly untreated or undertreated, thus, there is a need for effective and safe interventions and current guidelines recommend psychological and pharmaceutical interventions for people with MS. However, research suggests that other interventions, such as exercise, could also be effective. The comparative efficacy and safety of intervention modalities have not been quantified.

We plan to conduct a systematic review and network meta-analysis to compare efficacy and safety of psychological, pharmaceutical, physical and magnetic stimulation interventions for depression in people with MS.

Methods and analysis We will search EMBASE, Medline, Cochrane CENTRAL, APA PsycINFO, Web of Science, CINAHL and PEDro from inception to 31 December 2021. Search terms will stem from three concepts: MS, depression and randomised controlled trials. Included studies will be randomised controlled trials, where participants are people with MS randomised to receive one of the aforementioned intervention types, and depression or depressive symptoms is the primary outcome, only outcome or secondary outcome with an a priori power calculation. Screening, data extraction and risk of bias assessment (using the Risk of Bias 2 tool) will be conducted independently by two reviewers. If possible, we will synthesise the evidence by fitting a frequentist network meta-analysis model with multivariate random effects, or a pairwise random-effects meta-analysis model. For each model, efficacy will be measured using a standardised mean difference, and safety using an OR. We plan to provide summary measures including forest plots, a geometry of the network, surface under the cumulative ranking curve, and a league table, and perform subgroup analyses. Otherwise, a narrative review will be provided.

Ethics and dissemination Ethics is not required for a systematic review and network meta-analysis. Results will be published in a peer reviewed journal.

PROSPERO registration number CRD42020209803.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Advanced network meta-analysis methods together with sensitivity and subgroup analyses will comprehensively quantify the comparative efficacy, safety and tolerability of several interventions for depression in people with multiple sclerosis.
⇒ This systematic review will use a detailed search strategy and prespecified eligibility criteria, with all steps of the review process conducted independently by two reviewers.
⇒ Eligibility criteria include randomised controlled trials which are limited to depression as the primary outcome, only outcome or secondary outcome with a power analysis.
⇒ To meet the transitivity assumption, trials that include participants with treatment resistant/refractory depression will be excluded.

INTRODUCTION

Multiple sclerosis (MS) is a chronic, immune-mediated and neurodegenerative disease characterised by the formation of destructive lesions predominantly involving myelinated axons within the central nervous system.[1] There are a broad range of symptoms attributed to the multifocal lesions distinctive of MS including depression and depressive symptoms, pain, fatigue, impaired gait, incontinence, impaired vision and spasticity.[2] Depression can be particularly burdensome, and affects up to 50% of people with MS.[3] Depressive symptoms in people with MS are reported to impact adherence to disease modifying therapies,[4] and increase pain sensitivity.[2] Further, reduced participation in work and depressive symptoms are associated with poor health related quality of life[5] in people with MS. Major depressive disorder is the most commonly diagnosed depressive disorder.[6]

It is defined as experiencing a minimum of five of the following symptoms within a 2-week period: depressed mood or lack of pleasure, feelings of worthlessness/guilt, fatigue, appetite or weight changes, psychomotor agitation, diminished concentration, feelings of worthlessness/guilt, suicidality and sleep difficulties.[6] Depressive symptoms which do not meet the definition of major depressive disorder are even more prevalent in people with MS, and commonly require treatment.[7] Furthermore, people with MS who have moderate-to-severe depressive symptoms have been reportedly underdiagnosed and undertreated.[5 8] The aetiology of depression and depressive symptoms in people with MS is not yet fully understood[9] but due to the multitude of effects, safe and effective interventions are required.

Guidelines for treating depression in people with MS suggest that a combination of psychological and pharmaceutical interventions is the most effective therapy in reducing levels of depressive symptoms.[10 11] Specifically, these guidelines recommend pharmacotherapies such as antidepressants, psychological treatments such as cognitive behavioural therapy, and, where applicable and safe, exercise-based interventions.[11] However, some interventions, including third wave cognitive and behavioural (psychological) interventions that emphasise the role of mindfulness[12] and specific types of exercise such as Pilates,[13] have not been included in these guidelines. The American Association of Neurology review to inform guidelines[14] noted the scarcity of trials to treat depression in people with MS and therefore a lack of strong evidence. Following this review,[14] several studies have sought to address the treatment of depressive symptoms in MS. Evidence from systematic reviews reported that exercise[15 16] and mindfulness-based interventions[17] when compared with waitlist/usual care have a moderate effect at reducing depressive symptoms in people with MS. However, it is unclear how these interventions compare in terms of efficacy and safety.

