Antibiotic prophylaxis to reduce respiratory tract infections and mortality in adults receiving intensive care (Review)

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Antibiotic prophylaxis to reduce respiratory tract infections and mortality in adults receiving intensive care

Roberto D'Amico, Silvia Pifferi, Valter Torri, Luca Brazzi, Elena Parmelli, Alessandro Liberati

Background
Pneumonia is an important cause of mortality in intensive care units (ICUs). The incidence of pneumonia in ICU patients ranges between 7% and 40%, and the crude mortality from ventilator-associated pneumonia may exceed 50%. Although not all deaths in patients with this form of pneumonia are directly attributable to pneumonia, it has been shown to contribute to mortality in ICUs independently of other factors that are also strongly associated with such deaths.

Objectives
To assess the effects of prophylactic antibiotic regimens, such as selective decontamination of the digestive tract (SDD) for the prevention of respiratory tract infections (RTIs) and overall mortality in adults receiving intensive care.

Search methods
We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2009, issue 1), which contains the Cochrane Acute Respiratory Infections (ARI) Group's Specialised Register; MEDLINE (January 1966 to March 2009); and EMBASE (January 1990 to March 2009).

Selection criteria
Randomised controlled trials (RCTs) of antibiotic prophylaxis for RTIs and deaths among adult ICU patients.

Data collection and analysis
At least two review authors independently extracted data and assessed trial quality.
Main results

We included 36 trials involving 6914 people. There was variation in the antibiotics used, patient characteristics and risk of RTIs and mortality in the control groups. In trials comparing a combination of topical and systemic antibiotics, there was a significant reduction in both RTIs (number of studies = 16, odds ratio (OR) 0.28, 95% confidence interval (CI) 0.20 to 0.38) and total mortality (number of studies = 17, OR 0.75, 95% CI 0.65 to 0.87) in the treated group. In trials comparing topical antimicrobials alone (or comparing topical plus systemic versus systemic alone) there was a significant reduction in RTIs (number of studies = 17, OR 0.44, 95% CI 0.31 to 0.63) but not in total mortality (number of studies = 19, OR 0.97, 95% CI 0.82 to 1.16) in the treated group.

Authors' conclusions

A combination of topical and systemic prophylactic antibiotics reduces RTIs and overall mortality in adult patients receiving intensive care. Treatment based on the use of topical prophylaxis alone reduces respiratory infections but not mortality. The risk of resistance occurring as a negative consequence of antibiotic use was appropriately explored only in one trial which did not show any such effect.

Plain Language Summary

Antibiotics to help reduce mortality and respiratory infections in people receiving intensive care in hospital

Infections acquired in intensive care units (ICUs) are important complications of the treatment of patients with very severe diseases who need ventilation (mechanical breathing support). Some people will die because of these infections. Considerable efforts have been made to evaluate methods for reducing this problem; one of these involves the use of antibiotics administered as preventative intervention, usually referred to as selective decontamination of the digestive tract (SDD). This review includes 36 studies involving 6914 patients treated in ICUs to investigate whether the administration of antibiotics prevents the development of infections. Antibiotics were administered in two different ways. In some studies antibiotics were applied both directly to the oropharynx via a nasogastric tube (topical) and intravenously (systemic). In other studies they were applied only topically. Our results show that when patients received the combination of topical plus systemic antibiotics there were less infections and deaths. When patients received only topical treatment there were less infections but the number of deaths was not changed. Although this treatment seems to work it is not widely used in clinical practice because there is concern about the possible development of antibiotic resistance (that is, bacteria become unresponsive to drugs).
BACKGROUND

Description of the condition

Infections acquired in the intensive care unit (ICU), especially pneumonia, are important complications of the treatment of critically ill patients, increasing morbidity and mortality. The incidence of pneumonia has been reported to vary from 7% to more than 40% in ICU patients (Chevret 1996; Fagon 1996). The mortality rate for patients with ventilator-associated pneumonia (VAP) may exceed 50%. Although not all deaths in patients with pneumonia are directly attributable to pneumonia, it has been shown to contribute to ICU mortality, independently of other factors that are also strongly associated with deaths in these patients (Fagon 1996). In a case-controlled study an increase in mortality of 27% attributable to pneumonia was evidenced in ventilated patients (Fagon 1996).

Description of the intervention

Considerable efforts have been made to evaluate methods for reducing respiratory tract infections (RTIs). One strategy involves the use of selective decontamination of the digestive tract (SDD). Different SDD protocols have been used in different trials and investigators often disagree on which is the most appropriate definition of SDD. Traditionally, SDD indicates a method designed to prevent infection by eradicating and preventing carriage of aerobic, potentially pathogenic micro-organisms from the oropharynx, stomach and gut. It consists of antimicrobials applied topically to the oropharynx through a nasogastric tube. In some trials systemic antibiotic therapy has been added in the first days after the patients’ admission to prevent ‘early’ infections.

How the intervention might work

The use of oral non-absorbable antibiotics was first reported by Stoutenbeek (Stoutenbeek 1994) in an SDD protocol based upon a group of multiple trauma patients. The incidence of nosocomial (hospital-acquired) infection was reduced from 81% to 16% in a non-randomised comparison with an historical control group. Further studies tested the efficacy of SDD in ICU patients, with infection-related morbidity as the main endpoint. The results showed that SDD reduced infection but it was not clear whether there was a reduction in mortality.


<table>
<thead>
<tr>
<th>SR</th>
<th>N° of studies</th>
<th>N° of patients</th>
<th>Mortality</th>
<th>RTIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vanderbrouk-Gra 1991</td>
<td>6</td>
<td>491</td>
<td>Odds ratio (OR) 0.70 95% CI 0.45 to 1.09</td>
<td>OR 0.12 95% CI 0.08 to 0.19</td>
</tr>
<tr>
<td>SDD Group 1993</td>
<td>22</td>
<td>4142</td>
<td>OR 0.90 95% CI 0.79 to 1.04</td>
<td>OR 0.37 95% CI 0.31 to 0.43</td>
</tr>
<tr>
<td>Heyland 1994</td>
<td>24</td>
<td>3312</td>
<td>Risk ratio (RR) 0.87 95% CI 0.79 to 0.97</td>
<td>RR 0.46 95% CI 0.39 to 0.56</td>
</tr>
<tr>
<td>Kollef 1994</td>
<td>16</td>
<td>2270</td>
<td>Risk difference (RD) 0.019 95% CI -0.016 to 0.054</td>
<td>Pneumonia RD 0.145 95% CI 0.116 to 0.174</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tracheobronchitis RD 0.052 95% CI 0.017 to 0.087</td>
</tr>
<tr>
<td>Hurley 1995</td>
<td>26</td>
<td>3768</td>
<td>OR 0.86 95% CI 0.74 to 0.99</td>
<td>OR 0.35 95% CI 0.30 to 0.42</td>
</tr>
<tr>
<td>D’Amico 1998</td>
<td>33</td>
<td>5727</td>
<td><strong>Topical plus systemic</strong> (16 trials; 3361 pts) OR 0.80 95% CI 0.69 to 0.93</td>
<td><strong>Topical plus systemic</strong> (16 trials; 3361 pts) OR 0.35 95% CI 0.29 to 0.41</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Topical alone</strong> (17 trials; 2366 pts) OR 1.01 95% CI 0.84 to 1.22</td>
<td><strong>Topical alone</strong> (17 trials; 2366 pts) OR 0.56 95% CI 0.46 to 0.68</td>
</tr>
</tbody>
</table>
All studies assessing RTIs confirmed their statistically significant reduction, though the magnitude of the treatment effect varied from one review to another probably due to different numbers of studies and inclusion criteria among them. The estimated impact on overall mortality was less evident.

This is an update to the previous version published in The Cochrane Library which included trials published up to 2003.

OBJECTIVES

To determine whether antibiotic prophylaxis reduces RTIs and overall mortality in adult patients treated in ICUs.

Specifically, the main question left unanswered by existing randomised controlled trials (RCTs) and previous meta-analyses was whether different forms of antibiotic prophylaxis (that is, topical antimicrobials or a combination of topical and systemic drugs) are effective in reducing overall mortality.

METHODS

Criteria for considering studies for this review

Types of studies

RCTs on antibiotic prophylaxis for preventing RTIs and deaths in adult ICU patients.

Types of participants

Adult patients admitted to an ICU. Studies based on specific pre-selected types of patients (that is, patients undergoing elective oesophageal resection, cardiac or gastric surgery, liver transplant or suffering from acute liver failure) were excluded because these patients need co-interventions that may interact with the main treatment. Studies where the majority of patients (> 50%) did not undergo mechanical ventilation for more than 48 hours were also excluded. The characteristics of excluded studies are reported in the 'Characteristics of excluded studies' table.

Types of interventions

Available RCTs have been grouped into two categories, defined according to the type of antibiotic prophylaxis:

1. studies where a combination of systemic and topical antibiotics was tested against no prophylactic treatment (hereafter referred to as 'topical plus systemic versus no prophylaxis'); and
2. studies where the experimental treatment tested was a topical preparation applied in the oropharynx (hereafter referred to as 'topical versus control').

For further details about preparation and administration of antibiotic prophylaxis see the 'Characteristics of included studies' table.

In this latter category two RCT subgroups have been lumped together, that is, those where topical antibiotics were tested against an untreated control group and those where the combination of topical plus systemic drugs was compared with a protocol based on a systemic antimicrobial only.

Any topical or systemic antimicrobial combination (that is: type of drugs) was accepted, because there was no data to assume a difference in effect among the considered prophylactic treatments. This obviously does not mean that all topical and systemic regimens are truly equivalent, but simply reflects our pragmatic working assumption.

Types of outcome measures

Primary outcomes

Primary outcome measures considered for this review were RTIs and overall mortality.

No restriction was made on the type of RTIs considered, or on the RTIs diagnostic criteria chosen by the trialists. Both tracheobronchitis and pneumonia were acceptable. Pragmatically, both primary (diagnosed within 48 hours from admission) and acquired (diagnosed after 48 hours from admission) infections were considered, even though we used data on acquired infections (the most appropriate outcome to assess treatment effect) when both pieces of information were available. Mortality was evaluated at hospital discharge if this information was provided; otherwise mortality in ICU was used.
Search methods for identification of studies

Electronic searches

We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2009, issue 1); MEDLINE (January 1966 to March 2009); and EMBASE (January 1990 to March 2009).

MEDLINE was searched using the following search strategy in conjunction with the Cochrane Highly Sensitive Search Strategy for identifying randomised trials in MEDLINE: sensitivity- and precision-maximising version (2008 revision); Ovid format (Lefebvre 2008). The same strategy was used to search CENTRAL and adapted to search EMBASE.com (see Appendix 1).

MEDLINE (Ovid)

1 exp Respiratory Tract Infections/
2 respiratory tract infection*.tw.
3 exp Pneumonia/
4 pneumon*.tw.
5 (HAP or VAP).tw.
6 bronchopneumonia*.tw.
7 pleuropneumonia*.tw.
8 exp Bronchitis/
9 bronchit*.tw.
10 bronchiolit*.tw.
11 exp Pharyngitis/
12 pharyngit*.tw.
13 Tracheitis/
14 tracheit*.tw.
15 or/1-14
16 exp Intensive Care Units/
17 icu.tw.
18 exp Critical Care/
19 critical care.tw.
20 intensive care.tw.
21 burn unit*.tw.
22 care unit*.tw.
23 recovery room*.tw.
24 Critical Illness/
25 [critic* adj ill*].tw.
26 exp Ventilators, Mechanical/
27 mechanical ventilat*.tw.
28 ventilator*.tw.
29 Respiration, Artificial/
30 artificial respiration*.tw.
31 respirator*.tw.
32 or/16-31
33 15 and 32
34 Pneumonia, Ventilator-Associated/
35 33 or 34
36 Antibiotic Prophylaxis/
37 exp Anti-Bacterial Agents/
38 antibiotic*.tw.
39 or/36-38
40 35 and 39

Searching other resources

There were no language or publication restrictions. We searched reference lists of articles from January 1984 to March week 1 2009 and proceedings of scientific meetings from January 1984 to April 2002. We also contacted investigators in the field. We evaluated other studies listed in previous meta-analyses. We did not make any formal enquiries through pharmaceutical companies. We stopped the search for conference proceedings after the early phase of this review in 2002 when we decided that in subsequent updates we will include new data only if reported in fully published papers.

Data collection and analysis

Selection of studies

Three review authors (LB, EP, SP) independently screened the titles and abstracts of all the references retrieved by the search strategy. The full text of relevant studies were assessed independently to determine whether they met the inclusion criteria. Disagreements were resolved by discussion with the two review authors (AL, RD).

Data extraction and management

Three review authors (LB, EP, SP) independently extracted data from all the included studies using an ad hoc extraction form. Disagreements were solved by discussion with both review authors (AL, RD).

Assessment of risk of bias in included studies

At least two review authors (LB, EP, SP) independently assessed the methodological validity of selected trials according to two quality criteria:

- quality of randomisation procedures (‘adequate’ versus ‘unclear, inadequate or not done’ which will be referred hereafter as ‘not adequate’); and
- blinding of patients and doctors to allocated treatment (‘double-blind’ versus ‘open’).

We resolved outstanding issues by consensus.

Only RCTs were accepted in order to prevent possible selection bias. Studies including adult patients admitted to an ICU were included. Studies based on specific pre-selected types of patients (that is, patients undergoing elective oesophageal resection, cardiac or gastric surgery, liver transplant or suffering from acute liver failure) were excluded.

Measures of treatment effect

Crude proportions of RTIs and mortality were our main treatment end-points. Odds ratios (OR) for each trial and for each outcome were calculated and they were summarised by using the fixed-effect model, whereas the random-effects model was used in cases of statistically significant heterogeneity (P = 0.1). We also computed the number of ICU patients who need to be treated in order to prevent one infection and one death. The calculation was based on the median rates of RTIs and deaths in untreated controls and the common OR for all trials.

Dealing with missing data

We contacted study investigators in order to obtain data for intention-to-treat analysis. In 25 out of 36 studies we obtained data on patients lost to follow-up while for the remaining 11 studies we relied on published information only.

Data synthesis

Results from the trials were combined using a fixed-effect model to calculate odds ratio (OR) with 95% confidence intervals (CI) for
dichotomous data. In case of statistically significant heterogeneity a random-effects model was used.

The number needed to treat to benefit (NNTB) was calculated.

**Subgroup analysis and investigation of heterogeneity**

Two pre-specified subgroup analyses based on quality criteria were carried out within the two main groups of RCTs specified above:

- quality of randomisation procedures; and
- blinding of patients and doctors to allocated treatment.

**RESULTS**

**Description of studies**

**Results of the search**

Sixty potentially eligible RCTs were identified from the electronic searches.

**Included studies**

Thirty-six RCTs were finally included, all of them were published (34 as full reports and two in abstract form). Seventeen RCTs compared topical and systematic antibiotic treatment versus no treatment or placebo; 14 RCTs compared topical treatment to no treatment or placebo; and five trials compared topical and systemic antibiotic treatment versus systemic antibiotic only.

We included two studies (Gaussorgues 1991; Laggner 1994) among the 'topical SDD plus systemic antibiotic versus systemic antibiotic only' group even if their design did not explicitly foresee the use of systemic antibiotics because all patients in both arms were treated with systemic antibiotics on admission. Similarly, we included the Jacobs (Jacobs 1992) study among the 'topical SDD plus systemic antibiotics versus control' group because more than 90% of patients received a systemic antibiotic on admission.

The four studies with a three-arm comparison were analysed as follows. In two studies (Aerdts 1991; Verwaest 1997) the two control groups were pooled together and compared to the treatment group. In another study (Lingnau 1997) we split the study into two comparisons in which two different treatment arms were compared to the same control arm. In one study (Palomar 1997) one of the two control arms was excluded because patients received only sucralfate. Another study (Camus 2005) was a four-arm factorial design in which we considered only two arms comparing antibiotic prophylaxis versus placebo.

Overall, the total number of patients randomised to either antibiotic prophylaxis versus placebo or no treatment was 6914. The final meta-analysis was based upon 36 trials with 37 comparisons.

Two studies (Cerra 1992; Gaussorgues 1991) could not contribute to the RTIs analysis as they reported the number of episodes of RTIs and not the number of infected patients. Moreover, one trial (de Jonge 2003) did not assess RTIs as an endpoint.

Mortality was evaluated in ICU in 24 trials; hospital mortality was available only for six RCTs; two trials reported mortality in both ICU and hospital (de Jonge 2003; Georges 1994) and the exact time of assessment of mortality was not determined in four trials (Cerra 1992; Jacobs 1992; Kerver 1988; Pneumakos 2002).

Most RCTs included general ICU patients. A few trials included mostly trauma (Boland 1991; Georges 1994; Lingnau 1997; Pneumakos 2002; Quinio 1995; Stoutenbeek 1996; Stoutenbeek 2007) or surgical patients (Cerra 1992; Krueger 2002).

One-hundred percent of patients were mechanically ventilated in 26 studies; this percentage was lower in six trials (Brun-Buisson 1988; Blair 1991; Cockrell 1992; de Jonge 2003; Ulrich 1989; Winter 1992) and unknown in four (Camus 2005; Cerra 1992; Finch 1991; Krueger 2002). In Brun-Buisson’s study (Brun-Buisson 1989) the percentage of ventilated patients was very low (59%) probably because the setting of the study included both ‘acute’ and ‘intermediate’ areas of a medical ICU.

The percentage of immunocompromised patients was usually lower than 10%; it was higher only in four trials (Brun-Buisson 1989; Finch 1991; Gastinne 1992; Laggner 1994). Sucralfate was routinely used in all patients for stress ulcer prophylaxis in nine trials (Abele-Horn 1997; Bergmans 2001; Ferrer 1994; Gaussorgues 1991; Jacobs 1992; Krueger 2002; Laggner 1994; Quinio 1995; Verwaest 1997). In many RCTs only RTIs acquired in ICU (that is, diagnosed after 48 hours from admission) were considered. Data on primary and acquired infections were considered together only in three trials (Boland 1991; Stoutenbeek 1996; Stoutenbeek 2007). Most studies (26 RCTs) evaluated only the occurrence of pneumonia, while seven RCTs also evaluated tracheobronchitis; information was lacking in three RCTs. Diagnostic criteria differed across trials. Few trial authors provided quantitative details on the cut-off point used as positive bacteriological confirmation.

**Excluded studies**


**Risk of bias in included studies**

Study quality was assessed looking at two criteria. These two quality criteria were used to perform one-way subgroup analyses for two treatment comparisons (topical plus systemic versus no treatment and topical alone versus no treatment) on the two main outcomes (RTIs and overall mortality).

**Allocation**

A = adequate; B = unclear; C = inadequate; D = not used. Allocation concealment was evaluated according to the criteria in the Cochrane Handbook for Systematic Reviews of Interventions (Higgins 2008).

**Blinding**

Double-blind, open.
Effects of interventions

RTIs

Results from 33 RCTs including 5697 patients were available for the analysis on the effects of different types of antibiotic prophylaxis on RTIs. The frequency of RTIs was 19% among treated patients and 40% among controls in RCTs using a combination of topical plus systemic antibiotic and 20% and 31%, respectively, in RCTs testing the effectiveness of topical prophylaxis. Overall, the ORs were less than 1 in all but two trials (Lingnau 1997; Wiener 1995) and reached conventional statistical significance (P < 0.05) in 22/34 comparisons.

Since statistically significant heterogeneity was observed, a random-effects model was used to summarise study results. Results indicate a strong protective effect in RCTs where the combination of topical and systemic treatment (OR 0.28, 95% CI 0.20 to 0.38) was tested. A significant protection emerged when topical prophylaxis was considered (OR 0.44, 95% CI 0.31 to 0.63). The effect was stronger in RCTs where topical antimicrobials were tested against no prophylaxis (OR 0.34, 95% CI 0.21 to 0.55). Less extreme results were observed in trials testing the combination of topical and systemic antibiotic against systemic prophylaxis (OR 0.79, 95% CI 0.56 to 1.13).

These results indicate that four (95% CI 3 to 5) or seven (95% CI 6 to 12) patients need to be treated to prevent at least one infection, depending on whether a combination of topical and systemic treatment or topical antimicrobials alone were tested (assuming, as baseline risk, the median values of 46% and 27%, respectively, among control patients).

Regarding the pre-defined subgroup analyses, a statistically significant difference in the estimates of treatment effect was only found for quality of allocation concealment in the topical versus control comparison.

Mortality

Overall, 36 RCTs including 6,914 patients were available for the mortality analysis. The mortality was 24% among treated patients and 30% among controls on RCTs using a combination of topical plus systemic antibiotic; while it was 26% and 25% respectively in RCTs testing the effectiveness of topical SDD. The ORs were less than 1 in 26/38 comparisons but reached conventional statistical significance in three RCTs (de Jonge 2003; Krueger 2002; Stoutenbeek 1996); no trial showed a significant harmful effect of antibiotic prophylaxis.

