Protocols

Management and outcomes following emergency surgery for traumatic brain injury – A multi-centre, international, prospective cohort study (the Global Neurotrauma Outcomes Study)

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Abstract

Introduction: Traumatic brain injury (TBI) accounts for a significant amount of death and disability worldwide and the majority of this burden affects individuals in low-and-middle income countries. Despite this, considerable geographical differences have been reported in the care of TBI patients. On this background, we aim to provide a comprehensive international picture of the epidemiological
1. Background

The Global Burden of Disease study estimates that 27 million new cases of traumatic brain injury occur worldwide every year [1]. According to data from the US National Trauma Data Bank, almost 4% of these will require neurosurgical intervention [2]. Timely and adequate emergency surgery for TBI has long been known to dramatically improve outcome [3–6]. As such, multiple global health organisations recognise surgical procedures for neurotrauma, specifically the evacuation of traumatic intracranial haematomas and the elevation of depressed skull fractures, as essential to be available on an emergency basis to all worldwide [7,8]. However, although most injuries occur in LMICs [9], access to neurosurgical care in many LMICs is extremely limited – in sub-Saharan Africa, the average percentage of a country’s population within 2 h of a neurosurgical service is estimated to be 25% [10].

For patients with neurological pathology who do reach a centre that can provide the procedure they require, there is a paucity of data on their outcomes and the standard of management they receive [11]. To complicate matters, current best-practice guidelines for the management of TBI typically advocate the use of expensive technologies (such as invasive intracranial pressure monitoring) which are often unavailable in low-resource settings [12,13] despite the fact that this is where the majority of serious injuries occur globally [9]. As such, context-specific research is urgently required to determine best practice for delivering effective surgical care for traumatic neurological injuries globally. The first step in this is to describe current practice and outcomes across varied settings and neurosurgical care is an extremely important aspect of the management of TBI patients.

We propose to conduct an international, multi-centre, prospective cohort study of outcomes following emergency surgery for traumatic brain injury. We believe such a project would provide valuable information to advance the care of patients with traumatic brain injuries globally and be feasible with the proposed methodology.

2. Methods and analysis

2.1. Primary aim

The primary aim of the study is to compare 14-day mortality (or in-hospital mortality if discharge occurs before 14 days) following emergency surgery for traumatic brain injury (TBI) across HDI settings.

2.2. Secondary aims

To describe and compare the following across HDI settings following emergency surgery for TBI:

- Perioperative complications
- Length of stay in hospital and length of stay in the intensive care unit
- Glasgow Coma Scale (GCS) on discharge and discharge destination
- Epidemiological characteristics (demographics, injury characteristics, baseline clinical characteristics and surgical case mix)
- Preoperative, perioperative and postoperative processes of care (including temporal delays to care)
- Resources available for the management of acute brain injury

2.3. Study design

This is a multicentre, international, prospective, observational cohort study of all patients receiving emergency surgery for TBI in any consecutive 30-day period. Local study teams may select any 30-day period from the 1st of November 2018 and the 31st of December 2019 to start their study. Patients operated on who meet the inclusion criteria between 00:01 on day 0 and 23:59 on day 30 of the selected study period will be included. The final study period will therefore begin on 31st December 2019 00:01 and end on 30th January 23:59. Teams must follow patients up for 14-days from the date of surgery or until they are discharged or die – whichever of these comes first. Final day of data collection for the primary outcome measure is February 13th. Teams have 30 days after the end of their selected study period to complete the data validation exercise (see below) – all patient level data should therefore be submitted to the central study team by 29th February.

2.4. Study setting

Any hospital or clinic worldwide performing emergency surgery for traumatic brain injury is eligible to participate. In the majority of institutions, emergency surgery for TBI is provided by neurosurgeons – however, centres in which emergency surgery for TBI is provided by general surgeons, trauma surgeons, general medical doctors or even non-physician clinicians are also eligible to participate.
2.5. Patient inclusion and exclusion criteria

Table 1 summarises the patient inclusion and exclusion criteria.

