Short-term Outcomes of Infants Enrolled in Randomized Clinical Trials vs Those Eligible but Not Enrolled

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Letters

RESEARCH LETTER

Short-term Outcomes of Infants Enrolled in Randomized Clinical Trials vs Those Eligible but Not Enrolled

It is unknown whether participation in a neonatal randomized clinical trial (RCT) is independently associated with differences in outcomes. Our objective was to compare in-hospital outcomes between extremely premature infants enrolled in RCTs and those who were eligible but not enrolled in RCTs conducted by the National Institute of Child Health and Human Development Neonatal Research Network (NRN).

Methods | A retrospective analysis of infants at NRN sites between January 1, 1999, and December 31, 2012, was performed. Included infants were eligible for NRN RCTs and had outcomes recorded in the NRN very-low-birth-weight registry (Generic Database [GDB]). We excluded cluster randomized trials, trials of investigational therapies (to ensure that enrolled and nonenrolled infants were likely to be treated similarly), and infants eligible for the Surfactant Positive Airway Pressure and Pulse Oximetry Randomized Trial (a similar analysis was previously published).1

We identified all eligible infants using trial screening logs. The exposure was enrollment in at least 1 RCT. Nonexposed infants were eligible for at least 1 RCT but not enrolled in any trial. The primary outcome was a composite of (1) death; (2) bronchopulmonary dysplasia (supplemental oxygen at 36 weeks postmenstrual age); (3) severe brain injury (intraventricular hemorrhage with ventricular enlargement, intraparenchymal hemorrhage, or cystic periventricular leukomalacia); or (4) severe retinopathy of prematurity (≥stage 3 or treatment in either eye).

Secondary outcomes included individual components of the primary outcome, culture-proven late-onset sepsis, and necrotizing enterocolitis (≥stage 2). Outcomes were assessed at 120 days of life, hospital discharge or transfer, or death (whichever came first).

Using SAS version 9.3 (SAS Institute Inc), we explored the association between trial enrollment and outcomes using logistic regression with and without control for prespecified baseline covariates. All tests were 2-sided with P < .05 indicating statistical significance. Local institutional review boards approved all RCTs and the GDB. Written informed consent was obtained for enrollment in all RCTs. Informed or waiver of consent was obtained for the GDB, as determined by local review boards.

Table 1. Maternal and Infant Characteristics of Enrolled Infants in Randomized Controlled Trials and Those Eligible But Not Enrolled

<table>
<thead>
<tr>
<th>Maternal and Infant Characteristics</th>
<th>Enrolled (n = 3795)</th>
<th>Not Enrolled (n = 1594)*</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, mean (SD), y</td>
<td>26.7 (6.7)</td>
<td>27.0 (6.6)</td>
<td>.09</td>
</tr>
<tr>
<td>Married</td>
<td>3773</td>
<td>1677 (44)</td>
<td>1569</td>
</tr>
<tr>
<td>≥1 Prenatal visit</td>
<td>3793</td>
<td>3542 (93)</td>
<td>1587</td>
</tr>
<tr>
<td>Racec</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>3792</td>
<td>2053 (54)</td>
<td>1590</td>
</tr>
<tr>
<td>Black</td>
<td>3792</td>
<td>1624 (43)</td>
<td>1590</td>
</tr>
<tr>
<td>Other</td>
<td>3792</td>
<td>115 (3)</td>
<td>1590</td>
</tr>
<tr>
<td>Hispanicc</td>
<td>3691</td>
<td>652 (18)</td>
<td>1501</td>
</tr>
<tr>
<td>Antenatal steroids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any</td>
<td>3785</td>
<td>3014 (80)</td>
<td>1585</td>
</tr>
<tr>
<td>Complete course</td>
<td>3772</td>
<td>1604 (43)</td>
<td>1584</td>
</tr>
<tr>
<td>Infant Characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthweight, mean (SD), g</td>
<td>775 (145.9)</td>
<td>775 (151.5)</td>
<td>.96</td>
</tr>
<tr>
<td>Gestational age, mean (SD), wk</td>
<td>25.9 (1.9)</td>
<td>25.9 (2.0)</td>
<td>.80</td>
</tr>
<tr>
<td>Male sex</td>
<td>3795</td>
<td>1908 (50)</td>
<td>1594</td>
</tr>
<tr>
<td>Multiple gestation</td>
<td>3795</td>
<td>886 (23)</td>
<td>1594</td>
</tr>
<tr>
<td>Small for gestational age</td>
<td>3795</td>
<td>547 (14)</td>
<td>1593</td>
</tr>
<tr>
<td>Appar score &lt;4 at 5 min</td>
<td>3534</td>
<td>348 (10)</td>
<td>1483</td>
</tr>
<tr>
<td>Cardiopulmonary resuscitation at birth</td>
<td>3792</td>
<td>327 (9)</td>
<td>1589</td>
</tr>
<tr>
<td>Outborn</td>
<td>3795</td>
<td>339 (9)</td>
<td>1594</td>
</tr>
</tbody>
</table>