Regarding mortality no statistically significant heterogeneity was observed among study results.

Results indicated a statistically significant reduction in mortality attributable to the use of a combination of topical and systemic treatment (OR 0.75, 95% CI 0.65 to 0.87). This suggests that 18 patients (95% CI 12 to 36) (assuming a baseline risk of 29%, median among control patients) need to be treated to prevent one death. On the other hand, no treatment effect emerged when RCTs testing topical antimicrobials were analysed (OR 0.97; 95% CI 0.82 to 1.16).

The subgroup analyses produced the following results:

Topical versus control

Allocation concealment: adequate (OR 0.64, 95% CI 0.27 to 1.52), not adequate (OR 0.99, 95% CI 0.83 to 1.18).

Blind design: double blind (OR 0.99, 95% CI 0.83 to 1.20), open (OR 0.88, 95% CI 0.56 to 1.37).

Topical plus systemic versus no prophylaxis

Allocation concealment: adequate (OR 0.77, 95% CI 0.66 to 0.90), not adequate (OR 0.67, 95% CI 0.48 to 0.93).

Blind design: double blind (OR 0.63, 95% CI 0.48 to 0.83), open (OR 0.80, 95% CI 0.68 to 0.95).

DISCUSSION

Since antibiotic prophylaxis based on SDD was introduced as a preventative measure against infection in critically ill patients, it has remained a controversial intervention (Stoutenbeek 1994). Due to the lack of a standard protocol and insufficient patient numbers, it has proved difficult to derive meaningful conclusions from individual clinical trials. Following initial enthusiasm from results of early uncontrolled studies and RCTs, antibiotic prophylaxis is not widely used as a routine treatment in ICUs. Concerns about the risk of antimicrobial resistance and increased costs are often quoted as important factors preventing its widespread adoption. A conservative attitude in introducing a new treatment into practice is understandable as long as doubts about its efficacy exist. Studies on prevention of VAP in ICU patients are complex, as patients are heterogeneous, diagnosis of pneumonia is controversial and outcomes depend upon a variety of factors. Despite the fact that antibiotic prophylaxis reduces the emergence of RTIs with remarkable consistency across individual trials, the effect on mortality was individually statistically significant in only three trials. An historical examination of review articles and editorials in this area indicates that for many years it was not fully realised that this could have been due to the small sample sizes of individual studies.

The meta-analysis reported here combines data across several studies in order to estimate treatment effects with more precision than is possible in a single study. The main limitation of this type of pooled analysis is that the patient population, the antibiotic regimen and the outcome definitions are not the same across studies. Nonetheless, we believe that it provides the best global picture of the effectiveness of the intervention despite some recent criticisms on the quality of primary studies and their combination (van Nieuwenhove 2001) which we feel we have convincingly addressed (Liberati 2001). Compared to the other six published meta-analyses (Heyland 1994; Hurley 1995; Kollef 1994; Nathens 1999; SDD Group 1993; Vanderbrouck-Gra 1991) we decided in our previously published review (D’Amico 1998) to analyse separately trials testing a combination of systemic and topical antibiotics and those testing topical antimicrobials. Though there is no consensus on the best way to classify antibiotic prophylaxis regimens, eventually it seemed more appropriate to consider the two groups of trials as two distinct approaches to antibiotic prophylaxis. This decision was made a priori, independently of knowing their results.

As already shown in our previous review (D’Amico 1998) and confirmed in this update, both types of prophylaxis have a strong protective effect on RTIs - with the effect being more marked when patients are treated with a protocol using topical plus systemic antibiotics. This effect looks consistent in all subgroup
analyses, regardless of study design (adequate / not adequate allocation concealment, double-blind / open design). Overall, these results appear convincing even though it is acknowledged that no diagnostic test or procedure is ideal to diagnose RTIs in ICU patients.

More importantly, this updated review confirms that the use of a combination of topical and systemic antibiotics reduces overall mortality significantly. This treatment effect looks important from a clinical and public health point of view (in terms of the therapeutic implications for the care of ventilated patients in ICUs) and is also relevant from the scientific standpoint, as it suggests the future directions that research in this field should take.

**Figure 1.**

**Authors’ Conclusions**

**Implications for practice**

This systematic review indicates that a protocol testing a combination of topical and systemic antibiotics reduces the occurrence of RTIs and overall mortality. These results were initially obtained in an individual patient meta-analysis reported elsewhere (D’Amico 1998), which we have now updated using data reported in trials published between 1999 and 2007. The yield of the treatment expressed in terms of patients needed to be treated to prevent one infection and one death is substantial - 4 and 18 respectively - and compares very favourably with several interventions largely used in clinical practice. Though 11/17 trials used an identical regimen, including polymyxin, tobramycin and amphotericin as the topical combination and cefotaxime as the systemic component (Abele-Horn 1997; Blair 1991; de Jonge 2003; Ferrer 1994; Hammond 1992; Jacobs 1992; Kerver 1988; Palomar 1997; Rocha 1992; Stoutenbeek 1996; Stoutenbeek 2007), this review does not allow a unique regimen to be recommended. The use of a prophylaxis testing topical antimicrobials is, on the other hand, not warranted by available data.

Results of this review should be carefully considered by those who have been sceptical about the effectiveness of antibiotic prophylaxis, mostly on the grounds of a potentially harmful effect in terms of antibiotic resistance (Collard 2003). Moreover, important new information has become available in a large randomised trial (de Jonge 2003) that was the first to be formally designed to reliably assess the occurrence of antibiotic resistance by randomising ICUs rather than patients and monitoring the units for more than...
two years after the inception of treatment use: de Jonge et al reported that no patients were colonised with meticillin-resistant staphylococcus aureus, only 1% was colonised with vancomycin-resistant enterococcus and in 16% and 26% (in SDD and control patients, respectively) colonisation with gram negative bacteria resist to ceftazidime, ciprofloxacin, imipenem, polymyxin E and tobramycin occurred (de Jonge 2003).

We believe that insufficient data on cost-effectiveness and antibiotic resistance should stimulate future research rather than preventing the adoption of a seemingly effective intervention. The impact of antibiotic prophylaxis on costs has so far been evaluated only rarely and, more importantly, in an improper way (the analysis being essentially based on comparisons of lengths of stay and computation of charges due to antibiotic use). A proper economic analysis is, on the other hand, likely to be difficult in a highly specialised setting such as an ICU, given that it is hard to quantify the relative contribution of single procedures.

Implications for research

The number of RCTs so far conducted on antibiotic prophylaxis is substantial and provides sufficient statistical power to detect a moderate but humanly worthwhile effect of the treatment on mortality. According to this systematic review, the combination of topical and systemic antibiotics should be the standard against which new treatments should be tested. A logical next step for future trials would be the comparison of this protocol against a regimen based on a systemic antimicrobial only; only six trials included in this review chose this as their study design. However, it is unlikely that one or more even large conventional trial can satisfy the concerns of those who are afraid that antimicrobial resistance may occur as a consequence of widespread use of antibiotics. However, the trial by de Jonge (de Jonge 2003) has shown that trials with innovative designs are possible and that they allow for a more reliable assessment of the occurrence of antibiotic resistance.

At the current stage of development of this intervention there does not seem to be a commercial interest by pharmaceutical companies to support further trials. Similarly, the intensivists’ community seems rather sceptical about the merits of the intervention and it is not willing to embark on new, properly designed and conducted studies.

A systematic analysis of the quality and reliability of existing data on resistance might, in this sense, be important to get a more comprehensive view of the yield of the treatment. Such a review should be carried out even though it is highly likely that the necessary harms data are not available in published trials.

Acknowledgements

This systematic review would have not been possible without the continuous and enthusiastic support of most of the trials investigators. They collaborated in the different phases of this review up to the publication of our earlier review (D’Amico 1998) by providing information on the design and conduct of their studies, checking the accuracy of the data before the final analysis, attending a meeting where preliminary results were presented and, finally, reviewing earlier drafts of the manuscript. They are listed below:

M Abele-Horn 1997 (Ludwig-Maximilians-Universitat, Munich, Germany); SJA Aerdt 1991 (Sophia Hospital, Zwolle, The Netherlands); P Blair 1991, B J Rowlands, H Webb and K Lowry (Royal Victoria Hospital, Belfast, Northern Ireland); JP Boland 1991, D Sadler, A Stewart and J Pollock (Health Science Center Charlestone, West Virginia University, West Virginia, USA); C Brun-Buisson 1989 (Hospital Henry Monord, Creteil, France); FB Cerra 1992 (University of Minnesota Hospital and Clinic, Minneapolis, USA); FR Cockerill 1992 and RL Thompson (Mayo Clinic, Rochester, Minnesota, USA); M Ferenc 1992 and A Torrens (Servei de Pneumologia, Hospital Clinic, Barcelona, Spain); RG Finch 1991, P Tomlinson and G Rocker (Nottingham City Hospital, Nottingham, United Kingdom); H Gastinne 1992 (on behalf of the French study group on Selective Decontamination of the Digestive Tract - France); P Gaussorgues 1991 (Hospital Eduoard Herriot, Lyon, France); B Georges 1994 (Hospital de Rangueil, Toulouse, France); JM Hammond 1992, PD Potgieter (Grote Schuur Hospital, Cape Town, South Africa); S Jacobs (University Hospital of Wales, Cardiff, United Kingdom); S Jacobs and M Zuleika (Riyadh Armed Forces Hospital, Riyadh, Saudi Arabia); AJH Kerver 1988 (Sint Franciskus Hospital, Rotterdam, Utrecht, The Netherlands); AM Korinek 1993 (Hospital Pitie-Salpetriere, Paris, France); AN Lager 1994 (Vienna General Hospital, Vienna, Austria); FP Lenhart 1994 (University of Munich, Germany); W Lingnau (Leopold-Franzens-Universitat Innsbruck, Innsbruck, Austria); A Martinez-Pellus and J Rodriguez-Rolda 1990 (University Hospital Virgen de la Arrixaca, El Palmar, Murcia, Spain); M Palomar 1997 (Hospital Vall d’Hebron, Barcelona, Spain); J Pugin 1991 and P Suter (University Hospital, Geneva, Switzerland); C Martin, B Quinio 1995 and J Albanese (Hospital Nord, Marseilles, France); LA Rocha 1992 (Hospital Juan Canalejo, La Coruna, Spain); M Sanchez-Garcia 1992 (Hospital PPE Asturias, Alcala de Henares, Spain); CP Stoutenbeek 1994 (Academisch Ziekenhuis, Universiteit van Amsterdam, Amsterdam, The Netherlands); C Ulrich 1989 and J E Harinck-De Weerd (Westeinde Hospital, The Hague, The Netherlands); K Unertl 1987 (Klinikum Grosshadern, Munich, Germany); J Verhaegen and C Verwaest (University Hospital Gasthuisberg, Leuven, Belgium); J Wiener 1995 (Michael Reese Hospital, Chicago, USA); R Winter 1992 (Queens Medical Centre University Hospital, Nottingham, United Kingdom).

This review was originally initiated at the request of the French Society of Intensive Care in preparation for the consensus conference on Selective Decontamination of the Digestive Tract (Paris, December 1991) and led to the first publication in 1993 (SDD Group 1993). It was then continued and updated between 1993 and 1998 through resources made available from the Mario Negri Institute, Milan, Italy and an unrestricted grant provided by Hoechst Marion Roussel Italy, the sponsors had no control on the protocol preparation, data analysis and manuscript review and their support was sought after the decision of undertaking the review by the review authors. Since 2004 the review has been updated without any specific research grant attached using institutional resources of the review authors.

Finally, the review authors wish to thank the following referees for commenting on the 2009 updated review: Janet Wale, Tim Kenealy, Max Bulsara, and Jenny Doust.
Antibiotic prophylaxis to reduce respiratory tract infections and mortality in adults receiving intensive care (Review)

References to studies included in this review

Abele-Horn 1997 (published data only)

Aerdts 1991 (published and unpublished data)

Bergmans 2001 (published data only)

Blair 1991 (published and unpublished data)

Boland 1991 (published and unpublished data)

Brun-Buisson 1989 (published and unpublished data)

Camus 2005 (published data only)

Cerra 1992 (published and unpublished data)

Cockerill 1992 (published and unpublished data)

de Jonge 2003 (published data only)

Ferrer 1994 (published and unpublished data)

Finch 1991 (published and unpublished data)

Gastinne 1992 (published and unpublished data)

Gaussorgues 1991 (published and unpublished data)

Georges 1994 (published data only)

Hammond 1992 (published and unpublished data)

Jacobs 1992 (published and unpublished data)

Kerver 1988 (published and unpublished data)
Antibiotic prophylaxis to reduce respiratory tract infections and mortality in adults receiving intensive care (Review)

Korinek 1993 (published and unpublished data)

Krueger 2002 (published data only)

Lagner 1994 (published and unpublished data)

Lingnau 1997 (published and unpublished data)

Palomar 1997 (published and unpublished data)

Pneumatikos 2002 (published data only)

Pugin 1991 (published and unpublished data)

Quinio 1995 (published and unpublished data)

Rocha 1992 (published and unpublished data)

Rodriguez-Roldán 1990 (published and unpublished data)

Sanchez-Garcia 1992 (published and unpublished data)

Stoutenbeek 1996 (published data only)

Stoutenbeek 2007 (published data only)

Ulrich 1989 (published and unpublished data)

Unertl 1987 (published and unpublished data)

Verwaest 1997 (published and unpublished data)

Wiener 1995 (published data only)

Winter 1992 (published and unpublished data)
References to studies excluded from this review

Arnow 1996 {published data only}

Barret 2001 {published data only}

Bion 1994 {published data only}

Bouter 2002 {published data only}

de la Cal 2005 {published data only}

de Smet 2009 {published data only}

Flaherty 1990 {published data only}

Garbino 2002 {published data only}

Hellinger 2002 {published data only}

Hunefeld 1989 {published and unpublished data}

Jacobs 1995 {unpublished data only}
Jacobs S, Zuleika M. no title. provided by the authors.

Lenhart 1994 {published data only}

Lipman 1994 {published and unpublished data}

Luiten 1995 {published data only}

Martinez 1994 {published data only}

Martinez-Pellus 1993 {published data only}

Nardi 2001 {published data only}

Rayes 2002 {published data only}

Rolando 1996 {published and unpublished data}
Ruza 1998 (published data only)

Schardey 1997 (published and unpublished data)

Smith 1993 (published data only)

Stoutenbeek 2 (unpublished data only)
Stoutenbeek CP, Van Saene HFK, Little RA, Whitehead A. The effect of selective decontamination of the digestive tract on mortality in multiple trauma patients.. Contact with authors.

Tetteroo 1990 (published and unpublished data)

Zobel 1991 (published data only)

Zwaveling 2002 (published data only)

Additional references
Chevret 1996

Collard 2003

Fagon 1996

Heyland 1994

Higgins 2008

Hurley 1995

Kollef 1994

Lefebvre 2008

Liberati 2001

Nathens 1999

Redman 2001

Silvestri 2007

Stoutenbeek 1994
van Nieuwenhove 2001

Vanderbrouk-Graul 1991

References to other published versions of this review

D'Amico 1998

Liberati 1997

Liberati 2002

Liberati 2004

SDD Group 1993

**Characteristics of included studies [ordered by study ID]**

**Abele-Horn 1997**

<table>
<thead>
<tr>
<th>Methods</th>
<th>Randomised controlled study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blinding:</td>
<td>Open</td>
</tr>
<tr>
<td>Randomisation method: list block randomised assignments maintained by the main investigator</td>
<td></td>
</tr>
<tr>
<td>Accrual period:</td>
<td>not available</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants</th>
<th>Eligibility criteria: intubation within 24 hrs of admission, expected ventilation for at least four days, first microbial culture within 36 hrs of admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion criteria: transfer from other hospitals, evidence of infection, prior antibiotic therapy, ARDS, leucopenia, myelosuppression</td>
<td></td>
</tr>
<tr>
<td>Patients enrolled in the study: 125; 37 patients were excluded leaving 88 patients for analysis</td>
<td></td>
</tr>
<tr>
<td>Percentage of ventilated patients:</td>
<td>100%</td>
</tr>
<tr>
<td>ICU length of stay, mean:</td>
<td>19.3 days</td>
</tr>
<tr>
<td>Type of admission diagnosis: surgical unscheduled = 16% trauma = 84%</td>
<td></td>
</tr>
<tr>
<td>Severity score on admission: APACHE II mean = 17, ISS not available</td>
<td></td>
</tr>
<tr>
<td>Percentage of immunocompromised patients: not available</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients treated with systemic antibiotic therapy (not stated by protocol) in the first three days: not available</td>
<td></td>
</tr>
<tr>
<td>Stress ulcer prophylaxis applied: sucralfate 1 g x four to all patients</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Group A, Treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- polymyxin 100 mg, tobramycin 80 mg, amphotericin B 500 mg applied orally four times a day as a 2% paste during the ICU stay</td>
<td></td>
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<tr>
<td>- cefotaxime 2 g x 3 iv x three days</td>
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</tbody>
</table>

| Group B, CTR: | No prophylaxis |

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Antibiotic prophylaxis was performed only for abdominal, orthopedic and neurologic surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory infections (acquired pneumonia):</td>
<td></td>
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</tbody>
</table>
Diagnosis was based on Clinical Pulmonary Infection Score as defined by Pugin 1991: new pulmonary infiltrate on X-ray, increasing amount of tracheal secretions containing $> 3 \times 10^4$ granulocytes/ml and at least two of the following: temperature $> 38.5^\circ C$, WBC $> 12,000/mm^3$ or $< 4,000/mm^3$, decrease in PaO$_2$ requiring an increase in FiO$_2$. Besides a bacteriological confirmation is required: tracheal aspirates yielding bacteria $> 10^4$ CFU/ml and granulocytes $> 10/field.

Mortality: in ICU

Notes

Data about 37 excluded patients are not available

Risk of bias

<table>
<thead>
<tr>
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<th>Support for judgement</th>
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<tbody>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>B - Unclear</td>
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</tbody>
</table>

Aerdt 1991

Methods

Randomised study with three arms (one treatment arm versus two control arms)
Blinding: outcome assessor
Randomisation method: sealed envelopes, permuted block method.
Accrual period: May 86 to Sept 87

Participants

Eligibility criteria: expected ventilation for at least five days, inclusion within 24 hrs of admission
Exclusion criteria: age $< 16$ yrs, pregnancy, allergy to one of the component of the regimen
Patients enrolled in the study: 88
Percentage of ventilated patients: 100%
ICU length of stay, median: 16 days
Type of admission diagnosis: medical = 40% surgical scheduled = 6% surgical unscheduled = 20% trauma = 34%
Severity score on admission: APACHE II mean = 21.8, ISS not available
Percentage of immunocompromised patients: 4.6%
Percentage of patients treated with systemic antibiotic therapy (not stated by protocol) in the first three days: Treatment = 35% CTR = 80%
Stress ulcer prophylaxis applied: antacids until enteral feeding was possible

Interventions

Group A, CTR 1:
- No prophylaxis, infections of unknown origin were treated with ampicillin+gentamicin
Group B, CTR 2:
- No prophylaxis, infections of unknown origin were treated with cefotaxime+gentamicin and metronidazole if indicated.
Group C, Treatment:
- polymyxin E 200 mg, norfloxacin 50 mg, amphotericin B 500 mg applied enterally four times a day and, as a 2% paste, to the oropharynx until extubation
- cefotaxime 500 mg x 3 iv x five days. Infections of unknown origin were treated as group B

Outcomes

Respiratory infections (acquired pneumonia and tracheobronchitis):
Diagnosis of tracheobronchitis was based on: positive culture of the tracheal aspirate and a gram stain showing many leukocytes as well as the causative organism, associated with two of the following: temperature $> 38^\circ C$, WBC $> 12000/mm^3$, purulent tracheal aspirate
Diagnosis of pneumonia was based on: a new and persistent pulmonary infiltrate on X-ray and criteria of tracheobronchitis

Mortality: in ICU

Notes

The study presents two control groups that are considered as a whole in the meta-analysis
### Risk of bias

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<thead>
<tr>
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<tbody>
<tr>
<td>Allocation concealment</td>
<td>Low risk</td>
<td>A - Adequate</td>
</tr>
</tbody>
</table>

#### Bergmans 2001

**Methods**

Randomised, placebo-controlled study.
Blinding: double blind.