2.6. Outcome measures

The primary outcome measure will be 14-day mortality (or inhospital mortality if discharge occurs before 14 days). The secondary outcome measures will include:

1. Perioperative complications
   - Return to operating theatre during follow up period
   - Surgical site infection (SSI)
2. Length of stay (LOS)
   - LOS in hospital (days)
   - LOS in intensive care (days)
3. Glasgow Coma Score at discharge (GCS-D)
4. Discharge destination

2.7. Data points

A data set will be collected on all adult or paediatric patients receiving emergency surgery for TBI in the inclusion period (see Tables 2 through 5). The case report form is split into 3 subsections – injury/admission data, operative data and outcome data. The data fields were based on existing data sets and refined through iterative consultation with an interdisciplinary consortium of clinicians caring for TBI across a range of HDI settings.

Finally, each local study lead will complete a provider profiling questionnaire on resources available for the pre-hospital, emergency department, surgical, intensive care and rehabilitation management of patients with acute brain injuries at their institution. This questionnaire has been reviewed and endorsed by the WFNS Neurotraumatology Committee and British Neurotrauma Group.

2.8. Data capture

Collected data will be stored exclusively on a secure bespoke web-based system within the Outcome Registry Intervention and Operation Network (ORION) (https://orioncloud.org/). The platform enables secure data collection, validation and storage in a standard (SQL) format and is compliant with NHS security standards (including the NHS Information Governance toolkit). All patient data will be transmitted and held anonymously. An internal pilot has been conducted using the platform to assess feasibility prior to roll out of the full study. Prior to inputting data into the live platform, members of local study teams will be invited to practise entering ‘dummy’ data into an identical test platform with the aid of a comprehensive software guide.

2.9. Data quality

The protocol (including case report form and site questionnaire) has been translated, with the aid of global collaborators, into Arabic, Bengali, Chinese (traditional and simplified), French, Italian, Portuguese, Brazilian Portuguese, Spanish, Swahili and Urdu and to facilitate recruitment and participation from sites across the world. A comprehensive data dictionary is also available online.

2.10. Data validation

Data validation will occur by two mechanisms. Firstly, web-based forms in the online data capture platform will contain fixed options at the point of data entry to maximise the likelihood of accurate and complete data capture from the outset. Secondly, a local data validator independent of the local study team will be appointed at every participating site. After the study period has ended, each data validator will be asked to retrospectively identify all patients who received emergency surgery for TBI in their centre’s study period (independent of the rest of the study team) to assess case ascertainment and collect data on 2 variables, namely the date and nature of the operation.

2.11. Sample size

As there is a paucity of data on emergency surgery for TBI globally, it was not possible to perform an accurate sample size calculation. However, we expect between 100 and 200 centres to participate and expect the majority of these centres to collect data on 5–10 patients in a given 30-day study period. This will result in a total of 500–2000 patients which we believe will be sufficient to analyse the study endpoints.

2.12. Statistical analysis

For the patient level data, an a priori statistical analysis plan has been developed with a statistician. The mean and standard deviation will be reported for normally distributed variables and the median and interquartile range for not normally distributed variables. Participating centres will be stratified based on their country into groups based on their Human Development Index (HDI) rank. The Human Development Index is calculated for each country based on its life expectancy at birth, years of schooling and gross national income (GNI) per capita (http://hdr.undp.org/en/composite/HDI). 14 day mortality (or survival to discharge, whichever comes first) will be reported for each HDI group and compared using the Pearson chi squared test. Univariable logistic regression analyses will be conducted between covariates and the primary outcome measure. Based on the results, covariates with a p value <0.20 will be included in the multivariable model. The final multivariable logistic model will be determined using stepwise back...
Table 2
Injury/admission data.