a Infants were eligible but not enrolled because parent refused consent (967), consent not requested (597), and consent obtained but infant not randomized (30).b Data are expressed as No. (%) unless otherwise indicated.c As documented in the maternal medical record based on maternal interview. These characteristics were included because they may influence consent rates for randomized controlled trials.
Results | Six RCTs met the inclusion criteria. These investigated phototherapy, glutamine, nitric oxide, and umbilical cord clamping, delivery room continuous positive airway pressure, and vitamin E. Of 5389 eligible infants, 3795 were enrolled in at least one RCT and 1594 were not enrolled in any RCT. Enrolled infants were more likely to be white and Hispanic and less likely to be born out of state or to receive cardiopulmonary resuscitation at birth, outborn status, and birth center. The primary outcome did not differ significantly between groups (68% in enrolled group vs 69% in eligible but not enrolled group; adjusted odds ratio, 1.08 [95% CI, 0.93-1.26]; P = .29). There were no differences in the secondary outcomes in the adjusted analysis (Table 2). Furthermore, the primary outcome did not differ between groups when analyzed by individual trial.

Discussion | Only a few studies with divergent findings have examined whether trial participation is associated with differences in outcomes in preterm newborns. The present study did not find differences in mortality or neonatal morbidity between trial participants and nonparticipants. Similarly, meta-analyses of studies of adults and older children have demonstrated no significant differences in outcomes between trial participants and nonparticipants who were treated similarly outside trials.

Extremely preterm infants who were eligible for RCTs were simultaneously enrolled in the GDB, providing a unique opportunity to assess the association between trial participation and outcomes. We included all trial participants in the enrolled group rather than just control infants because some RCTs were comparative effectiveness trials without a control group. We did not directly compare outcomes of infants who received a specific intervention inside and outside of RCTs because exposures to some interventions, such as nitric oxide, were not consistently recorded in the GDB. One limitation is that maternal education and insurance status were not recorded consistently.

In a cohort of more than 5000 extremely preterm infants, important in-hospital outcomes were neither better nor worse in infants enrolled in RCTs compared with eligible but nonenrolled infants. These findings may reassure those who have concerns about performing RCTs in this vulnerable population.

| Abbreviations: CPAP, continuous positive airway pressure; OR, odds ratio. |
|---|---|
| a Indicates those who were eligible but not enrolled. See footnote "a" in Table 1 for reasons. |
| b Adjusted in logistic regression for gestational age, antenatal steroids, race, sex, multiple gestation, small for gestational age, cardiopulmonary resuscitation at birth, outborn status, and treatment center. |