**Participants**

Elegibility criteria: intubation within 24 hrs of admission and need for mechanical ventilation with an expected duration > two hours
Exclusion criteria: age < 16 yrs.
Patients enrolled in the study: 226
Percentage of ventilated patients: 100%
ICU length of stay, median treatment group: 13 days; median control A group: 15 days, median control B group: 12 days
Type of admission diagnosis: Medical = 35%, Surgery = 39%, Trauma = 19%, Neurology = 6%, Other = 1%
Severity score on admission: APACHE II mean = 21.4, ISS not available
Percentage of immunocompromised patients: 2%
Percentage of patients treated with systematic antibiotic therapy at admission:
Treatment: 47% CTR = 42%
Stress ulcer prophylaxis applied: Treatment = 61%
Control = 76%

**Interventions**

Group A, Treatment:
Orabase with 2% gentamicin, 2% colistin and 2% vancomycin
Orabase was applied in the buccal cavities on a gloved finger every six hrs.
The application of Orabase was started within 24 h of intubation.
Application of treatment was limited to 21 days.

Group B, CTR1
no prophylaxis
- this group was studied in ICU in which there was the presence of patients receiving topical antimicrobial prophylaxis

Group C: CTR2
no prophylaxis
This control group was studied in ICU in which no topical antimicrobial prophylaxis was used

**Outcomes**

Ventilator-associated pneumonia (VAP); diagnosis of VAP was established on the basis of positive quantitative cultures from BAL (cutoff point >= $10^4$ colony-forming units [cfu]/ml) or PSB (cutoff point >= $10^3$ cfu/ml), or a positive blood culture unrelated to another source of infection, or a positive culture from pleural fluid in the absence of previous pleural instrumentation.
Mortality: in hospital

**Notes**

Risk of bias...
### Bergmans 2001 (Continued)

<table>
<thead>
<tr>
<th>Bias</th>
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</table>

### Blair 1991

#### Methods
- Randomised study
- Blinding: Open.
- Randomisation method: sealed envelopes.
- Accrual period: Sept. 1988 to Jan 1990

#### Participants
- Eligibility criteria: all admitted patients who do not fulfil the exclusion criteria
- Exclusion criteria: patients discharged within 48 hrs of ICU admission; admission from CCU; patients expected to die after six hrs of ICU admission; patients with discharge anticipated within 48 hrs but remaining more than 48 hrs; drug overdose; security patients; age < 18 yrs; patients not randomised within six hrs of admission; readmission to ICU; burns; miscellaneous
- Patients enrolled in the study: 331
- Percentage of ventilated patients: 93%
- Length of stay in ICU, median: five days
- Type of admission diagnosis: medical = 14% surgical scheduled = 33% surgical unscheduled = 13% trauma = 40%
- Severity score on admission: APACHE II mean = 14.4, ISS mean = 24.8
- Percentage of immunocompromised patients: 1.8%
- Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 42% CTR = 74%
- Stress ulcer prophylaxis applied: all patients received ranitidine iv plus antacid therapy if gastric pH was low

#### Interventions
- Group A, CTR:
  - Standard antibiotic therapy (no prophylaxis)
- Group B, Treatment:
  - polymyxin 100 mg, tobramycin 80 mg, amphotericin B 500 mg applied enterally four times a day and, as a 2% gel, to the oropharynx
  - cefotaxime 50 mg/kg/day iv x four days

#### Outcomes
- Respiratory infections (pneumonia acquired after 48 hrs). Diagnosis of infection was based on the fulfilment of Criteria I or Criteria II.
- Criteria I: temperature > 38.5°C on two separate occasion, WBC > 12 x 10⁹/l or < 4 x 10⁹ and a new pulmonary infiltrate on X-ray.
- Criteria II: temperature > 37.5°C, a new pulmonary infiltrates on X-ray, purulent sputum and drop in PaO₂
- Mortality: in ICU

#### Notes
- Personal contact with the main investigator provided data about 75 patients who were excluded from the published paper for short length of stay; these data are considered in the analysis

### Risk of bias

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</tr>
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</table>
### Boland 1991

#### Methods
- Randomised, placebo-controlled study
- Blinding: double blind
- Randomisation method: computer generated randomisation directed by the pharmacy department
- Accrual period: Apr 89 to Mar 91

#### Participants
- Eligibility criteria: all multiple traumatised patients, intubated at the time of admission and likely to stay intubated at least five days
- Exclusion criteria: patients who did not remain intubated for five days

- Patients enrolled in the study: 64
- Percentage of ventilated patients: 100%
- Length of stay in ICU, median: eight days
- Type of admission diagnosis: trauma = 100%
- Severity score on admission: APACHE II mean = 16.8, ISS not available
- Percentage of immunocompromised patients: 0%
- Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 0% CTR = 0%
- Stress ulcer prophylaxis applied: H2-blockers or sucralfate (78%)

#### Interventions
- **Group A, CTR:** Placebo
- **Group B, Treatment:**
  - polymyxin 100 mg, tobramycin 80 mg, nystatin 1,600,000 units applied enterally four times a day and, as a 2% paste plus 60,000 units of nystatin, to the oropharynx until extubation or discharge
  - cefotaxime 1 g x 3 iv for the first three days

#### Outcomes
- Respiratory infections (acquired pneumonia and tracheobronchitis).
- Diagnosis of infection was based on:
  - positive sputum culture for bacteria, fever > 38°C and leukocytosis (> 10,000 WBC/mm³ of blood)
- Mortality: in ICU

#### Notes
- Personal contact with the main investigator provided data about 23 patients who were excluded from the published paper (20 early extubations, three early deaths); these data are considered in the analysis

#### Risk of bias

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</table>

### Brun-Buisson 1989

#### Methods
- Randomised trial
- Blinding: Open
- Randomisation method: odd and even birth year technique
- Accrual period: Apr 87 to May 87

#### Participants
- Eligibility criteria: patients with an admission SAPS > 2 and staying in the ICU more than 48 hrs
- Exclusion criteria: patients with severe neutropenia routinely receiving oral antibiotic prophylaxis
- Patients enrolled in the study: 133
- Percentage of ventilated patients: 59%
Brun-Buisson 1989 (Continued)

Length of stay in ICU, median: 3.5 days
Type of admission diagnosis: medical 75% surgical unscheduled 23% trauma 2%
Severity score on admission: SAPS mean = 10.4, ISS not available
Percentage of immunocompromised patients: 12.8%
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 41% CTR = 53%
Stress ulcer prophylaxis applied: none

Interventions
Group A, Treatment:
- polymyxin E 50 mg, neomycin 1 g, nalidixic acid 1 g, applied orally and enterally four times a day until discharge
- Oropharyngeal disinfectant in intubated patients

Group B, CTR:
- Oropharyngeal disinfectant in intubated patients

Outcomes
Respiratory infections (pneumonia acquired in the ICU or within 48 hrs from discharge)
Diagnosis of infection was based on:
- purulent sputum or tracheal aspirate associated with a new and persistent pulmonary infiltrate on X-ray and the culture of at least 10^9 CFU/l from a protected wedged catheter sample of bronchial aspirate, temperature > 38°C, WBC > 10 x 10^9
Mortality: in ICU

Notes
Setting: acute and intermediate areas of a medical ICU
Personal contact with the main investigator provided data about 47 patients who were excluded from the published paper (seven early deaths, one transferred, 39 other); these data are considered in the analysis

Risk of bias

<table>
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<tbody>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>High risk</td>
<td>C - Inadequate</td>
</tr>
</tbody>
</table>

Camus 2005

Methods
Randomised trial
Blinding: double
Randomisation method: performed by computer
Accrual period: April 1996 to October 1998

Participants
Eligibility criteria: adults intubated for < 48 hrs and likely to require mechanical ventilation for > 48 hrs
Exclusion criteria: patients with SAPS II > 80 and life expectancy of < 48 hrs resulting from brain death of a palliative treatment, a polymorphonuclear count of < 500 cells/mm^3, severe diarrhoea and anyone who had received either a prior decontamination regimen or was already participating in another ongoing clinical trial.
Patients enrolled: 256
Percentage of ventilated patients: not reported
Length of stay in ICU: not reported
Type of admission diagnosis: home/emergency department = 43%, hospital ward = 57%
Severity score on admission: median SAPS II = 46
Percentage of immunocompromised patients: 3.9%
Percentage of patients treated with systemic antibiotic therapy (not stated in protocol) in the first three days: none
Stress ulcer prophylaxis applied: not reported
### Camus 2005 (Continued)

**Interventions**
- Group A - Treatment: solution containing 15 mg/ml polymyxin E and 10 mg/ml tobramycin
- Group B - Control: placebo

**Outcomes**
- Respiratory infections: acquired infections
- Mortality: in ICU

**Notes**
- The study is a four arm, 2 x 2 factorial design. In this review we considered only two arms comparing SDD regimen versus placebo

### Risk of bias

<table>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

### Cerra 1992

**Methods**
- Randomised, placebo-controlled study
- Blinding: double blind
- Randomisation method: sealed envelopes
- Accrual period: Sept 1988 to Jan 1990

**Participants**
- Eligibility criteria: admission within 48 hrs from surgery, trauma or other acute event, expected stay at least five days, hypermetabolism ($\text{VO}_2 > 140 \text{ ml/m}^2$ or urinary nitrogen excretion > 10 g/day) without progressive MOSF (normal transaminases, stable bilirubin and creatinine)
- Exclusion criteria: Cirrhosis, allergy to used drugs, chemo-radiotherapy, progressive MOSF, gastrointestinal leak or fistula
- Patients enrolled in the study: 48
- Percentage of ventilated patients: not available
- ICU length of stay, median: not available
- Type of admission diagnosis: surgical = 96% trauma = 4%
- Severity score on admission: not available
- Percentage of immunocompromised patients: not available
- Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: not available
- Stress ulcer prophylaxis applied: not available

**Interventions**
- Group A, Treatment: - norfloxacin 500 mg x 3, nystatin one million U x 4 applied enterally until discharge
- Group B, CTR: - Placebo

**Outcomes**
- Respiratory infections: not possible to evaluate
- Mortality

**Notes**
- Personal contact with the main investigator provided data about two patients who were excluded from the published paper for short length of stay); these data are considered in the analysis

### Risk of bias

<table>
<thead>
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Antibiotic prophylaxis to reduce respiratory tract infections and mortality in adults receiving intensive care (Review)
### Cerra 1992

**Allocation concealment**

<table>
<thead>
<tr>
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</tr>
</tbody>
</table>

**Methods**

- Randomised study. Intention-to-treat
- Blinding: outcome assessor
- Randomisation method: randomisation table at a remote site in the pharmacy
- Accrual period: 1986 to 1989

**Participants**

- Eligibility criteria: all patients admitted to the mixed ICU if their condition suggested a prolonged stay (> three days), age > 18 yrs
- Exclusion criteria: age < 18 yrs, pregnancy, allergy to one of the component of the regimen, infections, antibiotic therapy 24 hrs before randomisation
- Patients enrolled in the study: 150
- Percentage of ventilated patients: 85%
- ICU length of stay, median: 4.5 days
- Type of admission diagnosis: medical = 18% surgical scheduled = 27% surgical unscheduled = 21% trauma = 34%
- Severity score on admission: APACHE II mean = 19.4, ISS mean 24.3
- Percentage of immunocompromised patients: 4%
- Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 75% CTR = 80%
- Stress ulcer prophylaxis applied: H2-blockers (80%)

**Interventions**

- Group A, CTR:
  - No prophylaxis
- Group B, Treatment:
  - gentamicin 80 mg, polymyxin B 100 mg, nystatin 2,000,000 units, applied enterally and as a 2% paste to the oropharynx four times a day during the ICU stay
  - cefotaxime 1 g/8 hrs iv for the first three days

**Outcomes**

- Respiratory infections (only acquired infections)
- Diagnosis of pneumonia was based on clinical and laboratory criteria: a new or progressive pulmonary infiltrate, purulent secretions, isolation of a potential pathogen and fever with or without leukocytosis.
- Diagnosis of tracheobronchitis was based on: the presence of increased purulent endotracheal secretions requiring frequent suctioning and the presence of a potential pathogen
- Mortality: in hospital

### Cockerill 1992

**Methods**

- Randomised study. Intention-to-treat
- Blinding: outcome assessor
- Randomisation method: randomisation table at a remote site in the pharmacy
- Accrual period: 1986 to 1989

**Participants**

- Eligibility criteria: all patients admitted to the mixed ICU if their condition suggested a prolonged stay (> three days), age > 18 yrs
- Exclusion criteria: age < 18 yrs, pregnancy, allergy to one of the component of the regimen, infections, antibiotic therapy 24 hrs before randomisation
- Patients enrolled in the study: 150
- Percentage of ventilated patients: 85%
- ICU length of stay, median: 4.5 days
- Type of admission diagnosis: medical = 18% surgical scheduled = 27% surgical unscheduled = 21% trauma = 34%
- Severity score on admission: APACHE II mean = 19.4, ISS mean 24.3
- Percentage of immunocompromised patients: 4%
- Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 75% CTR = 80%
- Stress ulcer prophylaxis applied: H2-blockers (80%)

**Interventions**

- Group A, CTR:
  - No prophylaxis
- Group B, Treatment:
  - gentamicin 80 mg, polymyxin B 100 mg, nystatin 2,000,000 units, applied enterally and as a 2% paste to the oropharynx four times a day during the ICU stay
  - cefotaxime 1 g/8 hrs iv for the first three days

**Outcomes**

- Respiratory infections (only acquired infections)
- Diagnosis of pneumonia was based on clinical and laboratory criteria: a new or progressive pulmonary infiltrate, purulent secretions, isolation of a potential pathogen and fever with or without leukocytosis.
- Diagnosis of tracheobronchitis was based on: the presence of increased purulent endotracheal secretions requiring frequent suctioning and the presence of a potential pathogen
- Mortality: in hospital

### Risk of bias

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<tr>
<th>Bias</th>
<th>Authors' judgement</th>
<th>Support for judgement</th>
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<tbody>
<tr>
<td>Allocation concealment</td>
<td>Unclear risk</td>
<td>B - Unclear</td>
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de Jonge 2003

Methods
Randomised study
Blinding: Open
Randomisation method: computer-generated random-number codes kept in sealed envelopes

Participants
Eligibility criteria: adult patients admitted to ICU: with an expected stay of at least 72 hours and an expected duration of mechanical ventilation of at least 48 hours
Exclusion criteria: previous admission in ICU within three months,iper sensitivity to study medication, pregnancy and perceived imminent death

Number of patients enrolled in the study: 934
Percentage of ventilated patients: 85%
Length of stay in ICU: median SDD group = 6.8 days
control group = 8.5 days

Type of admission diagnosis:
medical: 41%
surgical urgent: 25%
surgical elective: 34%

Severity score at admission:
APACHE II mean = 18.7
SAPS II in SDD group mean = 17.9
SAPSII in control group mean = 17.1

Percentage of immunocompromised patients
SDD group = 2.4%
control group = 1.7%

Information on prescribed antibiotics per 1,000 patients available in the main publication
No stress ulcer prophylaxis by protocol

Interventions
SDD group: topical plus systemic treatment
Topical: oral paste containing 2% polymyxin E, 2% tobramycin, 2% amphotericin
500 mg amphotericin B through gastric tubes
Systemic: cefotaxime 1000 mg four times daily for four days

Control group:
No antibiotic prophylaxis; antibiotic treatment based on clinical needs

Outcomes
Colonisation, antibiotic resistance
Mortality: in ICU and hospital

Notes
Patients were allocated to either an SDD or a control unit to prevent cross-colonisation between SDD and ICU control patients. Standard care was the same in the two units

Risk of bias

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Ferrer 1994

Methods
Randomised, placebo-controlled study
### Participants
Eligibility criteria: all mechanically ventilated patients expected to remain intubated for more than three days
Exclusion criteria: patients with HIV-related diseases or treated with antineoplastic chemotherapy as well as patients who received transplants, extubation or death within 72 hrs

Number of patients enrolled in the study: 101
Percentage of ventilated patients: 100%
Length of stay in ICU, median: 7.5 days
Type of admission diagnosis: medical 66% surgical scheduled 6.9% surgical unscheduled 6.9% trauma = 19.8%
Severity score admission: SAPS mean = 12.1, ISS not available
Percentage of immunocompromised patients: 0%
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: not available
treatment = 73% CTR = 74%
Stress ulcer prophylaxis applied: sucralfate except in patients with paralytic ileus or with upper gastrointestinal bleeding, who were treated with ranitidine

### Interventions
Group A, Treatment:
- polymyxin E 100 mg, tobramycin 80 mg, amphotericin B 500 mg applied enterally and, as a 2% paste, to the oropharynx four times a day until extubation or death
- cefotaxime 2 g/day iv for the first four days or others if required

Group B, CTR:
- Placebo
- cefotaxime 2 g/day iv for the first four days or others if required*

*patients infected on admission received adequate antibiotic treatment instead of cefotaxime

### Outcomes
Respiratory infections (pneumonia acquired after four days of mechanical ventilation)
Diagnosis of infection was based on clinical criteria plus brush or BAL confirmation.
Clinical criteria: new or progressive pulmonary X-ray infiltrate for at least 48 hrs, purulent tracheal secretions, temperature > 38.5 °C and leukocytosis >= 12 x 10⁹ WBC/l or leukopenia <= 4 x 10⁹
Mortality: in ICU

### Notes
Personal contact with the main investigator provided data about 21 patients who were excluded from the published paper (14 early extubations, six early deaths, one transfer); these data are considered in the analysis

### Risk of bias
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### Finch 1991
Methods
Randomised study
Blinding: Open
Randomisation method: sealed envelopes. Randomisation series made available to the hospital Pharmacy only
### Finch 1991 (Continued)

**Accrual period:** Aug 87 to Sept 89

| Participants | Eligibility criteria: all patients whose length of stay was > 60 hrs, age > 16 yrs  
Exclusion criteria: none  
Number of patients enrolled in the study: 49  
Percentage of ventilated patients: not available  
Length of stay in ICU: not available  
Type of admission diagnosis: medical 59% surgical scheduled 27% surgical unscheduled 10% trauma = 4%  
Severity score on admission: SAPS mean = 10.5, ISS not available  
Percentage of immunocompromised patients: 22%  
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 58% CTR = 68%  
Stress ulcer prophylaxis applied: not available |
|------------------|--------------------------------------------------------------------------------------------------|
| Interventions | Group A, Treatment:  
- polymyxin B 100 mg, gentamycin 120 mg, amphotericin B 500 mg applied enterally and, as a 2% paste, to the oropharynx four times a day  
- cefotaxime 1 g x 3 iv for the first four days  
Group B, CTR:  
- Conventional antibiotic therapy |
| Outcomes | Respiratory infections (acquired pneumonia)  
Diagnosis of pneumonia was based on:  
tracheal aspirate with numerous leukocytes associated with any of the following: a single bacterial species with a growth density > $10^5$ CFU, diagnosis of sepsis, clinical signs of pulmonary infections (fever, leukocytosis and appropriate radiological findings)  
Mortality: in ICU |
| Notes | Personal contact with the main investigator provided information about mortality on five patients who were excluded from the published paper (one early extubation, two early deaths, one transferring, one unknown); these data are considered in the analysis. Data about respiratory infections in patients excluded from published paper are not available |

### Risk of bias

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### Gastinne 1992

**Methods**
Randomised, placebo-controlled, multicenter (15 ICUs) study Intention to treat  
Blinding: double blind  
Randomisation method: a randomised list of consecutive treatment assignments, performed separately in each unit.  
Accrual period: Feb 90 to Jun 90

**Participants**
Eligibility criteria: all patients > 15 yrs who required mechanical ventilation and with intubation performed no more than 48 hrs before randomisation  
Exclusion criteria: patients with ventilation for less than 24 hrs, drug or alcohol overdose, neutropenia (WBC < 500/mm$^3$), SAPS > 24 or GCS < 4, chronic degenerative central nervous system disease or spinal cord injury above level of C4, acute severe enteropathy, pregnancy, participation in another ongoing...
clinical trial, refusal of consent, patients with conditions in which survival was strongly related to status on admission

Number of patients enrolled in the study: 445
Percentage of ventilated patients: 100%
Length of stay in ICU, median: 12 days
Type of admission diagnosis: medical 72% surgical scheduled 3% surgical unscheduled 10% trauma = 15%
Severity score on admission: SAPS mean = 13.5, ISS not available GCS mean = 11.7
Percentage of immunocompromised patients: 18%
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 89% CTR = 84%
Stress ulcer prophylaxis applied: sucralfate (43% patients), H2-blockers (13% patients)

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Group A, CTR:</th>
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<tr>
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<td>- Placebo</td>
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<tr>
<th>Group B, Treatment:</th>
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<tr>
<td>- tobramycin 80 mg, polymyxin E 100 mg, amphotericin B 100 mg applied enterally and, as a 2% paste, to the oropharynx four times a day throughout the period of ventilation</td>
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<thead>
<tr>
<th>Outcomes</th>
<th>Respiratory infections (pneumonia diagnosed within 48 hrs and acquired):</th>
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<tbody>
<tr>
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<td>Diagnosis of infection was based on:</td>
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<td>purulent tracheal aspirate, temperature &gt; 38.5°C, peripheral leukocytosis (&gt; 10,000 WBC/mm³ of blood) and a new and persistent infiltrate on the chest film. Brushing was recommended but not mandatory.</td>
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<td>Mortality: in hospital</td>
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<th>Notes</th>
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### Risk of bias