| Gender | Male, Female |
|--------|-------------|
| Age (in years at time of admission) | 
| Mechanism of injury | 
| Date / time of injury | 
| Date / time of admission to hospital where surgery is taking place | 
| Was the patient directly transferred from the accident scene to the hospital where surgery is taking place? | Yes, No |
| Method of transport to the hospital where surgery is taking place | 
| American Society of Anaesthesiologists (ASA) Physical Status Classification | 
| Glasgow Coma Score on admission (or last documented GCS off sedation if sedated on admission) | Total and Eyes, verbal (‘T’ if intubated/tracheostomy), Motor (option for ‘Unknown’) |
| Fixed and dilated pupil at any time point pre-operatively? | 
| Unreactive pupil at any time point pre-operatively? | 
| Did the patient have an episode of hypoxia at any point prior to surgery? | Yes, No, Not measured prior to surgery |
| Did the patient have an episode of hypotension (systolic BP < 90 mmHg*) at any point prior to surgery? | Yes, No, Not measured prior to surgery |
| If yes, is there any evidence of pneumocephalus on CT? | Yes, No |
| If yes, are any of the fragments depressed > 1 cm relative to the rest of the skull on CT? | Yes, No |
| If yes, is there any evidence of a compound depressed skull fracture on examination of the patient? | Yes, No |
| Supratentorial extradural haematoma? | 
| Supratentorial subdural haematoma? | 
| Supratentorial traumatic parenchymal lesion | 
| Is there a depressed skull fracture? | 
| Midline shift in mm? | 
| Traumatic subarachnoid haemorrhage? | 
| Is there a traumatic posterior fossa haemorrhage? | 
| 0–5 mm, 5–10 mm, >10 mm | 
| Yes, No | 
| Yes, No | 
| Yes, No | 
| No, 0–10 mm, 10–20 mm, >20 mm, Unknown | 
| No, 0–10 mm, 10–20 mm, >20 mm, Unknown | 
| No, Small, Large - >50 cm³ volume, Unknown | 
| No, Small, Large - >50 cm³ volume, Unknown |

ward elimination. Pre-specified sub-group analyses will also be conducted for patients with severe TBI (GCS 3 to 8), and moderate and severe TBI (GCS 3 to 12). Individual surgeons and hospitals will not be identifiable from analyses (unless explicit consent to do so is given). Statistical analyses will be conducted using R (www.r-project.org). A p value of less than 0.05 will be considered statistically significant. The study and statistical analysis plan was pre-registered on Open Science Framework prior to commencement of data analysis: osf.io/ryjbs.

3. Ethics and dissemination

According to the United Kingdom National Health Service (NHS) Health Research Authority tool, this study is considered a clinical audit rather than research and, as such, does not require approval by a Research Ethics Committee. This has been confirmed formally by the South East Scotland NHS Research Ethics Committee in Edinburgh, Scotland as well as the NHS Research and Development Office at Cambridge University Hospitals. Local teams are expected to seek approval from the appropriate department (research or audit) at their institution prior to commencing the study. Where these departments do not exist, teams should follow the local procedure for obtaining approval for a study of this nature. Written confirmation of local approval and a signed data access and use agreement must be submitted electronically prior to local study teams being granted access to the online data capture platform and commencing data collection. The study has been registered on ClinicalTrials.gov (NCT04212754) and the Clinical Trials Registry – India (CTRI/2019/02/017479).

The study will be reported following the Strengthening the Reporting of Observational Studies in Epidemiology statement guidelines and checklists [14]. The results will be submitted for open access publication in a peer reviewed journal. Fully named authors on the byline of publications resulting from this study will be those that satisfy the International Committee of Medical Journal Editors (ICMJE) guidelines for authorship. In addition, ‘on behalf of the Global Neurotrauma Outcomes Study Collaborators’ will be listed on the byline. The local study lead,
Table 4
Operative data.

| Grade of most senior surgeon present in the operating theatre | Grade of most senior anaesthesia provider present in the operating theatre |
|---------------------------------------------------------------|---------------------------------------------------------------|
| Fully qualified neurosurgeon, Neurosurgeon-in-training, Other qualified surgeon, Other surgeon in training, Medically qualified but not in a surgical training programme, Not medically qualified surgical provider | Fully qualified anaesthetist with medical qualification, Anaesthetist-in-training with medical qualification, Not medically qualified anaesthesia provider, Anaesthetic administered by the surgeon, Other (specify), No anaesthesia provided |

| Type of anaesthesia | Date / time operation started? | Date / time operation finished? |
|---------------------|-------------------------------|-------------------------------|
| General, Local, None | ...                            | ...                            |

| Class of surgical wound | Location of surgery | What was the main procedure undertaken? |
|-------------------------|---------------------|----------------------------------------|
| Clean, Clean-contaminated, Contaminated, Dirty-infected | Left, Right, Bilateral, Midline | * if > 1 procedure undertaken, select the main one |