Network meta-analysis (NMA) enables the comparison of multiple interventions by simultaneously combining direct and indirect evidence.[18] Synthesising the evidence in this manner will enable a comprehensive understanding of how interventions compare (in terms of efficacy and safety), which should greatly enhance evidence-based decision making for people with MS and their clinicians on how best to manage depressive symptoms. The major assumption underpinning NMA methods ensures that we can compare two interventions via a third (common) intervention and is referred to as transitivity. Transitivity requires that the trials included in the NMA are considered to be 'jointly randomisable', that the common intervention (comparator) from the different trials is similar enough to be combined, and that the characteristics associated with the effect of the intervention are similar across the included trials.[19 20]

This article outlines the protocol for a systematic review and NMA to compare the effectiveness and safety of intervention modalities, or combination of modalities, in reducing depressive symptoms in adults with MS. This review is the first stage of a larger project that aims to provide guidance for public health researchers on the design and analysis of systematic reviews with NMA and future trials in MS.

METHODS

This systematic review protocol is registered with The International Prospective Register of Systematic Reviews (PROSPERO) (CRD42020209803) and adheres to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for NMA statement[21] (see online supplemental file 1 for checklist).

Patient and public involvement

Neither patients nor the public were involved in the design, conduct or reporting of the research in this article.

Eligibility criteria

Participants

Adults (aged 18 years or older) of any gender who have been diagnosed with any type of MS.

Interventions

We will include interventions that aim to alleviate depressive symptoms in people with MS, including:

Psychological interventions delivered with the intention of treating depressive symptoms, informed by psychological theories or principle(s) and (1) implemented by a psychiatrist/psychologist or other mental health clinician or (2) manualised, with content developed by a mental health clinician or researcher, for example, online/app or web-based intervention.

Pharmaceutical interventions that involve the use of medication or drugs for the intention of treating depressive symptoms at a therapeutic dose according to the manufacturer guidelines (if available).

Physical interventions including physiotherapy and physical activity (any bodily movement that results in energy expenditure) including exercise, aimed at treating depressive symptoms. Subtypes of physical activity will be included.

Electromagnetic stimulations involve the use of targeted electromagnetic stimulation to stimulate areas of the brain to reduce depressive symptoms. Subtypes include transcranial magnetic stimulation, and transcranial direct current stimulation.

Combinations of the above-mentioned intervention modalities will be included and will form new categories. Any interventions that are specific to people with treatment resistant depression/refractory depression will not be included (eg, electroconvulsive therapy). These treatments will be excluded because they will compromise the transitivity assumption (ie, that all interventions are considered to be 'jointly randomisable'). Treatments for people with treatment resistant depression would not be

considered to meet this assumption because they are not considered first line treatments for people with MS.[18]

Grouping of interventions will depend on the eligible trials. The four broad categories will be split into smaller subcategories, for example, psychological interventions could have a subcategory of mindfulness-based interventions, similarly pharmaceutical interventions could have a sub-category of serotonin reuptake inhibitors.

Comparator

We will consider the following comparators: any intervention modality included in the above list, placebo, wait-list control, treatment as usual or no treatment. Classification of comparator groups will depend on the type of comparator used in the original randomised trial. Common types of comparators can include, but are not limited to, placebo, wait-list control, treatment as usual and no treatment control. These comparator groups do not have similar methodology and can influence participant outcome in altering ways. Therefore, for this protocol and subsequent systematic review and NMA, we will adopt the recommended framework for classification of comparator groups.[22] The groups will be (1) minimal treatment control, active control or similar; (2) wait-list control, treatment as usual or no treatment and (3) pill placebo.