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### Gaussorgues 1991

### Methods

- Randomised study. Intention to treat
- Blinding: Open
- Randomisation method: odd-even numbers
- Accrual period: Sept 88 to Sept 89

### Participants

Eligibility criteria: all patients admitted to the ICU, who required mechanical ventilation and inotropic drugs for haemodynamic reasons
Exclusion criteria: neutropenia

Patients enrolled in the study: 118
Percentage of ventilated patients: 100%
ICU length of stay: not available
Type of admission diagnosis: medical = 83% surgical scheduled = 17% (all patients were infected on admission)
Severity score on admission: SAPS mean = 17.5
Percentage of immunocompromised patients: not available
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 100% CTR = 100%
### Gaussorgues 1991 (Continued)

#### Stress ulcer prophylaxis applied: sucralfate 4 g to all patients

**Interventions**

<table>
<thead>
<tr>
<th>Group</th>
<th>Treatment</th>
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</thead>
</table>
| A     | - polymyxin E 36 mg, gentamycin 80 mg, Vancomycin 50 mg, amphotericin B 500 mg applied enterally four times a day until extubation  
- amphotericin B, Clorexidine applied orally four times a day  
- systemic antibiotic therapy |
| B     | - amphotericin B, Clorexidine applied orally four times a day  
- systemic antibiotic therapy |

**Group B, CTR:**

- amphotericin B, Clorexidine applied orally four times a day  
- systemic antibiotic therapy

**Outcomes**

- Respiratory infections: not possible to evaluate  
- Mortality: in ICU

**Notes**

- All patients were infected on admission  
- Data about respiratory infections are not provided

**Risk of bias**

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<tr>
<td>Allocation concealment</td>
<td>High risk</td>
<td>C - Inadequate</td>
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<tr>
<td>(selection bias)</td>
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### Georges 1994

#### Methods

- Randomised, placebo-controlled study  
- Blinding: open  
- Randomisation method: sealed envelopes  
- Accrual period: Jun 1990 to April 1992

**Participants**

- Eligibility criteria: Polytrauma, expected mechanical ventilation for at least four days, age > 18 years  
- Exclusion criteria: Hypersensitivity to the used agents, protocol violation, obesity, ventilation < four days, patients on mechanical ventilation two days before admission, severe maxillo-facial lesions

- Patients enrolled in the study: 138, but only 64 patients were analysed  
- Length of stay in ICU, mean: 33 days  
- Percentage of ventilated patients: 100%. Length of ventilation, mean: 16 days  
- Type of admission diagnosis: trauma 100%  
- Severity score on admission: APACHE II mean = 15, ISS = 41  
- Percentage of immunocompromised patients: 0%  
- Percentage of patients treated with systemic antibiotic therapy in the first 3 days: almost 100%  
- Stress ulcer prophylaxis: H2-blockers

**Interventions**

<table>
<thead>
<tr>
<th>Group</th>
<th>Treatment</th>
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</table>
| A     | - polymyxin E 75 mg, Netilmicin 150 mg, amphotericin B 400 mg applied enterally four times a day and, as a 2% paste, to the oropharynx until extubation  
- Systemic antibiotic prophylaxis was free |
| B     | - Placebo  
- Systemic antibiotic prophylaxis was free |

**Outcomes**

- Respiratory infections (acquired pneumonia)  
- Diagnosis of infection was based on:
Fever > 38.5 °C, leukocytosis > 12000/mm³, new infiltrates in the chest X-rays, purulent pulmonary secretions, positive bacteriologic findings (> 10^3 CFU/ml) obtained through a protected catheter

Mortality: in ICU and hospital

Notes
Antibiotic prophylaxis was free and almost all patients of both groups were treated with systemic antibiotics
74 potentially eligible patients were excluded from analysis; it is not evident if this happened before or after randomisation; these data are not available

Risk of bias

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</table>

Hammond 1992

Methods
Randomised, placebo-controlled study
Blinding: double blind
Randomisation method: computer generated random numbers.
Accrual period: Jan 89 to Dec 90

Participants
Eligibility criteria: expected intubation for longer than 48 hrs and stay in ICU for at least five days
Exclusion criteria: hypersensitivity to the study drugs, patients with asthma, drug overdose and patients admitted electively after surgery
Number of patients enrolled in the study: 322
Percentage of ventilated patients: 100%
Length of stay in ICU, median: 11 days
Type of admission diagnosis: medical 55% surgical scheduled 3% surgical unscheduled 11% trauma = 31%
Severity score on admission: APACHE II mean = 13.9, ISS mean = 28.7
Percentage of immunocompromised patients: 0.8%
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 54% CTR = 58%
Stress ulcer prophylaxis applied: none, H2-blockers only to high risk patients

Interventions
Group A, Treatment:
- polymyxin E 100 mg, tobramycin 80 mg, amphotericin B 500 mg applied enterally and, as a 2% gel, to the oropharynx four times a day until 48 hrs after extubation
- cefotaxime 1 g x 3 iv for the first three days to patients untreated on admission

Group B, CTR:
- Placebo
- cefotaxime 1 g x 3 iv for the first three days to patients untreated on admission

Outcomes
Respiratory infections (infections acquired after 48 hrs)
Diagnosis of pneumonia was based on:
a new infiltrate on X-ray and purulent bronchial secretions with many leukocytes, temperature > 38°C, WBC > 1010/l, substantial number of organism on gram stain with a pure growth culture from tracheal aspirate, deterioration of gas exchange of > 2 kPa
Diagnosis of bronchial infection was based on:
all the previous criteria except the X-ray changes
Mortality: in hospital
Hammond 1992 (Continued)

Notes

Personal contact with the main investigator provided data on 82 patients who were excluded and separately considered in the published paper (78 short stay, three protocol violation, one unknown); these data are considered in the analysis

Risk of bias

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Jacobs 1992

Methods

Randomised study
Blinding: open
Randomisation method: sealed envelopes.
Accrual period: Jul 89 to Aug 90

Participants

Eligibility criteria: expected stay in ICU > three days
Exclusion criteria: none

Patients enrolled in the study: 91
Percentage of ventilated patients: 100%
ICU length of stay, median: unknown
Type of admission diagnosis: medical = 25% surgical = 57% trauma = 18% (high percentage of neurologic and neurosurgical patients 52%)
Severity score on admission: APACHE II mean = 17.5, ISS not available
Percentage of immunocompromised patients: unknown
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: next to 100%
Stress ulcer prophylaxis applied: policy of maintenance a low gastric pH, H2-blockers only if peptic ulcer or steroid therapy (33%), sucralfate 4 g to all patients not on enteral feeding

Interventions

Group A, Treatment:
- polymyxin E 100 mg, tobramycin 80 mg, amphotericin B 500 mg applied orally and enterally four times a day until extubation
- cefotaxime 50 mg/kg/day iv x four days

Group B, CTR:
- No prophylaxis

Outcomes

Respiratory infections (acquired pneumonia)
Diagnosis of infection was based on:
alveolar infiltrates on two or more chest X-rays, moderate or copious purulent tracheal aspirate, rectal temperature > 38.4°C, leucocytosis > 13 x 10^9/l, a heavy growth of organisms from tracheal aspirate with a high polymorphonuclear leucocytes/epithelial cell ratio

Mortality

Notes

Almost 100% of patients received systemic antibiotic therapy on admission
Personal contact with the main investigator provided data about 12 patients who were excluded from the published paper (11 short stay in ICU, one HIV+); these data are considered in the analysis

Risk of bias

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Antibiotic prophylaxis to reduce respiratory tract infections and mortality in adults receiving intensive care (Review) 28
Copyright © 2013 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.
### Jacobs 1992 (Continued)

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<th>Allocation concealment (selection bias)</th>
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<th>A - Adequate</th>
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### Kerver 1988

#### Methods
- Randomised study
- Blinding: open
- Randomisation method: odd/even numbers
- Accrual period: Jan 85 to May 86

#### Participants
- Eligibility criteria: all patients admitted to the surgical ICU who required care > five days
- Exclusion criteria: none
- Patients enrolled in the study: 96
- Percentage of ventilated patients: 100%
- ICU length of stay, not available
- Type of admission diagnosis: surgical = 60% trauma = 28% other = 12%
- Severity score on admission: APACHE II mean = 14.8, ISS not available
- Percentage of immunocompromised patients: not available
- Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: about 85%
- Stress ulcer prophylaxis applied: not available

#### Interventions
- Group A, Treatment:
  - polymyxin E 200 mg, tobramycin 80 mg, amphotericin B 500 mg applied orally and enterally four times a day
  - Oral disinfectant
  - cefotaxime 50 to 70 mg/kg/day iv x five to seven days

- Group B, CTR:
  - Oral disinfectant

#### Outcomes
- Respiratory infections (primary pneumonia and pneumonia acquired after 48hs)
- Diagnosis of infection was based on X-ray findings and the presence of three of the following criteria on the same day: rectal temperature > 38.5°C for at least 12 hrs, WBC count > 10 x 10^3 or < 4 x 10^3/mcl, at least 3% band forming granulocytes, unexplained decrease in platelet count < 100,000/mcl, deterioration of renal function due to acute tubular necrosis, unexplained decrease in systolic blood pressure of > 30 mmHg, progressive respiratory failure

#### Mortality

### Notes

### Risk of bias

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### Korinek 1993

#### Methods
- Randomised, placebo-controlled, dual-centre study
- Blinding: double blind
- Randomisation method: randomisation performed by the hospital pharmacist on each unit separately
Cochrane Data Base of Systematic Reviews

Korinek 1993 (Continued)

Accrual period: Mar 89 to Sep 90

Participants
Eligibility criteria: all comatose patients with emergency admission to two neurosurgical ICUs and intubated within 24 hrs for at least five days, age > 16 yrs
Exclusion criteria: age < 16 yrs, known immunosuppression, antibiotic treatment during the two weeks preceding ICU admission, serious injury of oropharyngeal mucosa or epistaxis, abnormal chest X-ray on admission, extubation or infection occurring within the first five days of neurosurgical care
Number of patients enrolled in the study: 191
Percentage of ventilated patients: 100%
Length of stay in ICU, mean: 26 days
Type of admission diagnosis: surgical scheduled 11% surgical unscheduled 39% trauma 50%
Severity score on admission: SAPS mean = 10.9, ISS not available
Percentage of immunocompromised patients: 0%
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 0% CTR = 0%
Stress ulcer prophylaxis applied: sucralfate (32%), antacids (14%), H2-blockers (20%) until enteral feeding was started

Interventions
Group A, Treatment:
- polymyxin E 100 mg, tobramycin 80 mg, amphotericin B 500 mg applied enterally and, as a 2% paste, to the oropharynx four times a day for 15 days
- Vancomycin × os

Group B, CTR:
- Placebo

The non-absorbable antibiotics were discontinued if any infection requiring a parenteral antibiotic treatment occurred and at the time of patient's extubation

Outcomes
Respiratory infections (pneumonia acquired after five days)
Diagnosis of infection was based on:
fever > 38.5°C, leukocytosis > 12,000 cells/mm³, purulent sputum, new and persistent infiltrates on chest X-ray and a culture of > 10³ CFU/ml obtained with either brush or plugged telescoping catheter
Mortality: in ICU

Notes
Setting: neurosurgical ICU
Personal contact with the main investigator provided data about 68 patients who were excluded from the published paper (early extubation, early death, protocol violation, transferring, other); these data are considered in the analysis

Risk of bias

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Krueger 2002

Methods
Randomised, double blind, placebo-controlled, double centre study
Randomisation method: computer-generated randomisation
Accrual period: Apr 89 to Mar 91

Participants
Eligibility criteria: expected stay in ICU > two days and at least one risk factor for infection
Exclusion criteria: patients expected to die within 48 hrs or randomisation was not achieved within 12 hrs after admission to ICU.
Patients enrolled in the study: 546, 19 patients were excluded leaving 527 patients for analysis
Percentage of ventilated patients: not available
ICU length of stay: 10 days for both groups
Type of admission diagnosis: surgical
Severity score on admission: APACHE II mean = 20, ISS not available
Percentage of immunocompromised patients: not available
Percentage of patients treated with systemic antibiotic therapy (not stated by protocol) in the first three days: not available
Stress ulcer prophylaxis applied: sucralfate to all patients

Interventions

Group A, Treatment:
- polymyxin B 50 mg, gentamycin 80 mg, applied nasally, orally and enterally four times a day during the ICU stay
- ciprofloxacin 400 mg x 2 iv x four days to uninfected patients

Group B, CTR:
- Placebo applied nasally, orally and enterally
- Placebo iv to uninfected patients

Outcomes

Respiratory infections (acquired pneumonia)
Mortality in ICU

Notes

Information about accrual period and severity score was reported on an abstract previously published

Risk of bias

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Laggner 1994

Methods

Randomised, placebo-controlled study
Blinding: double blind
Randomisation method: computer generated randomisation in time blocks. Open
Accrual period: Aug 87 to Nov 90

Participants

Eligibility criteria: expected ventilation for five days, age > 18 yrs and < 80 yrs, acute onset of respiratory failure
Exclusion criteria: age < 18 yrs and > 80 yrs, bleeding of the nasopharynx and of the upper gastrointestinal tract on admission, stress ulcer prophylaxis with other drug therapy than sucralfate, mechanical ventilation for less than five days, patients on enteral nutrition or with known allergy to sucralfate or gentamicin

Number of patients enrolled in the study: 88, but only 67 patients were analysed
Percentage of ventilated patients: 100%
Length of stay in ICU, mean: 28.8 days
Type of admission diagnosis: medical 88% surgical scheduled 9% surgical unscheduled 1% trauma = 2%
Severity score on admission: APACHE II mean = 23, ISS not available
Percentage of immunocompromised patients: 15%
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: 100%
Stress ulcer prophylaxis applied: sucralfate

Interventions

Group A, Treatment:

- gentamycin 40 mg, amphotericin B 100 mg applied to the oropharynx four times a day until extubation
- Oropharyngeal disinfectant
- -aminopenicillin and clavulanic acid or other appropriate regimens

Group B, CTR:
- Placebo
- Amphotericin B 100 mg
- Oropharyngeal disinfectant
- Aminopenicillin and clavulanic acid or other appropriate regimens

Outcomes
Respiratory infections (acquired pneumonia):
Diagnosis of infection was based on:
appearance of a new infiltrate on the chest film with concomitant tracheal colonisation, fever > 38°C and > 15,000 or < 5,000 WBC/mm³ of blood
Mortality: in ICU

Notes
Data about 21 patients who were excluded from the published paper (18 short mechanical ventilation, three early enteral nutrition) are not available

Risk of bias

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Lingnau 1997

Methods
Randomised, placebo-controlled study with three arms (one control arm and two treatment arms). Intention to treat
Blinding: double blind
Randomisation method: continuous random numbers assigned to blinded study drugs or vehicle by Biometric department.
Accrual period: Aug 89 to Jan 94

Participants
Eligibility criteria: non-infected trauma patients, age > 18 yrs, expected ventilation for at least two days, expected ICU stay for at least three days, ISS > 16 and < 74, inclusion within 24 hrs of admission
Exclusion criteria: isolated brain injury, prior antibiotic treatment, history of infection
Patients enrolled in the study: 357 Percentage of ventilated patients: 100%
ICU length of stay, mean: 20 days
Type of admission diagnosis: trauma = 100%
Severity score on admission: APACHE II mean = 15.6, ISS mean = 35.2
Percentage of immunocompromised patients: 0%
Percentage of patients treated with systemic antibiotic therapy (not stated by protocol) in the first three days: treatment 1 = 2% treatment 2 = 2% CTR = 6%
Stress ulcer prophylaxis applied: free

Interventions
Group A, Treatment 1:
- polymyxin E 100 mg, tobramycin 80 mg, amphotericin B 500 mg applied orally and enterally four times a day during the ICU stay
- ciprofloxacin 200 mg x 2 iv, for four days

Group C, CTR:
- Placebo
Outcomes

Respiratory infections (acquired pneumonia):
Diagnosis of infection was based on:
concomitant occurrence of purulent sputum, positive cultures of bronchial secretions and deterioration of lung function
Mortality: in ICU

Notes

This three-arm study has been split in two comparisons; the control group C has been used twice:
comparison Lingnau a (group A versus group C)
comparison Lingnau b (group B versus group C)

Risk of bias

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Lingnau 1997b

Methods
see Lingnau 1997

Participants
see Lingnau 1997
Only two groups of patients, group B and C, are considered in this comparison, totaling 267 patients

Interventions

Group B, Treatment 2:
- polymyxin E 100 mg, ciprofloxacin 50 mg, amphotericin B 500 mg applied orally and enterally four times a day during the ICU stay
- ciprofloxacin 200 mg x 2 iv, for four days

Group C, CTR:
- Placebo
- ciprofloxacin 200 mg x 2 iv, for four days

Outcomes
see Lingnau 1997

Notes
see Lingnau 1997

Risk of bias

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Palomar 1997

Methods
Randomised, multicentric (10 ICUs) study with three arms (one treatment arm and two control arms; one control arm was excluded from meta-analysis because it was the only one receiving sucralfate)
Blinding: open
Randomisation method: sealed envelopes.
Accrual period: Jul 89 to Aug 91
Cochrane Library

Participants
Eligibility criteria: patients requiring mechanical ventilation for more than four days, not infected at the time of entry and not receiving antibiotic therapy
Exclusion criteria: ARDS, leukopenia, pregnancy

- Number of patients enrolled in the study: 97
- Percentage of ventilated patients: 100%
- Length of stay in ICU, median 10 days
- Type of admission diagnosis: medical 40% surgical 10% trauma 50%
- Severity score on admission: APACHE II mean = 16.8, ISS not available
- Percentage of immunocompromised patients: 0%
- Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 0% CTR = 6%
- Stress ulcer prophylaxis applied: sucralfate to one control group (excluded from meta-analysis), antibiotics or H2-blockers to the two other groups

Interventions
Group A, CTR 1:
- No prophylaxis

Group B, Treatment:
- polymyxin E + B 100 mg, tobramycin 80 mg, amphotericin B 500 mg applied enterally and, as a 2% paste, to the oropharynx four times a day until extubation
- cefotaxime 1 g x 3 iv for the first four days

Group C*, CTR 2:
- cefotaxime 1 g x 3 iv for the first four days
- sucralfate

* This group was excluded from analysis because it was the only one receiving sucralfate

Outcomes
Respiratory infections (acquired infections)
Diagnosis of pneumonia was based on the CDC criteria of 1980 (clinical or radiologic suspicion with: purulent sputum, organism isolated from blood culture, isolation of pathogen from tracheal aspirate, brush or biopsy. Bacteriologic evaluation was performed with brush or BAL in 50% of patients)
Diagnosis of tracheobronchitis was based on the CDC criteria of 1980

Mortality: in ICU

Notes
Personal contact with the main investigator provided data about 16 patients who were excluded from the published paper (seven early extubations, five early deaths, three protocol violation, one other); these data are considered in the analysis

Risk of bias

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Pneumatikos 2002

Methods
- Randomised, placebo-controlled
- Blinding: outcome assessor
- Randomisation method: not stated

Participants
Eligibility criteria: patients with multiple trauma admitted to the intensive care unit who required intubation and had an expected time for mechanical ventilation exceeding five days
- Absence of cardiopulmonary disease, negative chest radiography, and a PaO2/FIO2 ratio higher than 300 mmHg
Patients enrolled in the study: 61

Percentage of ventilated patients: 100%

ICU length of stay, median:
Treatment = 16 days
Control = 23 days

Type of admission diagnosis:
trauma = 100%

Severity score on admission: APACHE II
Treatment = 18.1
control = 19.1

Percentage of immunocompromised patients: not stated

Percentage of patients treated with systemic antibiotic therapy: not stated

Stress ulcer prophylaxis applied: H2 blockers or sucralfate
Treatment = 26%
Control = 19%

Interventions

Group A, treatment:
polymyxin 73 mg,
tobramycin 73 mg, amphotericin 500 ml in 500 ml 0.9 saline solution at an infusion rate of 2 ml/hr in the subglottic area for the entire period of the study

Group B CTR:
placebo

Outcomes

Ventilator associated pneumonia (VAP) defined as presence of new and persistent pulmonary infiltrates in addition to two of the following criteria: body temperature > 38.3 °C, leukocytes/mm³ or leukopenia (< 4000 leukocytes/mm³) and purulent tracheal secretions. The diagnosis of VAP was confirmed by quantitative cultures.