| Did the patient have an episode of hypotension (systolic BP < 90 mmHg) at any point during their surgery? |
|--------------------------------------------------|
| Yes, No |

| Did you have to perform a lobectomy? |
|-------------------------------------|
| Yes, No |

| Was a duraplasty performed? |
|-----------------------------|
| Yes, No, Unknown |

| Did the patient have a wound drain placed? |
|-------------------------------------------|
| Yes – subdural, Yes – extradural, Yes – subgaleal, No |

| Did the patient have an intracranial pressure (ICP) monitor in place for postoperative ICP monitoring? |
|-----------------------------------------------------------------------------------------------|
| Yes – intraparenchymal, Yes – ventricular, No |

| Intraoperative death |
|----------------------|
| ... |

additional members of the local study team and independent data validator at each participating site will be listed as PubMed citable collaborator status authors on all publications resulting from this study. After publication of the primary results, the pooled dataset will be available to all members of the GNOS collaboration for secondary analysis, after judgement and approval of each proposed analysis by the central study team.

4. Discussion

We present a study protocol for a multi-centre, international prospective cohort study to ascertain outcomes following emergency surgery for traumatic brain injury globally. We believe the planned 30-day data collection period for each site coupled with 14-day follow up for all patients will be feasible for clinicians even in low-resource settings where their time is at a premium. The collaborative methodology we propose to use in this study has already been employed successfully to obtain outcome data in national neurosurgical studies [15] as well as in international projects in surgery and intensive care [16–18]. Moreover, we have prospectively planned a data validation strategy to assess case ascertainment.

There is a scarcity of data on outcomes following neurosurgery globally in the literature. The African Surgical Outcomes Study (ASOS), a 7-day prospective observational cohort study of outcomes following all surgery (including neurosurgery, which made
up 2.2% of the 11,393 procedures included) in a convenience sample of 25 African countries, found that mortality and postoperative complications were significantly higher in their population relative to high income countries [19]. Similarly, the GlobalSurg study found that mortality following abdominal surgery is significantly higher in countries with a low HDI [17]. Finally, the Corticosteroid Randomisation After Head Injury (CRASH) trial found that mortality following severe, but not mild or moderate TBI, was higher in LMICs than high-income countries [20]. However, no detailed data on the differences in the participating sites, epidemiological characteristics, management and outcome of emergency surgery for TBI across different Human Development Index settings. The results of GNOS could help identify practices that may best explain differences in outcomes, and will help inform the design of future local, national and international quality improvement programmes and clinical trials for this patient population globally. Moreover, we intend for this study and the international collaboration of clinicians involved in it to inform the development and facilitate the rollout of an international, prospective, hospital-based traumatic brain injury registry, supported by the World Federation of Neurosurgical Societies.

**Ethical approval**

Confirmation of audit/service evaluation status by the South East Scotland Research Ethics Service in Edinburgh.

**Author contribution**

DC conceived the idea for the study, wrote the study protocol, designed the case report form and site questionnaire and revised the study design/data capture tools following feedback. PH, DC, AJ and AK are the Principal Investigators of the study. DC, AJ, AHB, TB, HB, KB, TF, DKG, MJ, TK, TL, VM, AR, HS, MT, MyT, MaT, RT, IDA, FS, DM, AK, PH contributed to the funding application. AJ, OIA, AOA, AHB, TB, HB, KB, RFM, TF, DKG, MJ, TK, TL, VM, KP, AR, HS, KS, MT, AT, MyT, MaT, RT, SV, IDB, FS, DM, AK, PH, NB, IC, CI, GR, BS contributed input and revisions to the study design and study protocol. SV, DC and RFM created the statistical analysis plan. AB, AJ, YS and KB were involved with the revision of the case report form and data capture platform, including assessing their feasibility. DC, PH, AJ and AK made critical revisions to the manuscript. All authors contributed to the manuscript and agreed to submission.

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Research registration number

The study has been registered on ClinicalTrials.gov (NCT04212754) and the Clinical Trials Registry – India (CTRI/2019/02/017479).

Guarantor

David Clark and Peter Hutchinson are the guarantors for the study.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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