Outcome

We will include trials that specified that depressive symptoms were the primary (or only) outcome, or as a secondary outcome where an *a priori* power calculation was provided. The severity of depressive symptoms must have been measured by a validated self-report questionnaire or by clinician interview. Although depression and depressive symptoms are likely to be measured and defined differently across trials,[23] we have chosen to accept all types of standardised measures or clinical interviews. To assess the acute efficacy of the intervention, depressive symptoms must be measured within 2 weeks of completion of the intervention. We will also assess the long-term efficacy of the intervention using trials that have measured depressive symptoms at approximately 6 months post-intervention (within 4–8 months). To measure long-term efficacy and safety of interventions for reducing depressive symptoms, we will also extract the relevant data that is measured 12 or more months post-intervention. Any trials that have measured just one of the aforementioned time points will still be eligible for inclusion.

Safety and tolerability outcomes will include:

- Frequency of serious adverse events (SAEs) defined as an untoward occurrence of a medical event that is fatal, life-threatening, requires hospitalisation or prolonging of existing hospitalisation and/or persistent disability.[24–27]
- Frequency of adverse events (AEs) defined as the occurrence of an undesirable event occurring during the study duration even if the event was not considered to be related to the intervention.[24–27]
- Tolerability of the intervention will be assessed as the number of participants who discontinue the study and/or have reduced compliance due to SAE or AEs.[24 28]

The events will be measured as dichotomous outcomes during the intervention period. We will consider combining the SAEs and AEs if they are rare events in the trials.

Types of studies

We will include randomised controlled trials, including multiarm randomised trials. Quasi-randomised, cluster and cross-over trials will not be included.

Search strategy

We will search the following seven databases: EMBASE, Medline, Cochrane CENTRAL, APA PsycINFO, Web of Science, CINAHL and PEDro. Note that EMBASE, Medline, Cochrane CENTRAL and APA PsycINFO will be searched through the Ovid platform. The search strategy was developed in conjunction with a medical librarian at the University of Melbourne, Australia, as well as a clinical physiotherapist (YCL) who works with people with MS, and a clinical psychologist (AM). The search terms relate to three main concepts of MS, depression and randomised controlled trials. Search strategies for all databases are listed in online supplemental file 2. All databases were searched from inception to the 11 July 2020 and the search will be updated to include articles published up to the 31 December 2021. We will also search the reference lists of relevant systematic reviews to identify any randomised trials that might have been missed in the database search. Trials will be limited to those published in English.

Study selection

Results from the search strategy will be uploaded to Endnote[29] where duplicates will be removed. The remaining citations will be uploaded into the software management system Covidence[30] where any additional duplicates will be removed. Covidence will then be used for title and abstract screening and full-text screening by at least two independent reviewers with any conflicts resolved by a third reviewer.

Data extraction

Data will be extracted using a data extraction tool developed for this review using Excel software by at least two independent reviewers, with conflicts resolved by a third reviewer. If data were missing from the published article the corresponding author will be contacted. We will not look at other sources of citations such as grey literature, clinical trial registries or protocol papers. The extracted data will relate to the following categories:

- Study characteristics: first author's last name, year of publication, year of baseline recruitment, method of recruitment, method of randomisation, inclusion

criteria (eg, a baseline level of depression cut-off for inclusion into study).
- Sample demographics: sample size, number of participants randomised, baseline characteristics such as diagnosis of MS, age (years), sex, years since diagnosis of MS, level of disability and disability tool.
- Intervention and comparator characteristics: type, frequency of intervention/treatment, duration of intervention/treatment and dose of intervention/treatment. We will use the Template for Intervention Description and Replication checklist (TIDieR) for clear reporting of the characteristics of the interventions and comparators.[31]
- Efficacy outcome data: type of outcome measurement scale, mean and SD of depressive symptom score at baseline, post-intervention, at 6 months post-intervention and at 12 months post-intervention (if available).
- Safety and tolerability data: type and number of SAEs and AEs, number of participants that discontinue participation due to an SAE or AE or discontinue participation for other reasons during the intervention. Safety and tolerability data will be extracted for each trial arm and time point where available.
- Data relating to the risk of bias (RoB) assessment: randomisation process, allocation concealment, deviations from intended treatment, baseline characteristics differences, missing outcome data, appropriateness of outcome measurement, potential influence in outcome assessment and selectively reporting results.