Mortality: not specified

Notes

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Pugin 1991

Methods

Randomised, placebo-controlled study
Blinding: double blind
Randomisation method: sealed envelopes
Accrual period: Apr 89 to Nov 89

Participants

Eligibility criteria: all adult patients admitted to the surgical ICU, at high risk of developing pneumonia and intubated for more than 48 hrs
Exclusion criteria: organ transplantation

Number of patients enrolled in the study: 79
Percentage of ventilated patients: 100%
Length of stay in ICU, mean 13.8 days
Type of admission diagnosis: medical 11% surgical scheduled 11% surgical unscheduled 22% trauma 56%
Severity score on admission: APACHE II mean = 15.2, ISS not available
Percentage of immunocompromised patients: not available
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 46% CTR = 53%
Stress ulcer prophylaxis applied: sucralfate (61%), ranitidine (11%)

Interventions
Group A, Treatment:
- polymyxin B sulfate 150 mg, neomycin sulfate 1 g, vancomycin hydrochloride 1 g applied as a solution to the retropharynx six times a day within 24 hrs after intubation until extubation or death
Group B, CTR:
- Placebo

Withdrawal from the study was possible at any time if the treating physicians estimated that there was any problem related to administration of the drugs or side effects

Outcomes
Respiratory infections (pneumonia acquired after 48 hrs): Pneumonia are defined by the "clinical pulmonary infections score" (CPIS) greater or equal to seven during the course of intubation and that remained elevated (=7) for at least three days (i.e. for two consecutive measurements)
Mortality: in hospital

Notes
Personal contact with the main investigator provided data about 27 patients who were excluded from the published paper (20 early extubations, seven early deaths); these data are considered in the analysis

Risk of bias

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Quinio 1995

Methods
Randomised, placebo-controlled study. Intention to treat
Blinding: double blind
Randomisation method: randomisation made by the Pharmacy’s Service according to computer generated random numbers.
Accrual period: Jan 91 to Jan 93

Participants
Eligibility criteria: trauma patients intubated within 24 hrs and ventilated for more than 48 hrs, ICU stay > five days and decontamination for more than four days
Exclusion criteria: age < 16 yrs, antibiotic treatment in the week precedent to ICU admission, pregnancy

Number of patients enrolled in the study: 149
Percentage of ventilated patients: 100%
Length of stay in ICU, mean = 20.5 days
Type of admission diagnosis: medical 2% trauma 98%
Severity score on admission: SAPS mean = 11.2, ISS mean = 31.3
GCS mean 6.5
Percentage of immunocompromised patients: 0%
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 35% CTR = 26%
Stress ulcer prophylaxis applied: sucralfate until enteral feeding was effective, H2-blockers in high risk patients
Interventions

Group A, Treatment:
- polymyxin E 100 mg, gentamicin 80 mg, amphotericin B 500 mg applied enteraly and in the nares and, as a 2% paste, to the oropharynx four times a day until extubation or starting of enteral nutrition

Group B, CTR:
- Placebo

Outcomes

Respiratory infections (pneumonia acquired after 48 hrs): Diagnosis of infection was based on:
- purulent tracheal aspirate, fever > 38.5°C, leukocytosis > 10,000 WBC/mm$^3$, new and persistent infiltrate on chest X-ray

Mortality: in ICU

Notes

Risk of bias

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Rocha 1992

Methods

Randomised, placebo-controlled study
Blinding: double blind
Randomisation method: made by the Pharmacy’s service according to computer generated random numbers
Accrual period: Sept 89 to Oct 90

Participants

Eligibility criteria: expected mechanical ventilation for more than three days, stay in ICU more than five days
Exclusion criteria: infection or strong suspicion of this at the start of ventilation, antibiotic treatment in the previous seven days, neutropenia (WBC < 500/mm$^3$) and fever, pregnancy, history of hypersensitivity to the topical agents

Number of patients enrolled in the study: 151
Percentage of ventilated patients: 100%
Length of stay in ICU, median eight days
Type of admission diagnosis: medical 28% surgical scheduled 3% surgical unscheduled 1% trauma 68%
Severity score on admission: APACHE II mean = 16.3, ISS not available, GCS mean = nine
Percentage of immunocompromised patients: 0.7%
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 0% CTR = 0%
Stress ulcer prophylaxis applied: H2-blockers and antiacids

Interventions

Group A, Treatment:
- polymyxin E 100 mg, tobramycin 80 mg, amphotericin B 500 mg applied enteraly and, as a 2% paste, to the oropharynx four times a day
- cefotaxime 6 g/day iv for the first four days

Group B, CTR:
- Placebo
- No systemic prophylaxis

Outcomes

Respiratory infections (acquired pneumonia):
Diagnosis of infection was based on:
- purulent pulmonary secretions, new infiltrates in the chest X-ray and one of the following: fever/hypothermia, leukocytosis/leukopenia, positive physical examination, drop in arterial partial oxygen pressure. Bacteriologic diagnosis, even if performed (with brush in few patients), was not essential

Mortality: in ICU

Notes

Personal contact with the main investigator provided mortality data about 50 patients who were excluded from the published paper (15 early extubations, 31 early deaths, two protocol violation, two other); these data are considered in the analysis. Data about respiratory infections in excluded patients are not available

**Risk of bias**

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**Rodriguez-Rolda 1990**

**Methods**
- Randomised, placebo-controlled, dual-center study
- Blinding: double blind
- Randomisation method: odd and even numbers
- Accrual period: Jun 88 to Dec 88

**Participants**
- Eligibility criteria: patients intubated an mechanically ventilated for more than 72 hrs
- Exclusion criteria: patients whose chest X-rays was difficult to interpret, with suspected inflammatory images during the first 72 hrs, patients ventilated for less time

- Number of patients enrolled in the study: 31
- Percentage of ventilated patients: 100%
- Length of stay in ICU, median 13.5 days
- Type of admission diagnosis: medical 39% surgical scheduled 16% surgical unscheduled 3% trauma 42%
- Severity score on admission: APACHE II mean = 17.1, ISS not available
- Percentage of immunocompromised patients: 0%
- Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 36% CTR = 35%
- Stress ulcer prophylaxis applied: sucralfate or alkaline agents plus ranitidine according to a randomised open protocol

**Interventions**
- Group A, Treatment:
  - polymyxin E, Tobramycin or Netilmicin, amphotericin B and antiseptic applied enterally and, as a 2% paste, to the oropharynx four times a day
  - Antiseptic
- Group B, CTR:
  - Placebo
  - Antiseptic

**Outcomes**
- Respiratory infections (pneumonia acquired after 72 hrs): Diagnosis of infection was based on the presence of at least one in each category of criteria:
  - A) Clinical criteria: temperature > 38°C, purulent bronchorrhoea, leukocytosis > 15,000 WBC/mm³, increased alveolar-arterial oxygen gradient;
  - B) Radiologic criteria: new and persistent infiltrate;
  - C) Bacteriologic criteria: quantitative culture of tracheal aspirates > 10^3 CFU/ml (in six patients either bronchoscopy or a telescoped catheter were used to obtain the sample)
**Rodriguez-Roldan 1990 (Continued)**

Mortality: in ICU

**Notes**

Personal contact with the main investigator provided data about three patients who were excluded from the published paper (two early deaths, one other); these data are considered in the analysis

**Risk of bias**

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**Sanchez-Garcia 1992**

**Methods**

Randomised, placebo-controlled, multicentric (five ICUs) study
Blinding: double blind
Randomisation method: sealed envelopes.
Accrual period: not available

**Participants**

Eligibility criteria: expected ventilation for longer than 48 hrs, age > 16 yrs
Exclusion criteria: death or extubation before 48 hrs, pregnancy, allergy to study antibiotics, organ transplantation, absence or contraindication to nasogastric tube

Number of patients enrolled in the study: 271
Percentage of ventilated patients: 100%
Length of stay in ICU, median 13 days
Type of admission diagnosis: medical 70% surgical scheduled 3% surgical unscheduled 9% trauma 18%
Severity score on admission: APACHE II mean = 26.6, ISS not available
Percentage of immunocompromised patients: 4.4%
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 70% CTR = 69%
Stress ulcer prophylaxis applied: each group was randomised to receive either sucralfate or H2-blockers

**Interventions**

Group A, Treatment:
- polymyxin E 100 mg, gentamycin 80 mg, amphotericin B 500 mg applied orally and enterally four times a day until extubation
- Ceftriaxone 2 g/day iv x three days to uninfected patients

Group B, CTR:
- Placebo
- Systemic placebo to uninfected patients

**Outcomes**

Respiratory infections (early and late acquired pneumonia):
Diagnosis of infection was based on:
new and persistent infiltrate on chest X-ray and three of the following: temperature > 38.5°C, leukocytosis > 12,000 WBC/mm³ or leukopenia < 3,000 WBC/mm³, purulent tracheal aspirate with growth of a potentially pathogenic micro-organism
Mortality: in ICU

**Notes**

Personal contact with the main investigator provided data about 45 patients who were excluded from the published paper (12 early extubations, 12 early deaths, 17 protocol violation, two transferring, two other); these data are considered in the analysis

**Risk of bias**
Sanchez-Garcia 1992 (Continued)

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Stoutenbeek 1996

**Methods**
- Randomised, placebo-controlled study
- Blinding: double blind.
- Randomisation method: closed envelope method (the code was known by the pharmacist only).
- Accrual period: Nov 84 to Aug 86

**Participants**
- Eligibility criteria: all patients admitted to the surgical ICU with blunt trauma and an HTI-ISS > 18, age > 18 yrs
- Exclusion criteria: patients mechanically ventilated for less than five days or discharged from ICU within seven days and with an HTI-ISS < 18 after 24 hrs
- Number of patients enrolled in the study: 91
- Percentage of ventilated patients: 100%
- Length of stay in ICU, mean = 15 days
- Type of admission diagnosis: trauma 100%
- Severity score on admission: APACHE II mean = 10.6, HTI-ISS mean = 35.1
- Percentage of immunocompromised patients: 0%
- Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 0% CTR = 0%
- Stress ulcer prophylaxis applied: none except for patients with history of preexisting ulcer or on H2-blockers

**Interventions**
- Group A, Treatment:
  - polymyxin E 100 mg, tobramycin 80 mg, amphotericin 500 mg applied enterally and, as a 2% paste, to the oropharynx four times a day until ICU discharge
  - cefotaxime 50 to 100 mg/kg/day iv for the first five days
- Group B, CTR:
  - Placebo
  - cefotaxime 50 to 100 mg/kg/day iv for the first five days

The blinded medication was discontinued and topical prophylaxis was started when a patient developed MOSF not responding to conventional therapy. The code was not broken and the patient was further evaluated

**Outcomes**
- Respiratory infections (tracheobronchitis and pneumonia - early and late infections)
- Diagnosis of infection was based on clinical criteria: temperature > 38.5°C, WBC > 12.5 x 10^9/l or leukopenia < 4 x 10^9/l, purulent secretions or X-ray changes and significant growth of bacteria
- Mortality: in ICU

**Notes**
- Data about 32 patients who were initially excluded (25 early extubations, four early deaths, three other) are considered in the analysis

Risk of bias

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Antibiotic prophylaxis to reduce respiratory tract infections and mortality in adults receiving intensive care (Review)
**Stoutenbeek 2007**

**Methods**  
Randomised, multicenter study. Intention to treat
Blinding: open
Randomisation method: randomisation lists prepared by the Biometrical Department and supplied with sealed envelopes
Accrual period: Oct 91 to Jun 94

**Participants**  
Eligibility criteria: patients admitted within 24 hrs after nonpenetrating blunt trauma with an HTI-ISS => 16, necessitating mechanical ventilation, age > 18 yrs
Exclusion criteria: previous antibiotic use for more than three days at study entry, allergy to cefotaxime, referred patients from other hospital or secondary admissions with trauma occurred > 24 hrs before

Number of patients enrolled in the study: 405, but 401 patients were analysed
Percentage of ventilated patients: 100%
Median length of ICU stay: SDD = 13 days, CTR = 12 days
Median duration of mechanical ventilation: SDD = nine days, CTR = eight days
Type of admission diagnosis: trauma 100%
Severity score on admission - APACHE II median: SDD = 15, CTR = 14 and HTI-ISS median: SDD = 34, CTR = 29
Percentage of immunocompromised patients: 0%
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 46% CTR = 88%
Stress ulcer prophylaxis applied: sucralfate, H2-blockers, omeprazole; no sucralfate

**Interventions**  
Group A, Treatment:
- polymyxin E, tobramycin, amphotericin B administered through the nasogastric tube and applied to the buccal mucosa four times a day until discharge
- cefotaxime 1 g every six hours for four days

Group B, CTR:
- Standard antibiotic prophylaxis used in each centres (no fluoroquinolones)

**Outcomes**  
Primary: Mortality from infection or multiple organ failure in ICU or up to two weeks after discharge
Secondary: incidence of infection, multiple organ failure and antibiotic usage

The maximum observation period was three months
Patients dying within 24 hours after injury or dying from craniocerebral trauma were excluded

Diagnosis of pneumonia was based on any of the following: presence of a new and progressive pulmonary infiltrate on chest X-ray for => 48 hrs, purulent tracheal aspirate, fever > 38.5°C, leukocytosis > 12,000/ml or leukopenia < 4000/ml
Diagnosis of tracheobronchitis was based on the same criteria except for the radiographic changes
Mortality: in ICU or up to two weeks after discharge

**Notes**  
four patients were excluded from the final analysis after randomisation: two because they did not fulfil the inclusion criteria, the data for one patient were not available and one was lost to follow-up after the 7th day

**Risk of bias**

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*Antibiotic prophylaxis to reduce respiratory tract infections and mortality in adults receiving intensive care (Review)*

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Ulrich 1989

Methods
Randomised, placebo-controlled study
Blinding: open
Randomisation method: sealed envelopes containing a random code for clusters of four patients
Accrual period: Oct 86 to Sep 87

Participants
Eligibility criteria: patients expected to stay in the ICU more than five days and ventilated more than 48 hrs
Exclusion criteria: patients who died within 24 hrs after randomisation
Number of patients enrolled in the study: 112
Percentage of ventilated patients: about 80%
Length of stay in ICU, median = 10 days
Type of admission diagnosis: medical 34% surgical scheduled 19% surgical unscheduled 31% trauma 16%
Severity score on admission: SAPS mean = 11.7, ISS mean = 36.9
Percentage of immunocompromised patients: 3%
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 83% CTR = 81%
Stress ulcer prophylaxis applied: not available

Interventions
Group A, Treatment:
- polymyxin E 100 mg, norfloxacin 50 mg, amphotericin B 500 mg, applied enterally and, as a 2% paste, to the oropharynx four times a day
- Trimethoprim 500 mg iv

Group B, CTR:
- Placebo

Outcomes
Respiratory infections (acquired pneumonia):
Diagnosis of infection was based on clinical and radiologic signs of pulmonary infiltrations with fever and leukocytosis and a dense growth in cultures of sputum of tracheal aspirate

Mortality: in ICU

Notes
Personal contact with the main investigator provided data about 12 patients who were excluded from the published paper (early death); these data are considered in the analysis

Risk of bias

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Unertl 1987

Methods
Randomised study
Blinding: outcome assessor
Randomisation method: blocked randomisation scheme and the sealed envelope technique. Blind
Accrual period: May 84 to Jan 85

Participants
Eligibility criteria: all patients admitted to the ICU with: intubation within 24 hrs after the onset of an acute disease or surgery, expected ventilation > six days, interval between intubation and first microbiologic culture < 36 hrs
Exclusion criteria: Patients with infection, systemic antibiotic treatment, respiratory distress syndrome, leucopenia and myelosuppression on admission, renal failure
Number of patients enrolled in the study: 39
Percentage of ventilated patients: 100%
Length of stay in ICU: not available
Type of admission diagnosis: medical 52%, surgical 15%, trauma 33%
Severity score on admission: SAPS mean = 12.5, GCS (75% of patients have GCS < 7)
Percentage of immunocompromised patients: not available
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: not available
Stress ulcer prophylaxis applied: H2-blockers to all patients and antacids if pH < 4

Interventions

**Group A, Treatment:**
- polymyxin B 50 mg, gentamycin 80 mg, applied orally, nasally and enterally four times a day until extubation
- Amphotericin B 300 mg applied orally four times a day

**Group B, CTR:**
- No prophylaxis

Outcomes

Respiratory infections (acquired pneumonia):
Diagnosis of infection was based on:
new 'definite' infiltrate on chest X-ray together with increasing amounts of purulent tracheobronchial secretion containing > 3 x 10^4 granulocytes/ml and at least two of the following: new febrile spikes > 38.5°C, blood leukocyte count > 12000/ml or < 4000/ml, decrease of PaO_2 requiring an increase of the FiO_2 of at least 15% to maintain oxygen tension.
'Definite' is an infiltrate confirmed by two blind independent radiologists and not reversible after chest physiotherapy
Mortality: in ICU

Notes

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Verwuest 1997

Methods
Randomised study with three arms (one control arm and two treatment arms)
Blinding: open
Randomisation method: sealed envelopes with computer generated random numbers
Accrual period: Sept 89 to Mar 91

Participants
Eligibility criteria: expected ventilation > 48 hrs
Exclusion criteria: age < 18 yrs, pregnancy, recent organ transplantation, serious granulocytopenia (<= 500 WBC/mm^3), ventilation < 48 hrs, death before 48 hrs, missing of essential data in the clinical or bacteriological dossier

Number of patients enrolled in the study: 660 (only two groups of patients, A and B, are considered in this comparison, totaling 440 patients)
Percentage of ventilated patients: 100%
Length of stay in ICU, mean = 19.6 days
Type of admission diagnosis: medical 10%, surgical 67% trauma 23%
Severity score on admission: APACHE II mean = 18.1, ISS not available
Percentage of immunocompromised patients: not available
Verwaest 1997 (Continued)

Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment one = 34% treatment two = 31% CTR = 34%
Stress ulcer prophylaxis applied: sucralfate 2 g x 4

Interventions

Group A, CTR:
- No prophylaxis, antibiotic therapy was used only if an infection was suspected

Group B, Treatment 1:
- Ofloxacin 200 mg x 2, Amphotericin B 500 mg x 4 applied enterally and, as a 2% paste, to the oropharynx four times a day until discharge
- Ofloxacin 200 mg iv x four days

Outcomes

Respiratory infections (pneumonia acquired after 48 hrs):
Diagnosis of infection was based on:
Fever > 38.5°C, leukocytosis > 10,000 cells/mcl, luxuriant growth of potentially pathogenic micro-organisms in culture of bronchial aspirate, new and persistent infiltrate on chest X-ray
Mortality: in ICU

Notes

Personal contact with the main investigator provided mortality data about 82 patients who were excluded (33 early deaths, 49 other); these data are considered in the analysis. Data about respiratory infections in excluded patients are not available

Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
<td>A - Adequate</td>
</tr>
</tbody>
</table>

Wiener 1995

Methods
Randomised, placebo-controlled study
Blinding: double blind
Randomisation method: random number table in blocks of six patients
Accrual period: eight months

Participants
Eligibility criteria: expected intubation for more than 48 hrs, inclusion within 18 hrs of intubation, age > 18 yrs
Exclusion criteria: refusal to consent, allergy to one of the components of the regimen, active inflammatory bowel disease
Patients enrolled in the study: 121, but 60 patients were excluded leaving 61 patients for analysis
Percentage of ventilated patients: 100%
Length of stay in ICU, mean: 11.3 days
Type of admission diagnosis: not available
Severity score on admission: APACHE II mean = 27.2, ISS not available
Percentage of immunocompromised patients: > 5%
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 93% CTR = 81%
Stress ulcer prophylaxis applied: H2-blockers to most patients

Interventions

Group A, Treatment:
- polymyxin E 100 mg, gentamycin 80 mg, nystatin 2,000,000 UI applied enterally four times a day and, as a 2% paste, to the oropharynx until extubation or tracheostomy

Group B, CTR:
### Outcomes

Respiratory infections (pneumonia acquired after 48 hrs): Diagnosis of infection was based on the presence of the following: persistence of a new or progressive infiltrate on chest-film, fever > 38.5°C and/or leukocytosis > 12,000/mm³, growth of > 10³ bacteria from a quantitative culture of lower respiratory tract secretions obtained with a blind protected catheter. Mortality: in ICU.

### Notes

60 patients were excluded after randomisation; data are not available.

### Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors' judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>B - Unclear</td>
</tr>
</tbody>
</table>

### Winter 1992

**Methods**

Randomised study  
Blinding: open.  
Randomisation method: sealed envelopes based on a computer generated table of random numbers.  
Accrual period: Jul 88 to May 90

**Participants**

Eligibility criteria: patients likely to remain in the ICU for at least 48 hrs  
Exclusion criteria: allergy to the antibiotics used, age > 85 yrs, pregnancy  
Patients enrolled in the study: 183  
Percentage of ventilated patients: 92%  
Length of stay in ICU, median = four days  
Type of admission diagnosis: medical 40% surgical scheduled 10% surgical unscheduled 37% trauma 13%  
Severity score on admission: APACHE II mean = 15.3, ISS mean = 26.2  
Percentage of immunocompromised patients: 2.2%  
Percentage of patients treated with systemic antibiotic therapy (not stated in the protocol) in the first three days: treatment = 47% CTR = 64%  
Stress ulcer prophylaxis applied: all CTR patients received sucralfate; H2-blockers were used in patients of both groups with peptic ulcer or pancreatitis

**Interventions**

**Group B, CTR:**  
- Conventional infections treatment and prophylaxis

**Group C, Treatment:**  
- polymyxin E 100mg, tobramycin 80mg, amphotericin B 500 mg applied enterally and, as a 2% gel, to the oropharynx four times a day  
- Ceftazidime 50mg/kg/day iv x three days

**Outcomes**

Respiratory infections (pneumonia acquired after 48 hrs): Diagnosis of infection was based on: temperature > 38.5°C two times in 24 hrs, WBC < 4 or > 12 x 10⁹/l, positive BAL, two of the following: new pulmonary infiltrates on chest X-ray, purulent sputum, increase of 15% in FiO₂ to maintain previous oxygenation  
Mortality: in hospital

**Notes**

Few patients were excluded after randomisation; data are not available.
Winter 1992 (Continued)

Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors' judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
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</tr>
</tbody>
</table>

APACHE Acute Physiology and Chronic Health Evaluation
ARDS Acute Respiratory Distress Syndrome
BAL Broncho-Alveolar-Lavage
CCU Coronary Care Unit
CDC Centre for Disease Control
CFU Colony Forming Unit
CI Confidence Interval
CTR Control group
GCS Glasgow Coma Score
hrs hours
HTI-ISS Hospital Trauma Index-Injury Severity Score
ICU Intensive Care Unit
ISS Injury Severity Score
iv intravenous
MOSF Multi-Organ-System-Failure
OR Odds Ratio
RCTs Randomised Controlled Trials
RD Risk Differences
RR Relative Risk
RTIs Respiratory Tract Infections
SAPS Simplified Acute Physiology Score
SDD Selective Decontamination of the Digestive Tract
VAP Ventilator Associated Pneumonia
VO2 Oxygen Consumption
yrs years
WBC White Blood Count

Characteristics of excluded studies [ordered by study ID]

<table>
<thead>
<tr>
<th>Study</th>
<th>Reason for exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arnow 1996</td>
<td>The study included a selected population of patients undergoing liver transplant</td>
</tr>
<tr>
<td>Barret 2001</td>
<td>The study included only paediatric burns patients</td>
</tr>
<tr>
<td>Bion 1994</td>
<td>The study included a selected population of patients undergoing liver transplant</td>
</tr>
<tr>
<td>Bouter 2002</td>
<td>The study included only patients undergoing cardiopulmonary by-pass</td>
</tr>
<tr>
<td>de la Cal 2005</td>
<td>The study included only critically ill burns patients</td>
</tr>
<tr>
<td>de Smet 2009</td>
<td>The study adopted a cluster design with type of treatments alternated for specific periods of time across participating hospitals. As a consequence patients were not properly randomised and the study could be affected by selection bias.</td>
</tr>
<tr>
<td>Flaherty 1990</td>
<td>The study included a selected population of cardio surgical patients</td>
</tr>
<tr>
<td>Garbino 2002</td>
<td>The study tested the effectiveness of fluconazole as both groups received SDD</td>
</tr>
<tr>
<td>Study</td>
<td>Reason for exclusion</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hellinger 2002</td>
<td>The study included only liver transplant patients</td>
</tr>
<tr>
<td>Hunefeld 1989</td>
<td>After contacting the principal investigator it became apparent that it was not a randomised study</td>
</tr>
<tr>
<td>Jacobs 1995</td>
<td>This study, included in the previous version of this review as a personal contact with the principal investigator, has been excluded due to lack of feedback from the trial author. To date, this study has never been published</td>
</tr>
<tr>
<td>Lenhart 1994</td>
<td>This study, included in the previous version of this review as a congress proceeding, has been replaced by its published article (Krueger 2002)</td>
</tr>
<tr>
<td>Lipman 1994</td>
<td>After contacting the principal investigator it became apparent that it was not a randomised study</td>
</tr>
<tr>
<td>Luiten 1995</td>
<td>The study included a selected population of patients affected by pancreatitis characterised by a low percentage of ICU admissions.</td>
</tr>
<tr>
<td>Martinez 1994</td>
<td>The study compared the effect of two different prophylactic regimens without a control group</td>
</tr>
<tr>
<td>Martinez-Pellus 1993</td>
<td>The study included a selected population of cardio surgical patients</td>
</tr>
<tr>
<td>Nardi 2001</td>
<td>The study tested the effectiveness of mupirocin as both groups received SDD</td>
</tr>
<tr>
<td>Rayes 2002</td>
<td>The study included only liver transplant patients</td>
</tr>
<tr>
<td>Rolando 1996</td>
<td>The study included a selected population of patients with acute hepatic failure</td>
</tr>
<tr>
<td>Ruza 1998</td>
<td>The study included only paediatric burns patients</td>
</tr>
<tr>
<td>Schardey 1997</td>
<td>The study included a selected population of patients undergoing gastric surgery and characterised by a low percentage of ICU admission</td>
</tr>
<tr>
<td>Smith 1993</td>
<td>The study included only paediatric, liver transplant patients</td>
</tr>
<tr>
<td>Stoutenbeek 2</td>
<td>This unpublished study, included in the previous version of this review, has been replaced by its published article (Stoutenbeek 2007)</td>
</tr>
<tr>
<td>Tetteroo 1990</td>
<td>The study included a selected population of patients undergoing oesophageal resection and characterised by a short length of stay in ICU</td>
</tr>
<tr>
<td>Zobel 1991</td>
<td>The study included only paediatric patients</td>
</tr>
<tr>
<td>Zwaveling 2002</td>
<td>The study included only liver transplant patients</td>
</tr>
</tbody>
</table>

**DATA AND ANALYSES**
### Comparison 1. Topical plus systemic versus no prophylaxis

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Overall mortality</strong></td>
<td>17</td>
<td>4075</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.75 [0.65, 0.87]</td>
</tr>
<tr>
<td><strong>2 Mortality according to quality of allocation concealment</strong></td>
<td>17</td>
<td>4075</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.75 [0.65, 0.87]</td>
</tr>
<tr>
<td>2.1 Adequate</td>
<td>10</td>
<td>3336</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.77 [0.66, 0.90]</td>
</tr>
<tr>
<td>2.2 Not adequate</td>
<td>7</td>
<td>739</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.67 [0.48, 0.93]</td>
</tr>
<tr>
<td><strong>3 Mortality according to blinding of the studies</strong></td>
<td>17</td>
<td>4075</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.75 [0.65, 0.87]</td>
</tr>
<tr>
<td>3.1 Double-blind</td>
<td>4</td>
<td>1013</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.63 [0.48, 0.83]</td>
</tr>
<tr>
<td>3.2 Open</td>
<td>13</td>
<td>3062</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.80 [0.68, 0.95]</td>
</tr>
<tr>
<td><strong>4 RTIs</strong></td>
<td>16</td>
<td>3024</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.28 [0.20, 0.38]</td>
</tr>
<tr>
<td><strong>5 RTIs according to quality of allocation concealment</strong></td>
<td>16</td>
<td>3024</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.28 [0.20, 0.38]</td>
</tr>
<tr>
<td>5.1 Adequate</td>
<td>9</td>
<td>2335</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.36 [0.27, 0.47]</td>
</tr>
<tr>
<td>5.2 Not adequate</td>
<td>7</td>
<td>689</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.19 [0.10, 0.37]</td>
</tr>
<tr>
<td><strong>6 RTIs according to blinding of the studies</strong></td>
<td>16</td>
<td>3024</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.28 [0.20, 0.38]</td>
</tr>
<tr>
<td>6.1 Double-blind</td>
<td>4</td>
<td>963</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.40 [0.30, 0.53]</td>
</tr>
<tr>
<td>6.2 Open</td>
<td>12</td>
<td>2061</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.22 [0.14, 0.34]</td>
</tr>
</tbody>
</table>

#### Analysis 1.1. Comparison 1 Topical plus systemic versus no prophylaxis, Outcome 1 Overall mortality.

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment</th>
<th>Control</th>
<th>Odds Ratio M-H, Fixed, 95% CI</th>
<th>Weight</th>
<th>Odds Ratio M-H, Fixed, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abele-Horn 1997</td>
<td>11/58</td>
<td>5/30</td>
<td>1.21%</td>
<td>1.17[0.37,3.74]</td>
<td></td>
</tr>
<tr>
<td>Aerdt's 1991</td>
<td>4/28</td>
<td>12/60</td>
<td>1.48%</td>
<td>0.67[0.19,2.29]</td>
<td></td>
</tr>
<tr>
<td>Blair 1991</td>
<td>24/161</td>
<td>32/170</td>
<td>6%</td>
<td>0.76[0.42,1.35]</td>
<td></td>
</tr>
<tr>
<td>Boland 1991</td>
<td>2/32</td>
<td>4/32</td>
<td>0.85%</td>
<td>0.47[0.08,2.75]</td>
<td></td>
</tr>
<tr>
<td>Cockernill 1992</td>
<td>11/75</td>
<td>16/75</td>
<td>3.09%</td>
<td>0.63[0.27,1.48]</td>
<td></td>
</tr>
<tr>
<td>de Jonge 2003</td>
<td>113/466</td>
<td>146/468</td>
<td>24.99%</td>
<td>0.71[0.53,0.94]</td>
<td></td>
</tr>
<tr>
<td>Finch 1991</td>
<td>15/24</td>
<td>10/25</td>
<td>0.83%</td>
<td>2.5[0.79,7.9]</td>
<td></td>
</tr>
<tr>
<td>Jacobs 1992</td>
<td>14/45</td>
<td>23/46</td>
<td>3.55%</td>
<td>0.45[0.19,1.06]</td>
<td></td>
</tr>
<tr>
<td>Kerver 1988</td>
<td>14/49</td>
<td>15/47</td>
<td>2.48%</td>
<td>0.85[0.36,2.04]</td>
<td></td>
</tr>
<tr>
<td>Krueger 2002</td>
<td>52/265</td>
<td>75/262</td>
<td>13.73%</td>
<td>0.61[0.41,0.91]</td>
<td></td>
</tr>
<tr>
<td>Palomar 1997</td>
<td>14/50</td>
<td>14/49</td>
<td>2.31%</td>
<td>0.97[0.41,2.33]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Favours treatment</th>
<th>0.1</th>
<th>0.2</th>
<th>0.5</th>
<th>1</th>
<th>2</th>
<th>5</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favours control</td>
<td>0.1</td>
<td>0.2</td>
<td>0.5</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>10</td>
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</tbody>
</table>
### Analysis 1.2. Comparison 1 Topical plus systemic versus no prophylaxis, Outcome 2 Mortality according to quality of allocation concealment.

#### 1.2.1 Adequate

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H, Fixed, 95% CI</td>
<td></td>
<td>M-H, Fixed, 95% CI</td>
</tr>
<tr>
<td>Aerds 1991</td>
<td>4/28</td>
<td>12/60</td>
<td>1.48%</td>
<td>1.48%</td>
<td>0.67[0.19,2.29]</td>
</tr>
<tr>
<td>Blair 1991</td>
<td>24/161</td>
<td>32/170</td>
<td>6%</td>
<td>6%</td>
<td>0.76[0.42,1.35]</td>
</tr>
<tr>
<td>de Jonge 2003</td>
<td>113/466</td>
<td>146/468</td>
<td>24.99%</td>
<td>24.99%</td>
<td>0.71[0.53,0.94]</td>
</tr>
<tr>
<td>Finch 1991</td>
<td>15/24</td>
<td>10/25</td>
<td>0.83%</td>
<td>0.83%</td>
<td>2.5[0.79,7.9]</td>
</tr>
<tr>
<td>Sanchez-Garcia 1992</td>
<td>51/131</td>
<td>65/140</td>
<td>8.69%</td>
<td>8.69%</td>
<td>0.74[0.45,1.19]</td>
</tr>
<tr>
<td>Stoutenbeek 2007</td>
<td>42/201</td>
<td>44/200</td>
<td>7.9%</td>
<td>7.9%</td>
<td>0.94[0.58,1.51]</td>
</tr>
<tr>
<td>Ulrich 1989</td>
<td>22/55</td>
<td>33/57</td>
<td>4.4%</td>
<td>4.4%</td>
<td>0.48[0.23,1.03]</td>
</tr>
<tr>
<td>Verwaest 1997</td>
<td>47/220</td>
<td>40/220</td>
<td>7.12%</td>
<td>7.12%</td>
<td>1.22[0.76,1.96]</td>
</tr>
<tr>
<td>Winter 1992</td>
<td>33/91</td>
<td>40/92</td>
<td>5.74%</td>
<td>5.74%</td>
<td>0.74[0.41,1.34]</td>
</tr>
<tr>
<td>Krueger 2002</td>
<td>52/265</td>
<td>75/262</td>
<td>13.73%</td>
<td>13.73%</td>
<td>0.61[0.41,0.91]</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>1642</strong></td>
<td><strong>1694</strong></td>
<td><strong>80.88%</strong></td>
<td><strong>80.88%</strong></td>
<td><strong>0.77[0.66,0.9]</strong></td>
</tr>
</tbody>
</table>

Total events: 403 (Treatment), 497 (Control)

Heterogeneity: $\tau^2=0.00$, $p=0.92$; $I^2=22.31\%$

Test for overall effect: $Z=3.23$ ($P=0.00$)

#### 1.2.2 Not adequate

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H, Fixed, 95% CI</td>
<td></td>
<td>M-H, Fixed, 95% CI</td>
</tr>
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<td>5/30</td>
<td>1.21%</td>
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<tr>
<td>Boland 1991</td>
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<td>4/32</td>
<td>0.85%</td>
<td>0.85%</td>
<td>0.47[0.08,2.75]</td>
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<tr>
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<td>11/75</td>
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<td>0.63[0.27,1.48]</td>
</tr>
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<td>23/46</td>
<td>3.55%</td>
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<td>0.45[0.19,1.06]</td>
</tr>
<tr>
<td>Kerver 1988</td>
<td>14/49</td>
<td>15/47</td>
<td>2.48%</td>
<td>2.48%</td>
<td>0.85[0.36,2.04]</td>
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<tr>
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<td>14/50</td>
<td>14/49</td>
<td>2.31%</td>
<td>2.31%</td>
<td>0.97[0.41,2.33]</td>
</tr>
<tr>
<td>Rocha 1992</td>
<td>27/74</td>
<td>40/77</td>
<td>5.64%</td>
<td>5.64%</td>
<td>0.53[0.28,1.02]</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>383</strong></td>
<td><strong>356</strong></td>
<td><strong>19.12%</strong></td>
<td><strong>19.12%</strong></td>
<td><strong>0.67[0.48,0.93]</strong></td>
</tr>
</tbody>
</table>

Total events: 93 (Treatment), 117 (Control)

Heterogeneity: $\tau^2=0.00$, $p=0.92$; $I^2=0\%$

Test for overall effect: $Z=2.39$ ($P=0.02$)

Total (95% CI) 2025 2050 100% 0.75[0.65,0.87]

Total events: 496 (Treatment), 614 (Control)
### Analysis 1.3. Comparison 1 Topical plus systemic versus no prophylaxis, Outcome 3 Mortality according to blinding of the studies.

#### 1.3.1 Double-blind

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment n/N</th>
<th>Control n/N</th>
<th>Odds Ratio M-H, Fixed, 95% CI</th>
<th>Weight</th>
<th>Odds Ratio M-H, Fixed, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boland 1991</td>
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</tr>
<tr>
<td>Krueger 2002</td>
<td>52/265</td>
<td>75/262</td>
<td></td>
<td>13.73%</td>
<td>0.61[0.41,0.91]</td>
</tr>
<tr>
<td>Rocha 1992</td>
<td>27/74</td>
<td>40/77</td>
<td></td>
<td>5.64%</td>
<td>0.53[0.28,1.02]</td>
</tr>
<tr>
<td>Sanchez-Garcia 1992</td>
<td>51/131</td>
<td>65/140</td>
<td></td>
<td>8.69%</td>
<td>0.74[0.45,1.19]</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>502</strong></td>
<td><strong>511</strong></td>
<td></td>
<td><strong>28.9%</strong></td>
<td><strong>0.63[0.48,0.83]</strong></td>
</tr>
</tbody>
</table>

Total events: 132 (Treatment), 184 (Control)

Heterogeneity: Tau²=0; Chi²=0.79, df=3 (P=0.85); I²=0%

Test for overall effect: Z=3.3 (P=0)

#### 1.3.2 Open

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment n/N</th>
<th>Control n/N</th>
<th>Odds Ratio M-H, Fixed, 95% CI</th>
<th>Weight</th>
<th>Odds Ratio M-H, Fixed, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abele-Horn 1997</td>
<td>11/58</td>
<td>5/30</td>
<td></td>
<td>1.21%</td>
<td>1.17[0.37,3.74]</td>
</tr>
<tr>
<td>Aerds 1991</td>
<td>4/28</td>
<td>12/60</td>
<td></td>
<td>1.48%</td>
<td>0.67[0.19,2.29]</td>
</tr>
<tr>
<td>Blair 1991</td>
<td>24/161</td>
<td>32/170</td>
<td></td>
<td>6%</td>
<td>0.76[0.42,1.35]</td>
</tr>
<tr>
<td>Cockerill 1992</td>
<td>11/75</td>
<td>16/75</td>
<td></td>
<td>3.09%</td>
<td>0.63[0.27,1.48]</td>
</tr>
<tr>
<td>de Jonge 2003</td>
<td>113/466</td>
<td>146/468</td>
<td></td>
<td>24.99%</td>
<td>0.71[0.53,0.94]</td>
</tr>
<tr>
<td>Finch 1991</td>
<td>15/24</td>
<td>10/25</td>
<td></td>
<td>0.83%</td>
<td>2.5[0.79,7.9]</td>
</tr>
<tr>
<td>Jacobs 1992</td>
<td>14/45</td>
<td>23/46</td>
<td></td>
<td>3.55%</td>
<td>0.45[0.19,1.06]</td>
</tr>
<tr>
<td>Kerver 1988</td>
<td>14/49</td>
<td>15/47</td>
<td></td>
<td>2.48%</td>
<td>0.85[0.36,2.04]</td>
</tr>
<tr>
<td>Palomar 1997</td>
<td>14/50</td>
<td>14/49</td>
<td></td>
<td>2.31%</td>
<td>0.97[0.41,2.33]</td>
</tr>
<tr>
<td>Stoutenbeek 2007</td>
<td>42/201</td>
<td>44/200</td>
<td></td>
<td>7.9%</td>
<td>0.94[0.58,1.51]</td>
</tr>
<tr>
<td>Ullrich 1989</td>
<td>22/55</td>
<td>33/57</td>
<td></td>
<td>4.4%</td>
<td>0.48[0.23,1.03]</td>
</tr>
<tr>
<td>Verwaest 1997</td>
<td>47/220</td>
<td>40/220</td>
<td></td>
<td>7.12%</td>
<td>1.22[0.76,1.96]</td>
</tr>
<tr>
<td>Winter 1992</td>
<td>33/91</td>
<td>40/92</td>
<td></td>
<td>5.74%</td>
<td>0.74[0.41,1.34]</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>1523</strong></td>
<td><strong>1539</strong></td>
<td></td>
<td><strong>71.1%</strong></td>
<td><strong>0.8[0.68,0.95]</strong></td>
</tr>
</tbody>
</table>

Total events: 364 (Treatment), 430 (Control)

Heterogeneity: Tau²=0; Chi²=12.55, df=12 (P=0.4); I²=4.36%

Test for overall effect: Z=2.61 (P=0.01)

#### Total (95% CI)

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>2025</td>
<td>2050</td>
</tr>
</tbody>
</table>

Total events: 496 (Treatment), 614 (Control)

Heterogeneity: Tau²=0; Chi²=15.55, df=16 (P=0.49); I²=0%

Test for overall effect: Z=3.94 (P=0.0001)

Test for subgroup differences: Chi²=2.24, df=1 (P=0.13), I²=55.36%
### Analysis 1.4. Comparison 1 Topical plus systemic versus no prophylaxis, Outcome 4 RTIs.