Table 2. Primary and Secondary Outcomes by Enrollment Status and Primary Outcome by Individual Trial

| Primary Outcome by Individual Trial<sup>b</sup> |
|---|---|---|---|---|---|---|
| Infants Enrolled | Infants Not Enrolled<sup>a</sup> | Unadjusted OR (95% CI) | P Value | Adjusted OR (95% CI)<sup>b</sup> | P Value<sup>b</sup> |
| Mortality | 3793 | 823 (22) | 1594 | 361 (23) | 0.95 (0.82-1.09) | .44 | 1.01 (0.86-1.19) | .88 |
| Bronchopulmonary dysplasia | 3087 | 1522 (49) | 1284 | 646 (50) | 0.96 (0.84-1.09) | .54 | 1.08 (0.93-1.25) | .32 |
| Severe brain injury | 3670 | 719 (20) | 1505 | 279 (19) | 1.07 (0.92-1.25) | .38 | 1.10 (0.93-1.30) | .27 |
| Severe retinopathy of prematurity | 3030 | 675 (22) | 1256 | 290 (23) | 0.95 (0.82-1.12) | .56 | 0.99 (0.83-1.18) | .88 |
| Late-onset sepsis | 3641 | 1466 (40) | 1520 | 566 (37) | 1.14 (1.00-1.29) | .04 | 1.09 (0.95-1.24) | .22 |
| Necrotizing enterocolitis | 3778 | 394 (10) | 1577 | 175 (11) | 0.93 (0.77-1.13) | .47 | 0.94 (0.77-1.14) | .53 |

* Composites of 1 or more of the following: death; bronchopulmonary dysplasia; severe brain injury; or retinopathy of prematurity at 120 days of life, discharge, transfer, or death.

<sup>b</sup> Unadjusted P value calculated using the Fisher exact test and exact 95% CIs calculated for the ORs are presented to account for small sample sizes in some studies.
presurgery sedation and patient experience

to the editor

In a randomized clinical trial by dr maurice-
szumburski and colleagues,1 premedication with oral loraze-
pam 2 hours prior to arriving in the operating room did not im-
prove patient satisfaction after surgery and was associated with
prolonged time to extubation and decreased cognitive recov-
ery compared with placebo or no medication. these results may
not indicate that all sedative premedication is unwarranted but
may suggest lorazepam is inadequate.

maurice-szumburski and colleagues explained why loraze-
pam was used instead of midazolam for their trial: “the choice
of lorazepam was motivated by its use in the largest survey of
sedative premedication published to date,” referring to a study
by kain et al.2 there is some discrepancy between this statement
and the survey results, in which among adults, the most com-
monly used sedative premedication was midazolam (>75%),
followed by diazepam (7%), and lorazepam (2%).2 seven years later,
a follow-up survey study by kain et al3 found that adult inpatients
received midazolam most often (80%), followed by diazepam
(3%), fentanyl (2%), and lorazepam (4%).

lorazepam may have disadvantages compared with mid-
azolam. midazolam is a short-acting benzodiazepine with an
elimination half-life of 2.0 hours to 2.5 hours, whereas loraze-
pam has a half-life of 10 hours to 20 hours. in a randomized
clinical trial that compared midazolam with lorazepam for post-
operative sedation, delays in emergence from sedation were
observed in the lorazepam group.4

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reported.

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to the editor

The key purpose of patient premedication with
benzodiazepines is preoperative anxiolysis,1 which allows for
safer monitoring and induction of anesthesia. in contrast, the
primary outcome parameter of the study by dr maurice-
szumburski and colleagues1 was the patient’s perception quan-
tified with a patient satisfaction index (évaluation du vécu de
l’anesthésie générale; evan-g)3 on the first postoperative day.
From a clinical viewpoint, a patient’s perception on the first
postoperative day is not the key parameter to judge the value
of premedication.

the more important outcomes were the secondary outcomes
measuring preoperative and intraoperative conditions. Anxiety
upon arrival in the operating room was significantly lower (visual
analog scale scores for anxiety: 35 points for lorazepam group vs

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letters

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