RoB assessment

We will use the RoB 2 to assess the RoB for each study that meets the eligibility criteria.[32] This tool evaluates the RoB in five key domains: randomisation process, deviations from intended interventions, missing outcome data, measurement of the outcome, and selection of the reported result. The RoB 2 tool provides an overall assessment of the RoB in the study using three categories: low risk, some concerns or high RoB. At least two independent reviewers will assess the RoB in each study with any conflicts between judgements resolved by a third reviewer. In this systematic review and NMA, there will be an inherent difference in the overall RoB between trials due to the type of intervention. Blinding of the participants to the assigned intervention is difficult in some study designs and interventions. For example, in a trial that randomised participants to exercise and wait-list control, participants will be aware of the treatment arm that they were allocated to. However, in a trial that randomised participants to an antidepressant and placebo, participants are unlikely to be aware which treatment they were allocated. As well, blinding of the outcome assessors can also be difficult in these trials as depressive symptoms are typically measured using self-reported tools. Despite this inherent difference, we have chosen not to deviate from the protocol of the RoB 2 tool or alter the tool in any way.

Data synthesis

Characteristics of the included trials

We will generate descriptive statistics for the sample populations to understand the demographics of the review participants across all eligible trials. These descriptive statistics will describe key clinical and methodological characteristics such as age, sex, type of MS and type of intervention modality.

Outcome data

We will have two primary and four secondary outcomes.

Primary outcomes

1. Efficacy of the interventions (reduction of depressive symptoms) measured immediately post-intervention and quantified using standardised mean difference.[33]
2. Safety of the interventions (SAEs, AEs and tolerability) measured immediately post-intervention and quantified using Odds Ratios (ORs).

Secondary outcomes

1. Efficacy of the interventions (reduction of depressive symptoms) measured immediately 6 months post-intervention (between four and 8 months) and quantified using standardised mean differences;
2. Safety of the interventions (SAEs, AEs and tolerability) measured 6 months post-intervention (between four and 8 months) and quantified using ORs.
3. Efficacy of intervention (reduction of depressive symptoms) measured 12 months post-intervention (12 months or longer) and quantified using standardised mean differences.
4. Safety of interventions (SAEs, AEs and tolerability) measured 12 months post-intervention (12 months or longer) and quantified using ORs.

Pairwise meta-analysis

First, we will pool the data that compare the same major category of intervention modality (ie, psychological, pharmaceutical, physical, electromagnetic stimulation therapies or combination) to each other or to placebo/usual care by fitting a random effects pairwise meta-analysis model and using the restricted maximum likelihood estimator to estimate the between study heterogeneity. The random effects model will assume that the underlying intervention effects across the trials are similar but not identical allowing an estimation of the heterogeneity in the model.[34] This will be performed for both the efficacy outcome, using the standardised mean difference and the safety outcome, using ORs. Effect sizes will be presented with their corresponding 95% CIs. Heterogeneity will be estimated using the I^2 and τ^2 statistics.[35]

NMA model

We will fit a multivariate meta-analysis contrast-based model within a frequentist framework using the network package in Stata version 17.0.[36] We will assume common heterogeneity across the trials.

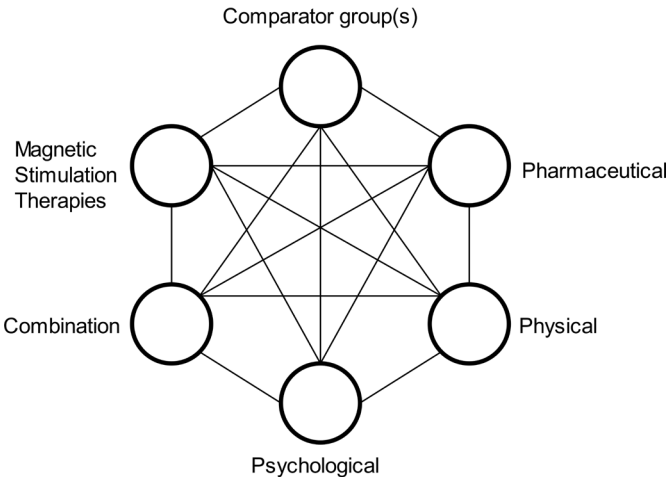


Figure 1 The possible network structure for the major categories of interventions. Comparator group(s) may be split into multiple nodes as outlined in the comparator group section.