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H, Random, 95% CI</td>
<td></td>
<td>M-H, Random, 95% CI</td>
</tr>
<tr>
<td>Abele-Horn 1997</td>
<td>13/58</td>
<td>23/30</td>
<td>5.34% 0.09 [0.03,0.25]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aerdts 1991</td>
<td>1/28</td>
<td>29/60</td>
<td>1.94% 0.04 [0.01,0.31]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blair 1991</td>
<td>12/161</td>
<td>38/170</td>
<td>8.17% 0.28 [0.14,0.56]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boland 1991</td>
<td>14/32</td>
<td>17/32</td>
<td>5.75% 0.69 [0.26,1.84]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cockerill 1992</td>
<td>4/75</td>
<td>12/75</td>
<td>4.58% 0.30 [0.09,0.96]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finch 1991</td>
<td>4/20</td>
<td>7/24</td>
<td>3.58% 0.61 [0.15,2.48]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jacobs 1992</td>
<td>0/45</td>
<td>4/46</td>
<td>1.02% 0.10 [0.01,1.99]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kerver 1988</td>
<td>5/49</td>
<td>31/47</td>
<td>5% 0.06 [0.02,0.18]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palomar 1997</td>
<td>10/50</td>
<td>25/49</td>
<td>6.43% 0.24 [0.10,0.59]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rocha 1992</td>
<td>7/47</td>
<td>25/54</td>
<td>5.89% 0.20 [0.08,0.53]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sanchez-Garcia 1992</td>
<td>32/131</td>
<td>60/140</td>
<td>9.91% 0.43 [0.26,0.73]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stoutenbeek 2007</td>
<td>62/201</td>
<td>100/200</td>
<td>11.11% 0.45 [0.30,0.67]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulrich 1989</td>
<td>7/55</td>
<td>26/57</td>
<td>6% 0.17 [0.07,0.45]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verwaest 1997</td>
<td>22/193</td>
<td>40/185</td>
<td>9.43% 0.47 [0.26,0.82]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winter 1992</td>
<td>3/91</td>
<td>17/92</td>
<td>4.17% 0.15 [0.04,0.53]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Krueger 2002</td>
<td>91/265</td>
<td>149/262</td>
<td>11.69% 0.40 [0.28,0.56]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>1501</strong></td>
<td><strong>1523</strong></td>
<td>100% 0.28 [0.20,0.38]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total events: 287 (Treatment), 603 (Control)
Heterogeneity: Tau²=0.18; Chi²=33.77, df=15(P=0); I²=55.58%
Test for overall effect: Z=8.11(P<0.0001)

### Analysis 1.5. Comparison 1 Topical plus systemic versus no prophylaxis, Outcome 5 RTIs according to quality of allocation concealment.

#### 1.5.1 Adequate

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H, Random, 95% CI</td>
<td></td>
<td>M-H, Random, 95% CI</td>
</tr>
<tr>
<td>Aerdts 1991</td>
<td>1/28</td>
<td>29/60</td>
<td>1.94% 0.04 [0.01,0.31]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blair 1991</td>
<td>12/161</td>
<td>38/170</td>
<td>8.17% 0.28 [0.14,0.56]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finch 1991</td>
<td>4/20</td>
<td>7/24</td>
<td>3.58% 0.61 [0.26,0.73]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sanchez-Garcia 1992</td>
<td>32/131</td>
<td>60/140</td>
<td>9.91% 0.43 [0.26,0.73]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stoutenbeek 2007</td>
<td>62/201</td>
<td>100/200</td>
<td>11.11% 0.45 [0.30,0.67]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulrich 1989</td>
<td>7/55</td>
<td>26/57</td>
<td>6% 0.17 [0.07,0.45]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verwaest 1997</td>
<td>22/193</td>
<td>40/185</td>
<td>9.43% 0.47 [0.26,0.82]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winter 1992</td>
<td>3/91</td>
<td>17/92</td>
<td>4.17% 0.15 [0.04,0.53]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Krueger 2002</td>
<td>91/265</td>
<td>149/262</td>
<td>11.69% 0.40 [0.28,0.56]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>1145</strong></td>
<td><strong>1190</strong></td>
<td><strong>66.01% 0.36 [0.27,0.47]</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total events: 234 (Treatment), 466 (Control)
Heterogeneity: Tau²=0.05; Chi²=12.03, df=8(P=0.15); I²=33.49%
Test for overall effect: Z=7.37(P<0.0001)

#### 1.5.2 Not adequate

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H, Random, 95% CI</td>
<td></td>
<td>M-H, Random, 95% CI</td>
</tr>
<tr>
<td>Abele-Horn 1997</td>
<td>13/58</td>
<td>23/30</td>
<td>5.34% 0.09 [0.03,0.25]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kerver 1988</td>
<td>5/49</td>
<td>31/47</td>
<td>5% 0.06 [0.02,0.18]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boland 1991</td>
<td>14/32</td>
<td>17/32</td>
<td>5.75% 0.69 [0.26,1.84]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cockerill 1992</td>
<td>4/75</td>
<td>12/75</td>
<td>4.58% 0.30 [0.09,0.96]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Analysis 1.6. Comparison 1 Topical plus systemic versus no prophylaxis, Outcome 6 RTIs according to blinding of the studies.

#### 1.6.1 Double-blind

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H, Random, 95% CI</td>
<td>M-H, Random, 95% CI</td>
<td></td>
</tr>
<tr>
<td>Boland 1991</td>
<td>14/32</td>
<td>17/32</td>
<td>5.75%</td>
<td>0.69[0.26,1.84]</td>
<td></td>
</tr>
<tr>
<td>Rocha 1992</td>
<td>7/47</td>
<td>25/54</td>
<td>5.89%</td>
<td>0.2[0.08,0.53]</td>
<td></td>
</tr>
<tr>
<td>Sanchez-Garcia 1992</td>
<td>32/131</td>
<td>60/140</td>
<td>9.91%</td>
<td>0.43[0.26,0.73]</td>
<td></td>
</tr>
<tr>
<td>Krueger 2002</td>
<td>91/265</td>
<td>149/262</td>
<td>11.69%</td>
<td>0.4[0.28,0.56]</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>475</strong></td>
<td><strong>488</strong></td>
<td><strong>33.23%</strong></td>
<td><strong>0.4[0.3,0.53]</strong></td>
<td></td>
</tr>
</tbody>
</table>

Total events: 144 (Treatment), 251 (Control)

Heterogeneity: Tau²=0.18; Chi²=33.77, df=15 (P=0); I²=55.58%

Test for overall effect: Z=6.37 (P=0.0001)

Test for subgroup differences: Chi²=0.37, df=3 (P=0.37); I²=4.29%

Test for overall effect: Z=6.37 (P=0.0001)

#### 1.6.2 Open

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H, Random, 95% CI</td>
<td>M-H, Random, 95% CI</td>
<td></td>
</tr>
<tr>
<td>Abele-Horn 1997</td>
<td>13/58</td>
<td>23/30</td>
<td>5.34%</td>
<td>0.09[0.03,0.25]</td>
<td></td>
</tr>
<tr>
<td>Aerdts 1991</td>
<td>2/28</td>
<td>29/60</td>
<td>1.94%</td>
<td>0.04[0.01,0.31]</td>
<td></td>
</tr>
<tr>
<td>Blair 1991</td>
<td>12/161</td>
<td>38/170</td>
<td>8.17%</td>
<td>0.28[0.14,0.56]</td>
<td></td>
</tr>
<tr>
<td>Cockerill 1992</td>
<td>4/75</td>
<td>12/75</td>
<td>4.58%</td>
<td>0.3[0.2,0.76]</td>
<td></td>
</tr>
<tr>
<td>Finch 1991</td>
<td>4/20</td>
<td>7/24</td>
<td>3.58%</td>
<td>0.61[0.15,2.48]</td>
<td></td>
</tr>
<tr>
<td>Jacobs 1992</td>
<td>0/45</td>
<td>4/46</td>
<td>1.02%</td>
<td>0.1[0.01,1.19]</td>
<td></td>
</tr>
<tr>
<td>Kerver 1988</td>
<td>5/49</td>
<td>31/47</td>
<td>5%</td>
<td>0.06[0.02,0.18]</td>
<td></td>
</tr>
<tr>
<td>Palomar 1997</td>
<td>10/50</td>
<td>25/49</td>
<td>6.43%</td>
<td>0.24[0.1,0.59]</td>
<td></td>
</tr>
<tr>
<td>Stoutenbeek 2007</td>
<td>62/201</td>
<td>100/200</td>
<td>11.11%</td>
<td>0.45[0.3,0.67]</td>
<td></td>
</tr>
<tr>
<td>Ullrich 1989</td>
<td>7/55</td>
<td>26/57</td>
<td>6%</td>
<td>0.17[0.07,0.45]</td>
<td></td>
</tr>
<tr>
<td>Verwaest 1997</td>
<td>22/193</td>
<td>40/185</td>
<td>9.43%</td>
<td>0.47[0.26,0.82]</td>
<td></td>
</tr>
<tr>
<td>Winter 1992</td>
<td>3/91</td>
<td>17/92</td>
<td>4.17%</td>
<td>0.15[0.04,0.53]</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>1026</strong></td>
<td><strong>1035</strong></td>
<td><strong>66.77%</strong></td>
<td><strong>0.22[0.14,0.34]</strong></td>
<td></td>
</tr>
</tbody>
</table>

Total events: 143 (Treatment), 352 (Control)

Heterogeneity: Tau²=0.3; Chi²=27.71, df=11 (P=0); I²=60.3%

Test for overall effect: Z=6.75 (P=0.0001)

Test for overall effect: Z=6.75 (P=0.0001)
## Comparison 2. Topical versus control

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall mortality</strong></td>
<td>20</td>
<td>3016</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.97 [0.82, 1.16]</td>
</tr>
<tr>
<td><strong>Topical plus systemic versus systemic</strong></td>
<td>7</td>
<td>1233</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.98 [0.73, 1.32]</td>
</tr>
<tr>
<td><strong>Topical versus no prophylaxis</strong></td>
<td>13</td>
<td>1783</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.97 [0.79, 1.20]</td>
</tr>
<tr>
<td><strong>Mortality according to quality of allocation concealment</strong></td>
<td>20</td>
<td>3016</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.97 [0.82, 1.16]</td>
</tr>
<tr>
<td><strong>Adequate</strong></td>
<td>2</td>
<td>139</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.64 [0.27, 1.52]</td>
</tr>
<tr>
<td><strong>Not adequate</strong></td>
<td>18</td>
<td>2877</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.99 [0.83, 1.18]</td>
</tr>
<tr>
<td><strong>Mortality according to blinding of the studies</strong></td>
<td>20</td>
<td>3016</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.98 [0.82, 1.16]</td>
</tr>
<tr>
<td><strong>Double-blind</strong></td>
<td>15</td>
<td>2601</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.99 [0.83, 1.20]</td>
</tr>
<tr>
<td><strong>Open</strong></td>
<td>5</td>
<td>415</td>
<td>Odds Ratio (M-H, Fixed, 95% CI)</td>
<td>0.88 [0.56, 1.37]</td>
</tr>
<tr>
<td><strong>RTIs</strong></td>
<td>18</td>
<td>2850</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.44 [0.31, 0.63]</td>
</tr>
<tr>
<td><strong>Topical plus systemic versus systemic</strong></td>
<td>6</td>
<td>1115</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.79 [0.56, 1.13]</td>
</tr>
<tr>
<td><strong>Topical versus no prophylaxis</strong></td>
<td>12</td>
<td>1735</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.34 [0.21, 0.55]</td>
</tr>
<tr>
<td><strong>RTIs according to quality of allocation concealment</strong></td>
<td>18</td>
<td>2850</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.44 [0.31, 0.63]</td>
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<tr>
<td><strong>Adequate</strong></td>
<td>1</td>
<td>91</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.18 [0.04, 0.91]</td>
</tr>
<tr>
<td><strong>Not adequate</strong></td>
<td>17</td>
<td>2759</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.46 [0.32, 0.66]</td>
</tr>
<tr>
<td><strong>RTIs according to blinding of the studies</strong></td>
<td>18</td>
<td>2850</td>
<td>Odds Ratio (M-H, Random, 95% CI)</td>
<td>0.44 [0.31, 0.63]</td>
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</tbody>
</table>
### Analysis 2.1. Comparison 2 Topical versus control, Outcome 1 Overall mortality.

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment n/N</th>
<th>Control n/N</th>
<th>Odds Ratio M-H, Fixed, 95% CI</th>
<th>Weight</th>
<th>Odds Ratio M-H, Fixed, 95% CI</th>
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<tbody>
<tr>
<td><strong>2.1.1 Topical plus systemic versus systemic</strong></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Ferrer 1994</td>
<td>15/51</td>
<td>14/50</td>
<td>3.75%</td>
<td>0.10</td>
<td>1.07 [0.45, 2.54]</td>
</tr>
<tr>
<td>Guassorgues 1991</td>
<td>29/59</td>
<td>29/59</td>
<td>5.54%</td>
<td>0.16</td>
<td>1 [0.49, 2.06]</td>
</tr>
<tr>
<td>Hammond 1992</td>
<td>34/162</td>
<td>31/160</td>
<td>9.25%</td>
<td>0.35</td>
<td>1.11 [0.64, 1.91]</td>
</tr>
<tr>
<td>Laggner 1994</td>
<td>9/33</td>
<td>14/34</td>
<td>3.77%</td>
<td>0.15</td>
<td>0.54 [0.19, 1.5]</td>
</tr>
<tr>
<td>Lingnau 1997</td>
<td>9/90</td>
<td>17/177</td>
<td>3.87%</td>
<td>0.12</td>
<td>1.05 [0.45, 2.45]</td>
</tr>
<tr>
<td>Lingnau 1997b</td>
<td>13/90</td>
<td>17/177</td>
<td>3.68%</td>
<td>0.11</td>
<td>1.59 [0.73, 3.44]</td>
</tr>
<tr>
<td>Stoutenbeek 1996</td>
<td>2/49</td>
<td>8/42</td>
<td>3.1%</td>
<td>0.05</td>
<td>0.18 [0.04, 0.91]</td>
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<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td>534</td>
<td>699</td>
<td>32.96%</td>
<td>0.98</td>
<td>0.98 [0.73, 1.32]</td>
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<tr>
<td><strong>Total events</strong>: 111 (Treatment), 130 (Control)</td>
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<tr>
<td>Heterogeneity: Tau²=0; Chi²=7.32, df=6 (P=0.29); I²=18.04%</td>
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<td>Test for overall effect: Z =0.14 (P=0.89)</td>
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<tr>
<td><strong>2.1.2 Topical versus no prophylaxis</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Bergmans 2001</td>
<td>30/87</td>
<td>59/139</td>
<td>11.17%</td>
<td>0.71</td>
<td>0.41 [1.12, 1.24]</td>
</tr>
<tr>
<td>Brun-Buisson 1989</td>
<td>14/65</td>
<td>15/68</td>
<td>4.32%</td>
<td>0.97</td>
<td>0.63 [0.22, 1.2]</td>
</tr>
<tr>
<td>Camus 2005</td>
<td>32/130</td>
<td>34/126</td>
<td>9.77%</td>
<td>0.88</td>
<td>0.5 [0.46, 1.55]</td>
</tr>
<tr>
<td>Cerra 1992</td>
<td>13/25</td>
<td>10/23</td>
<td>1.88%</td>
<td>1.41</td>
<td>0.13 [2.75]</td>
</tr>
<tr>
<td>Gastinne 1992</td>
<td>88/220</td>
<td>82/225</td>
<td>18.26%</td>
<td>0.16</td>
<td>0.79 [1.97, 1.7]</td>
</tr>
<tr>
<td>Georges 1994</td>
<td>3/31</td>
<td>5/33</td>
<td>1.64%</td>
<td>0.66</td>
<td>0.13 [2.75]</td>
</tr>
<tr>
<td>Korinek 1993</td>
<td>22/96</td>
<td>17/95</td>
<td>4.95%</td>
<td>1.36</td>
<td>0.67 [0.27, 1.77]</td>
</tr>
<tr>
<td>Pneumatikos 2002</td>
<td>5/31</td>
<td>7/30</td>
<td>2.24%</td>
<td>0.63</td>
<td>0.18 [2.27]</td>
</tr>
<tr>
<td>Pugin 1991</td>
<td>10/38</td>
<td>11/41</td>
<td>2.93%</td>
<td>0.97</td>
<td>0.36 [0.62, 2.65]</td>
</tr>
<tr>
<td>Quinio 1995</td>
<td>12/76</td>
<td>10/73</td>
<td>3.23%</td>
<td>1.18</td>
<td>0.48 [2.93]</td>
</tr>
<tr>
<td>Rodriguez-Rolda 1990</td>
<td>5/14</td>
<td>7/17</td>
<td>1.53%</td>
<td>0.79</td>
<td>0.18 [3.41]</td>
</tr>
<tr>
<td>Unertl 1987</td>
<td>5/19</td>
<td>6/20</td>
<td>1.62%</td>
<td>0.83</td>
<td>0.21 [3.38]</td>
</tr>
<tr>
<td>Wiener 1995</td>
<td>11/30</td>
<td>15/31</td>
<td>3.51%</td>
<td>0.62</td>
<td>0.22 [1.72]</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td>862</td>
<td>921</td>
<td>67.04%</td>
<td>0.97</td>
<td>0.79 [1.2]</td>
</tr>
<tr>
<td><strong>Total events</strong>: 250 (Treatment), 278 (Control)</td>
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</tr>
<tr>
<td>Heterogeneity: Tau²=0; Chi²=5.3, df=12 (P=0.95); I²=0%</td>
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<tr>
<td>Test for overall effect: Z =0.26 (P=0.8)</td>
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<tr>
<td><strong>Total (95% CI)</strong></td>
<td>1396</td>
<td>1620</td>
<td>100%</td>
<td>0.97</td>
<td>0.82 [1.16]</td>
</tr>
<tr>
<td><strong>Total events</strong>: 361 (Treatment), 408 (Control)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterogeneity: Tau²=0; Chi²=12.63, df=19 (P=0.86); I²=0%</td>
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</tr>
<tr>
<td>Test for overall effect: Z =0.29 (P=0.77)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test for subgroup differences: Chi²=0, df=1 (P=0.97); I²=0%</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Favours treatment

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<th>0.2</th>
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<th>5.0</th>
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</thead>
</table>

Favours control

---

Antibiotic prophylaxis to reduce respiratory tract infections and mortality in adults receiving intensive care (Review)  
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### Analysis 2.2. Comparison 2 Topical versus control, Outcome 2 Mortality according to quality of allocation concealment.