Geometry of the network

We will generate a network diagram, separately for efficacy and safety, to visualise the network of intervention modalities. The nodes (or intervention modalities) will represent the total number of trials in each treatment group; the larger the size of the node the larger the sample size. The edges of the lines connecting each node will represent the precision of the evidence, that is, the thicker the line the more precise evidence. Figure 1 shows an example of the possible network structure with the major intervention modalities included.

Assessment of transitivity in the network

The transitivity assumption, which underpins the method of an NMA, requires that the characteristics associated with the effect of the intervention are similar across the included trials.[18] Participant characteristics (eg, age, sex, type of MS, level of disability and years since diagnosis of MS) could indicate violation of the transitivity assumption.[18] To assess this requirement of the transitivity assumption the characteristics of the participants recruited into each trial will be summarised and compared. If this requirement of the transitivity assumption is thought to be violated, we will undertake narrative synthesis of the data (described below) and possibly pair wise meta-analyses (described above). If we find no reason to suggest that violation of the transitivity assumption, we will synthesise the available evidence using NMA techniques. We will fit a random effects NMA model in a frequentist framework and assume a common heterogeneity parameter across the eligible trials. The random effects model assumes that the variation between trials could be a result of heterogeneity and not from sampling variation.[18 36]

Summary statistics and presentation of results

We will present forest plots that will include pooled estimates from the direct and mixed intervention effects and league tables with the summary standardised mean differences or ORs for all pairwise comparisons.[37 38] We will use a predictive interval plot to show the grouped intervention modality standardised mean differences or ORs in a future trial.[37] We will then obtain a hierarchy of the intervention modalities using the surface under the cumulative ranking curve (SUCRA). SUCRA uses probabilities to determine which intervention modality is most likely to be the most effective at reducing depressive symptoms in people with MS. A probability of 1 (or 100%) is indicative of the stated intervention modality being the most effective intervention modality, conversely, a probability of 0 (or 0%) is indicative of the stated intervention modality being the least effective.[38]

Assessment of inconsistency

Consistency is a measure of the agreement between direct evidence and indirect evidence. If inconsistency occurs in a network it may suggest that there is significant heterogeneity and that the transitivity assumption could be violated.[18 34] Using the NMA package in Stata,[36] a consistency and an inconsistency model can be separately fitted to assess whether the direct and indirect evidence are in agreement for each outcome. These models can provide information to help ascertain if the direct and indirect evidence are in statistical agreement.[39] If there is evidence of inconsistency in the network, we will use the side-splitting approach to identify if there is a specific modality of interventions that contribute to inconsistency in the network.[36 39] This will enable us to further investigate the possible sources of inconsistency.[40]

Subgroup analysis

We will conduct separate subgroup analyses for the efficacy and the safety outcome if there is substantial heterogeneity or inconsistency and the data allows this.

For the efficacy outcome, we will assess the following subgroups:

- Year of baseline recruitment; to determine if treatments have become more effective over time.
- Severity of depression at baseline (ie, trials that recruited based on level of depression vs trials that did not); to determine whether interventions are efficacious when a level of depressive symptoms is present.
- Comparison of self-reported outcome measures vs clinical assessment; to determine if there is a difference in the efficacy of the treatment due to the measurement of the outcome.
- Level of disability at enrolment (eg, as measured by Patient Determined Disease Steps, Expanded Disability Disease Scale: categorised in mild, moderate or severe disability); to determine if level of disability is associated with the efficacy of the intervention.
- Whether the intervention was conducted in a dose according to guidelines that exist for that type of interventions (eg, exercise guidelines for people with MS); to determine if a minimum dose is associated with the efficacy of the intervention.

For the safety and tolerability outcome, we will undertake subgroup analyses by year of baseline recruitment and level of disability at enrolment.

Assessment of small study effects

We will use the comparison-adjusted[37] and contour-enhanced[41] funnel plots to investigate whether results in imprecise trials differ from those in more precise trials. NMA models will be used to investigate associations between study sample size and effect size.[42]

Narrative synthesis

If we are unable to conduct an NMA or pairwise meta-analyses, we plan to conduct a narrative synthesis to assess which interventions reported the outcomes of interest and if there were any patterns relating to specific interventions, or gaps in the literature.