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H, Fixed, 95% CI</td>
<td></td>
<td>M-H, Fixed, 95% CI</td>
</tr>
<tr>
<td><strong>2.2.1 Adequate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerra 1992</td>
<td>13/25</td>
<td>10/23</td>
<td>1.88%</td>
<td>1.41[0.45,4.4]</td>
<td></td>
</tr>
<tr>
<td>Stoutenbeek 1996</td>
<td>2/49</td>
<td>8/42</td>
<td>3.1%</td>
<td>0.18[0.04,0.91]</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>74</strong></td>
<td><strong>65</strong></td>
<td><strong>4.98%</strong></td>
<td><strong>0.64[0.27,1.52]</strong></td>
<td></td>
</tr>
<tr>
<td>Total events: 15 (Treatment), 18 (Control)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterogeneity: Tau²=0; Chi²=4.2, df=1(P=0.04); I²=76.21%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test for overall effect: Z=1.01(P=0.31)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **2.2.2 Not adequate** |           |         |             |        |            |
| Bergmans 2001         | 30/87     | 59/139  | 9.25%       | 1.11[0.64,1.91] |           |
| Brun-Buisson 1989     | 14/65     | 15/68   | 4.95%       | 1.36[0.67,2.77] |           |
| Camus 2005            | 32/130    | 34/126  | 7.37%       | 0.50[0.19,1.55] |           |
| Ferrer 1994           | 15/51     | 14/50   | 3.75%       | 1.05[0.45,2.45] |           |
| Gastinne 1992         | 88/220    | 82/225  | 16.26%      | 1.16[0.79,1.77] |           |
| Gaussorgues 1991      | 28/59     | 29/59   | 5.54%       | 1.49[0.26,0.96] |           |
| Georges 1994          | 3/31      | 5/33    | 1.64%       | 0.60[0.13,3.75] |           |
| Hammonds 1992         | 34/162    | 31/160  | 9.25%       | 1.11[0.64,1.91] |           |
| Korinek 1993          | 22/96     | 17/95   | 4.95%       | 1.36[0.67,2.77] |           |
| Laggnar 1994          | 9/33      | 14/34   | 3.77%       | 0.50[0.19,1.55] |           |
| Lingnan 1997          | 9/90      | 17/177  | 3.68%       | 1.59[0.73,3.44] |           |
| Lingnan 1997b         | 13/90     | 17/177  | 2.24%       | 0.63[0.18,2.27] |           |
| Pneumatikos 2002      | 5/31      | 7/30    | 2.93%       | 0.97[0.36,2.65] |           |
| Pugin 1991            | 10/38     | 11/41   | 2.93%       | 0.97[0.36,2.65] |           |
| Quinio 1995           | 12/76     | 10/73   | 3.23%       | 1.18[0.48,2.93] |           |
| Rodriguez-Rolda 1990  | 5/14      | 7/17    | 1.53%       | 0.79[0.18,3.41] |           |
| Unertl 1987           | 5/19      | 6/20    | 1.62%       | 0.83[0.21,3.38] |           |
| Wiener 1995           | 11/30     | 15/31   | 3.51%       | 0.62[0.22,1.72] |           |
| **Subtotal (95% CI)** | **1322** | **1555** | **95.02%** | **0.99[0.83,1.18]** |           |
| Total events: 346 (Treatment), 390 (Control) | | | | |
| Heterogeneity: Tau²=0; Chi²=7.98, df=17(P=0.97); I²=0% | | | | |
| Test for overall effect: Z=0.09(P=0.93) | | | | |

| **Total (95% CI)** | **1396** | **1620** | **100%** | **0.97[0.82,1.16]** |           |
| Total events: 361 (Treatment), 408 (Control) | | | | |
| Heterogeneity: Tau²=0; Chi²=12.63, df=19(P=0.86); I²=0% | | | | |
| Test for overall effect: Z=0.29(P=0.77) | | | | |
| Test for subgroup differences: Chi²=0.94, df=1 (P=0.33), I²=0% | | | | |

### Analysis 2.3. Comparison 2 Topical versus control, Outcome 3 Mortality according to blinding of the studies.

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
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<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H, Fixed, 95% CI</td>
<td></td>
<td>M-H, Fixed, 95% CI</td>
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<tr>
<td><strong>2.3.1 Double-blind</strong></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Bergmans 2001</td>
<td>30/87</td>
<td>57/139</td>
<td>10.82%</td>
<td>0.76[0.43,1.32]</td>
<td></td>
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</tbody>
</table>

Favours treatment

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<tr>
<td>Study or subgroup</td>
<td>Treatment</td>
<td>Control</td>
<td>Odds Ratio</td>
<td>Weight</td>
<td>Odds Ratio</td>
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<tr>
<td></td>
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<td>n/N</td>
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<td>M-H, Fixed, 95% CI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerra 1992</td>
<td>12/25</td>
<td>10/23</td>
<td></td>
<td>2.04%</td>
<td>1.2[0.38,3.74]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ferrer 1994</td>
<td>15/51</td>
<td>14/50</td>
<td></td>
<td>3.76%</td>
<td>1.07[0.45,2.54]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastinne 1992</td>
<td>88/220</td>
<td>82/225</td>
<td></td>
<td>18.31%</td>
<td>1.16[0.79,1.7]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hammond 1992</td>
<td>34/162</td>
<td>31/160</td>
<td></td>
<td>9.27%</td>
<td>1.11[0.64,1.91]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Korinek 1993</td>
<td>22/96</td>
<td>17/95</td>
<td></td>
<td>4.96%</td>
<td>1.36[0.67,2.77]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lagrner 1994</td>
<td>9/33</td>
<td>14/34</td>
<td></td>
<td>3.77%</td>
<td>0.54[0.19,1.15]</td>
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</tr>
<tr>
<td>Cerra 1992</td>
<td>12/25</td>
<td>10/23</td>
<td></td>
<td>2.04%</td>
<td>1.2[0.38,3.74]</td>
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</tr>
<tr>
<td>Ferrer 1994</td>
<td>15/51</td>
<td>14/50</td>
<td></td>
<td>3.76%</td>
<td>1.07[0.45,2.54]</td>
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<tr>
<td>Gastinne 1992</td>
<td>88/220</td>
<td>82/225</td>
<td></td>
<td>18.31%</td>
<td>1.16[0.79,1.7]</td>
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<td>Hammond 1992</td>
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<td>31/160</td>
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<td>1.11[0.64,1.91]</td>
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<td>Korinek 1993</td>
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<td>4.96%</td>
<td>1.36[0.67,2.77]</td>
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<tr>
<td>Lagrner 1994</td>
<td>9/33</td>
<td>14/34</td>
<td></td>
<td>3.77%</td>
<td>0.54[0.19,1.15]</td>
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</table>

**Total (95% CI)**

<table>
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<tr>
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<th>Treatment</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
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<tbody>
<tr>
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<td>n/N</td>
<td>M-H, Fixed, 95% CI</td>
<td></td>
<td>M-H, Fixed, 95% CI</td>
</tr>
<tr>
<td>Cerra 1992</td>
<td>12/25</td>
<td>10/23</td>
<td></td>
<td>2.04%</td>
<td>1.2[0.38,3.74]</td>
</tr>
<tr>
<td>Ferrer 1994</td>
<td>15/51</td>
<td>14/50</td>
<td></td>
<td>3.76%</td>
<td>1.07[0.45,2.54]</td>
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<tr>
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<td>82/225</td>
<td></td>
<td>18.31%</td>
<td>1.16[0.79,1.7]</td>
</tr>
<tr>
<td>Hammond 1992</td>
<td>34/162</td>
<td>31/160</td>
<td></td>
<td>9.27%</td>
<td>1.11[0.64,1.91]</td>
</tr>
<tr>
<td>Korinek 1993</td>
<td>22/96</td>
<td>17/95</td>
<td></td>
<td>4.96%</td>
<td>1.36[0.67,2.77]</td>
</tr>
<tr>
<td>Lagrner 1994</td>
<td>9/33</td>
<td>14/34</td>
<td></td>
<td>3.77%</td>
<td>0.54[0.19,1.15]</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td>1191</td>
<td>1410</td>
<td>84.61%</td>
<td></td>
<td>0.99[0.83,1.12]</td>
</tr>
</tbody>
</table>

**Analysis 2.4. Comparison 2 Topical versus control, Outcome 4 RTIs.**

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment</th>
<th>Control</th>
<th>Odds Ratio</th>
<th>Weight</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H, Random, 95% CI</td>
<td></td>
<td>M-H, Random, 95% CI</td>
</tr>
<tr>
<td>Ferrer 1994</td>
<td>7/51</td>
<td>11/50</td>
<td></td>
<td>5.43%</td>
<td>0.56[0.2,1.6]</td>
</tr>
<tr>
<td>Hammond 1992</td>
<td>25/162</td>
<td>30/160</td>
<td></td>
<td>7.87%</td>
<td>0.79[0.44,1.42]</td>
</tr>
<tr>
<td>Lagrner 1994</td>
<td>1/33</td>
<td>4/34</td>
<td></td>
<td>2.05%</td>
<td>0.23[0.02,2.22]</td>
</tr>
<tr>
<td>Lingnau 1997</td>
<td>38/90</td>
<td>71/177</td>
<td></td>
<td>8.24%</td>
<td>1.09[0.65,1.83]</td>
</tr>
<tr>
<td>Lingnau 1997b</td>
<td>34/90</td>
<td>71/177</td>
<td></td>
<td>8.21%</td>
<td>0.91[0.54,1.53]</td>
</tr>
<tr>
<td>Stountenbeek 1996</td>
<td>2/49</td>
<td>8/42</td>
<td></td>
<td>3.33%</td>
<td>0.18[0.04,0.91]</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td>475</td>
<td>640</td>
<td>35.13%</td>
<td></td>
<td>0.79[0.56,1.13]</td>
</tr>
</tbody>
</table>
Analysis 2.5. Comparison 2 Topical versus control, Outcome 5 RTIs according to quality of allocation concealment.

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment n/N</th>
<th>Control n/N</th>
<th>Odds Ratio M-H, Random, 95% CI</th>
<th>Weight</th>
<th>Odds Ratio M-H, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5.1 Adequate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stoutenbeek 1996</td>
<td>2/49</td>
<td>8/42</td>
<td>3.33%</td>
<td>0.18</td>
<td>0.04</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td>49</td>
<td>42</td>
<td>3.33%</td>
<td>0.18</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Total events: 2 (Treatment), 8 (Control)
Heterogeneity: Not applicable
Test for overall effect: Z=2.08 (P=0.04)

2.5.2 Not adequate

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment n/N</th>
<th>Control n/N</th>
<th>Odds Ratio M-H, Random, 95% CI</th>
<th>Weight</th>
<th>Odds Ratio M-H, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ferrer 1994</td>
<td>7/51</td>
<td>11/50</td>
<td>5.43%</td>
<td>0.56</td>
<td>0.21</td>
</tr>
<tr>
<td>Georges 1994</td>
<td>4/31</td>
<td>15/33</td>
<td>4.51%</td>
<td>0.18</td>
<td>0.05</td>
</tr>
<tr>
<td>Pugin 1991</td>
<td>4/38</td>
<td>24/41</td>
<td>4.7%</td>
<td>0.08</td>
<td>0.02</td>
</tr>
<tr>
<td>Unertl 1987</td>
<td>1/19</td>
<td>9/20</td>
<td>2.12%</td>
<td>0.07</td>
<td>0.01</td>
</tr>
<tr>
<td>Brun-Buisson 1989</td>
<td>3/65</td>
<td>6/68</td>
<td>3.88%</td>
<td>0.51</td>
<td>0.12</td>
</tr>
<tr>
<td>Gastinne 1992</td>
<td>26/220</td>
<td>33/225</td>
<td>8.04%</td>
<td>0.78</td>
<td>0.45</td>
</tr>
<tr>
<td>Hammond 1992</td>
<td>25/162</td>
<td>30/160</td>
<td>7.87%</td>
<td>0.79</td>
<td>0.44</td>
</tr>
<tr>
<td>Lagger 1994</td>
<td>1/33</td>
<td>4/34</td>
<td>2.05%</td>
<td>0.23</td>
<td>0.02</td>
</tr>
</tbody>
</table>

Favours treatment

Favours control

Heterogeneity: Not applicable
### Analysis 2.6. Comparison 2 Topical versus control, Outcome 6 RTIs according to blinding of the studies.

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment n/N</th>
<th>Control n/N</th>
<th>Odds Ratio M-H, Random, 95% CI</th>
<th>Weight</th>
<th>Odds Ratio M-H, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.6.1 Double-blind</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ferrer 1994</td>
<td>7/51</td>
<td>11/50</td>
<td></td>
<td>5.43%</td>
<td>0.56[0.2,1.16]</td>
</tr>
<tr>
<td>Bergmans 2001</td>
<td>9/87</td>
<td>38/139</td>
<td></td>
<td>6.75%</td>
<td>0.31[0.14,0.67]</td>
</tr>
<tr>
<td>Gastinne 1992</td>
<td>26/220</td>
<td>33/225</td>
<td></td>
<td>8.04%</td>
<td>0.78[0.45,1.35]</td>
</tr>
<tr>
<td>Hammond 1992</td>
<td>25/162</td>
<td>30/160</td>
<td></td>
<td>7.87%</td>
<td>0.79[0.44,1.42]</td>
</tr>
<tr>
<td>Korinek 1993</td>
<td>20/96</td>
<td>37/95</td>
<td></td>
<td>7.54%</td>
<td>0.41[0.22,0.79]</td>
</tr>
<tr>
<td>Laggner 1994</td>
<td>1/33</td>
<td>4/34</td>
<td></td>
<td>2.05%</td>
<td>0.23[0.02,2.22]</td>
</tr>
<tr>
<td>Lingnau 1997</td>
<td>38/90</td>
<td>71/177</td>
<td></td>
<td>8.24%</td>
<td>1.09[0.65,1.83]</td>
</tr>
<tr>
<td>Lingnau 1997b</td>
<td>34/90</td>
<td>71/177</td>
<td></td>
<td>8.21%</td>
<td>0.91[0.54,1.53]</td>
</tr>
<tr>
<td>Pugin 1991</td>
<td>4/38</td>
<td>24/41</td>
<td></td>
<td>4.7%</td>
<td>0.08[0.02,0.28]</td>
</tr>
<tr>
<td>Quinio 1995</td>
<td>19/76</td>
<td>38/73</td>
<td></td>
<td>7.25%</td>
<td>0.31[0.15,0.61]</td>
</tr>
<tr>
<td>Rodriguez-Rolda 1990</td>
<td>1/14</td>
<td>11/17</td>
<td></td>
<td>2.02%</td>
<td>0.04[0.04,0.4]</td>
</tr>
<tr>
<td>Stoutenbeek 1996</td>
<td>2/49</td>
<td>8/42</td>
<td></td>
<td>3.33%</td>
<td>0.18[0.04,0.91]</td>
</tr>
<tr>
<td>Wiener 1995</td>
<td>8/30</td>
<td>8/31</td>
<td></td>
<td>4.98%</td>
<td>1.05[0.33,3.27]</td>
</tr>
<tr>
<td>Camus 2005</td>
<td>53/130</td>
<td>53/126</td>
<td></td>
<td>8.33%</td>
<td>0.95[0.58,1.56]</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td>1166</td>
<td>1387</td>
<td></td>
<td>84.74%</td>
<td>0.52[0.36,0.75]</td>
</tr>
</tbody>
</table>

Total events: 247 (Treatment), 437 (Control)

Heterogeneity: \( \tau^2=0.28; \chi^2=39.32, \text{df}=13; (P=0.001); I^2=66.94\%

Test for overall effect: \( Z=3.5(P=0.04) \)

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Treatment n/N</th>
<th>Control n/N</th>
<th>Odds Ratio M-H, Random, 95% CI</th>
<th>Weight</th>
<th>Odds Ratio M-H, Random, 95% CI</th>
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<tr>
<td><strong>2.6.2 Open</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georges 1994</td>
<td>4/31</td>
<td>15/33</td>
<td></td>
<td>4.51%</td>
<td>0.18[0.05,0.62]</td>
</tr>
<tr>
<td>Brun-Buisson 1989</td>
<td>3/65</td>
<td>6/68</td>
<td></td>
<td>3.88%</td>
<td>0.5[0.12,2.09]</td>
</tr>
<tr>
<td>Uernert 1987</td>
<td>1/19</td>
<td>9/20</td>
<td></td>
<td>2.12%</td>
<td>0.07[0.01,0.61]</td>
</tr>
</tbody>
</table>

Total events: 258 (Treatment), 475 (Control)

Heterogeneity: \( \tau^2=0.34; \chi^2=49.49, \text{df}=16; (P<0.0001); I^2=67.67\%

Test for overall effect: \( Z=4.22(P<0.0001) \)

Test for subgroup differences: \( \chi^2=1.2, \text{df}=1; (P=0.27); I^2=16.79\%

<table>
<thead>
<tr>
<th>Favo ures treatment</th>
<th>0.01</th>
<th>0.1</th>
<th>1</th>
<th>10</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favo ures control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study or subgroup</td>
<td>Treatment</td>
<td>Control</td>
<td>Odds Ratio</td>
<td>Weight</td>
<td>Odds Ratio</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------</td>
<td>---------</td>
<td>------------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td></td>
<td>n/N</td>
<td>n/N</td>
<td>M-H, Random, 95% CI</td>
<td></td>
<td>M-H, Random, 95% CI</td>
</tr>
<tr>
<td>Pneumatikos 2002</td>
<td>5/31</td>
<td>16/30</td>
<td>4.74% 0.17[0.05,0.56]</td>
<td>4.46% 0.2[0.1,0.41]</td>
<td></td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td>146</td>
<td>151</td>
<td>15.26% 0.44[0.31,0.63]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>1312</td>
<td>1538</td>
<td>100% 0.44[0.31,0.63]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total events: 13 (Treatment), 46 (Control)
Heterogeneity: Tau²=0; Chi²=2.63, df=3 (P=0.45); I²=0%
Test for overall effect: Z=4.46 (P<0.0001)

Total events: 260 (Treatment), 483 (Control)
Heterogeneity: Tau²=0.34; Chi²=51.61, df=17 (P=0.0001); I²=67.06%
Test for overall effect: Z=4.45 (P<0.0001)
Test for subgroup differences: Chi²=5.39, df=1 (P=0.02), I²=81.43%

A P P E N D I C E S

Appendix 1. Embase.com search strategy

1. ‘respiratory tract infection’/exp
2. ‘respiratory tract infection’:ti,ab OR ‘respiratory tract infections’:ti,ab
3. ‘pneumonia’/exp
4. pneumon*:ti,ab
5. hap:ti,ab OR vap:ti,ab
6. bronchopneumonia*:ti,ab OR pleuropneumonia*:ti,ab
7. ‘bronchitis’/exp
8. bronchit*:ti,ab OR bronchiolit*:ti,ab
9. ‘pharyngitis’/exp
10. pharyngit*:ti,ab
11. ‘tracheitis’/exp
12. tracheit*:ti,ab
13. #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12
14. ‘intensive care unit’/exp
15. icu:ti,ab OR ‘critical care’:ti,ab OR ‘intensive care’:ti,ab OR ‘burn unit’:ti,ab OR ‘burn units’:ti,ab OR ‘care unit’:ti,ab OR ‘care units’:ti,ab OR ‘recovery room’:ti,ab OR ‘recovery rooms’:ti,ab
16. ‘critical illness’/exp
17. ‘critically ill’:ti,ab OR ‘critical illness’:ti,ab
18. ‘ventilator’/exp
19. ventilator*:ti,ab
20. ‘artificial ventilation’/exp
21. respirator*:ti,ab
22. #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21
23. #13 AND #22
24. ‘ventilator associated pneumonia’/exp
25. ‘ventilator associated pneumonia’:ti,ab
26. #24 OR #25
27. #23 OR #26
28. ‘antibiotic prophylaxis’/exp
29. ‘antibiotic agent’/exp
30. antibiotic*:ti,ab
31. #28 OR #29 OR #30
32. #27 AND #31
33. ‘randomized controlled trial’/exp
34. ‘controlled clinical trial’/exp
35. ‘single blind procedure’/exp
36. ‘crossover procedure’/exp

Antibiotic prophylaxis to reduce respiratory tract infections and mortality in adults receiving intensive care (Review)

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WHAT'S NEW

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Description</th>
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<tr>
<td>20 March 2012</td>
<td>Amended</td>
<td>Byline citation updated.</td>
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</table>

HISTORY


<table>
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<th>Event</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>19 May 2011</td>
<td>New search has been performed</td>
<td>Searches conducted</td>
</tr>
<tr>
<td>13 March 2009</td>
<td>New search has been performed</td>
<td>Searches conducted.</td>
</tr>
<tr>
<td>13 March 2009</td>
<td>New citation required but conclusions have not changed</td>
<td>One study has been included in this update (Camus 2005). Two studies, whose data were reported in congress proceedings (Lenhart 1994) and were unpublished (Stoutenbeek 2), have been replaced by Krueger 2002 and Stoutenbeek 2007 which are their published versions in peer-reviewed journals. One study (Jacobs 1995) included in the previous version of this review as a personal contact with the principal investigator, has been excluded due to lack of feedback from the trial author. To date, this study has not been published.</td>
</tr>
<tr>
<td>30 January 2008</td>
<td>Amended</td>
<td>Converted to new review format</td>
</tr>
<tr>
<td>5 September 2003</td>
<td>New search has been performed</td>
<td>Searches conducted. Updated review published Issue 4, 2002</td>
</tr>
<tr>
<td>5 December 1999</td>
<td>New search has been performed</td>
<td>Searches conducted. Review published Issue 3, 1997</td>
</tr>
<tr>
<td>5 December 1995</td>
<td>New search has been performed</td>
<td>Searches conducted. Updated review published Issue 1, 2004</td>
</tr>
</tbody>
</table>

CONTRIBUTIONS OF AUTHORS

Alessandro Liberati prepared the protocol and review, oversaw the data collection and critical appraisal of studies, updated the review and prepared the final version of the manuscript. Roberto D’Amico prepared the protocol and review, oversaw the data collection and critical appraisal of studies, carried out the statistical analysis, updated the review and prepared the final version of the manuscript. Luca Brazzi collaborated in the preparation of the protocol, the identification of trials and their critical appraisal. Valter Torri collaborated in the preparation of the protocol and the statistical analysis. Silvia Pifferi collaborated in the identification and critical appraisal of trials. Elena Parmelli collaborated in the update of the review.

DECLARATIONS OF INTEREST

None known.
SOURCES OF SUPPORT

Internal sources
- Italian Cochrane Centre, Italy.

External sources
- No sources of support supplied

INDEX TERMS

Medical Subject Headings (MeSH)
*Antibiotic Prophylaxis; *Critical Care; *Hospital Mortality; Anti-Bacterial Agents [therapeutic use]; Cross Infection [mortality] [*prevention & control]; Randomized Controlled Trials as Topic; Respiratory Tract Infections [mortality] [*prevention & control]

MeSH check words
Adult; Humans