ETHICS AND DISSEMINATION

Ethical approval is not needed for a systematic review and NMA as we will use aggregated data from previously published randomised trials. The dissemination of the results of the systematic review and NMA will include publishing in a peer-reviewed journals to apprise MS researchers and clinicians, and people with MS. The results of the systematic review and NMA have the potential to inform future treatment guidelines for depression in people with MS. Further, the review may highlight any gaps in the literature and provide recommendations for the conduct and reporting of future randomised trials.

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Contributors AK and CHM conceived the study. AK, CHM, JL, SC, YCL, AGK and AM contributed to the study design. JL drafted the manuscript and AK, CHM, SC and YCL edited the manuscript. All authors read and approved the final manuscript.

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Competing interests None declared.

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REFERENCES

1 Hunter SF. Overview and diagnosis of multiple sclerosis. *Am J Manag Care* 2016;22:s141–50.
2 Feinstein A, Magalhaes S, Richard J-F, *et al*. The link between multiple sclerosis and depression. *Nat Rev Neurol* 2014;10:507–17.
3 Arnett PA, Barwick FH, Beeney JE. Depression in multiple sclerosis: review and theoretical proposal. *J Int Neuropsychol Soc* 2008;14:691–724.
4 Tarrants M, Oleen-Burkey M, Castelli-Haley J, *et al*. The impact of comorbid depression on adherence to therapy for multiple sclerosis. *Mult Scler Int* 2011;2011:271321
5 Ploughman M, Wallack EM, Chatterjee T, *et al*. Under-treated depression negatively impacts lifestyle behaviors, participation and health-related quality of life among older people with multiple sclerosis. *Mult Scler Relat Disord* 2020;40:101919.
6 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (DSM-5®)*. USA: American Psychiatric Association Publishing, 2019.
7 Boeschoten RE, Braamse AMJ, Beekman ATF, *et al*. Prevalence of depression and anxiety in multiple sclerosis: a systematic review and meta-analysis. *J Neurol Sci* 2017;372:331–41.
8 Grech LB, Haines S, Marck CH. Untreated and under-treated depressive symptoms in people with multiple sclerosis in an Australian context: a secondary analysis. *Collegian* 2020.
9 Feinstein A. Multiple sclerosis and depression. *Mult Scler* 2011;17:1276–81.
10 Goldman Consensus Group. The goldman consensus statement on depression in multiple sclerosis. *Mult Scler* 2005;11:328–37.
11 Toward Optimized Practice (TOP) MS in Depression Working Group. Identification and management of depression in multiple sclerosis: clinical practice guideline; 2015. http://www.topalbertadoctors.org [Accessed 15 May 2020].
12 Kolahkaj B, Zargar F. Effect of mindfulness-based stress reduction on anxiety, depression and stress in women with multiple sclerosis. *Nurs Midwifery Stud* 2015;4:e29655.
13 Fleming KM, Coote SB, Herring MP. The feasibility of pilates to improve symptoms of anxiety, depression, and fatigue among people with multiple sclerosis: an eight-week randomized controlled pilot trial. *Psychol Sport Exerc* 2019;45:9.
14 Minden SL, Feinstein A, Kalb RC, *et al*. Evidence-based guideline: assessment and management of psychiatric disorders in individuals with MS: report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology* 2014;82:174–81.
15 Dalgas U, Stenager E, Sloth M, *et al*. The effect of exercise on depressive symptoms in multiple sclerosis based on a meta-analysis and critical review of the literature. *Eur J Neurol* 2015;22:443–e34.
16 Ensari I, Motl RW, Pilutti LA. Exercise training improves depressive symptoms in people with multiple sclerosis: results of a meta-analysis. *J Psychosom Res* 2014;76:465–71.
17 Simpson R, Simpson S, Ramparsad N, *et al*. Mindfulness-based interventions for mental well-being among people with multiple sclerosis: a systematic review and meta-analysis of randomised controlled trials. *J Neurol Neurosurg Psychiatry* 2019;90:1051–8.

18 Rouse B, Chaimani A, Li T. Network meta-analysis: an introduction for clinicians. *Intern Emerg Med* 2017;12:103–11.
19 Salanti G. Indirect and mixed-treatment comparison, network, or multiple-treatments meta-analysis: many names, many benefits, many concerns for the next generation evidence synthesis tool. *Res Synth Methods* 2012;3:80–97.
20 Higgins JPT, Thomas J, Chandler J, *et al*. *Cochrane Handbook for systematic reviews of interventions version 6.3 (updated February 2022*. Cochrane, 2022. www.training.cochrane.org/handbook
21 Hutton B, Salanti G, Caldwell DM, *et al*. The PRISMA extension statement for reporting of systematic reviews incorporating network meta-analyses of health care interventions: checklist and explanations. *Ann Intern Med* 2015;162:777–84.
22 Gold SM, Enck P, Hasselmann H, *et al*. Control conditions for randomised trials of behavioural interventions in psychiatry: a decision framework. *Lancet Psychiatry* 2017;4:725–32.
23 Patten SB. Current perspectives on co-morbid depression and multiple sclerosis. *Expert Rev Neurother* 2020;20:867–74.
24 Ioannidis JPA, Evans SJW, Gøtzsche PC, *et al*. Better reporting of harms in randomized trials: an extension of the CONSORT statement. *Ann Intern Med* 2004;141:781–8.
25 Edwards IR, Aronson JK. Adverse drug reactions: definitions, diagnosis, and management. *Lancet* 2000;356:1255–9.
26 Duggan C, Parry G, McMurran M, *et al*. The recording of adverse events from psychological treatments in clinical trials: evidence from a review of NIHR-funded trials. *Trials* 2014;15:335.
27 Ory M, Resnick B, Jordan PJ, *et al*. Screening, safety, and adverse events in physical activity interventions: collaborative experiences from the behavior change Consortium. *Ann Behav Med* 2005;29 Suppl:20–8.
28 Cipriani A, Zhou X, Del Giovane C, *et al*. Comparative efficacy and tolerability of antidepressants for major depressive disorder in children and adolescents: a network meta-analysis. *Lancet* 2016;388:881–90.
29 Clarivate Analytics. *The Endnote team*. Philadelphia: PA, 2013.
30 Covidence systematic review software, Veritas Health Innovation, Melbourne, Australia. Available: www.covidence.org
31 Hoffmann TC, Oxman AD, Ioannidis JP, *et al*. Enhancing the usability of systematic reviews by improving the consideration and description of interventions. *BMJ* 2017;358:j2998.
32 Sterne JAC, Savović J, Page MJ, *et al*. Rob 2: a revised tool for assessing risk of bias in randomised trials. *BMJ* 2019;366:l4898.
33 Higgins JP, Li T, Deeks JJ. Chapter 6: Choosing effect measures and computing estimates of effect. In: Higgins JPT, Thomas J, Chandler J, *et al*, eds. *Cochrane Handbook for systematic reviews of interventions version 6.0 Cochrane*, 2019.
34 Chaimani A, Caldwell DM, Li T, *et al*. Additional considerations are required when preparing a protocol for a systematic review with multiple interventions. *J Clin Epidemiol* 2017;83:65–74.
35 Higgins JPT, Thompson SG, Deeks JJ, *et al*. Measuring inconsistency in meta-analyses. *BMJ* 2003;327:557–60.
36 White IR. Network meta-analysis. *Stata J* 2015;15:951–85.
37 Chaimani A, Higgins JPT, Mavridis D, *et al*. Graphical tools for network meta-analysis in STATA. *PLoS One* 2013;8:e76654.
38 Salanti G, Ades AE, Ioannidis JPA. Graphical methods and numerical summaries for presenting results from multiple-treatment meta-analysis: an overview and tutorial. *J Clin Epidemiol* 2011;64:163–71.
39 White IR, Barrett JK, Jackson D, *et al*. Consistency and inconsistency in network meta-analysis: model estimation using multivariate meta-regression. *Res Synth Methods* 2012;3:111–25.
40 Dias S, Welton NJ, Caldwell DM, *et al*. Checking consistency in mixed treatment comparison meta-analysis. *Stat Med* 2010;29:932–44.
41 Peters JL, Sutton AJ, Jones DR, *et al*. Contour-enhanced meta-analysis funnel plots help distinguish publication bias from other causes of asymmetry. *J Clin Epidemiol* 2008;61:991–6.
42 Chaimani A, Salanti G. Using network meta-analysis to evaluate the existence of small-study effects in a network of interventions. *Res Synth Methods* 2012;3:161–76.