Comparison of routine and on-demand prescription of chest radiographs in mechanically ventilated adults: a multicentre, cluster-randomised, two-period crossover study

Gilles Hejblum, Ludwine Chalumeau-Lemoine, Vincent Ioos, Pierre-Yves Boelle, Laurence Salomon, Tabassome Simon, Jean-François Vibert, Bertrand Guidet

Summary

Background Present guidelines recommend routine daily chest radiographs for mechanically ventilated patients in intensive care units. However, some units use an on-demand strategy, in which chest radiographs are done only if warranted by the patient’s clinical status. By comparison between routine and on-demand strategies, we aimed to establish which strategy was more efficient and effective for optimum patient care.

Methods In a cluster-randomised, open-label crossover study, we randomly assigned 21 intensive care units at 18 hospitals in France to use a routine or an on-demand strategy for prescription of chest radiographs during the first of two treatment periods. Units used the alternative strategy in the second period. Each treatment period lasted for the time taken for enrolment and study of 20 consecutive patients per intensive care unit; patients were monitored until discharge from the unit or for up to 30 days’ mechanical ventilation, whichever was first. Units enrolled 967 patients, but 118 were excluded because they had been receiving mechanical ventilation for less than 2 days. The primary outcome measure was the mean number of chest radiographs per patient-day of mechanical ventilation. Analysis was by intention to treat. This study is registered with ClinicalTrials.gov, number NCT00893672.

Findings 11 intensive care units were randomly allocated to use a routine strategy to order chest radiographs in the first treatment period, and 10 units to use an on-demand strategy. Overall, 424 patients had 4607 routine chest radiographs (mean per patient-day of mechanical ventilation 1.09, 95% CI 1.05–1.14), and 425 had 3148 on-demand chest radiographs (mean 0.75, 0.67–0.83), which corresponded to a reduction of 32% (95% CI 25–38) with the on-demand strategy (p<0.0001).

Interpretation Our results strongly support adoption of an on-demand strategy in preference to a routine strategy to decrease use of chest radiographs in mechanically ventilated patients without a reduction in patients’ quality of care or safety.

Funding Assistance Publique-Hôpitaux de Paris (Direction Régionale de la Recherche Clinique Ile de France).

Introduction The American College of Radiology recommends routine daily chest radiographs for mechanically ventilated patients, and use of further radiographs if necessary.1 This strategy is controversial: some clinicians are in support,2–8 whereas others advocate on-demand prescription of chest radiographs when warranted by the patient’s clinical status.9–15 Routine chest radiography has two main advantages. First, some potentially life-threatening situations that might otherwise fail to be diagnosed can be discovered and treated.16 Second, the decision to do a chest radiograph is not necessary, and in the case of restricted mobile resources for chest radiography, scheduling of the examinations during morning rounds might be more efficient. By contrast, the on-demand strategy might avoid unnecessary radiation exposure and provides substantial cost savings. Moreover, very few routine chest radiographs lead to therapeutic or diagnostic interventions.12,15,16 However, the consequences of the on-demand strategy on the quality of patient care are uncertain, and an increased number of chest radiographs might be needed during the rest of the day to compensate for those not done in the morning.

Findings from a study based on the opinions of 82 physicians working in the intensive care unit have underscored the absence of consensus regarding the need for systematic daily chest radiographs for mechanically ventilated patients.9 Substantial variation was recorded between the physicians’ opinions of whether routine chest radiographs were needed for mechanically ventilated patients with different clinical conditions. This absence of consensus results from the lack of conclusive data to guide practice. Therefore, we did a large prospective multicentre study to assess the efficiency and effectiveness of routine versus on-demand chest radiographs for optimum care of mechanically ventilated patients, using a two-period cluster-randomised design.

Methods

Intensive care units and patients 21 intensive care units for adults, all of which are part of a Paris network for such units,20 participated in the study:
13 medical, two surgical, and six mixed; 17 units were located in university hospitals. These 21 closed units account for about a third of all intensive care unit beds in the Paris region (ie, Ile de France), and 5% in France. Before the study, only one intensive care unit was operating an on-demand strategy for prescription of chest radiographs; all other units were using a routine strategy.

Newly admitted adult patients were eligible for the study if they were receiving mechanical ventilation at the time of morning rounds on any day during their stay in the intensive care unit. Only patients who were mechanically ventilated for at least 2 days were included in the analyses. These patients were monitored until discharge from the intensive care unit or for up to 30 days' mechanical ventilation, whichever was first. The first patient was enrolled on Dec 21, 2006, and the last was discharged on Aug 22, 2007; global distributions of the inclusion dates in the routine and on-demand periods were similar.

The study was approved by the patients’ protective committee of Saint-Antoine hospital. The committee underscored that both strategies for giving chest radiographs were standard care procedures in intensive care units. The study was also approved by the institutional review board of the Société de Réanimation de Langue Française, and received the required legal approval from the appropriate French data protection committees. According to the French regulation on clinical research using standard care procedures,21 informed consent was unnecessary, and instead patients were given information about the study. This information was posted in the visitor’s waiting room of every intensive care unit, and included the procedure by which the patients could access their data and confirmed that patients could refuse to participate.

Randomisation and masking
The 21 intensive care units were randomly allocated to use a routine or on-demand strategy to order chest radiographs in the first treatment period; in the second treatment period, units used the remaining strategy. Randomisation was balanced according to the number of mechanically ventilated patients treated by each unit every year, and GH generated the allocation sequence with R software.22 The study was open-label with respect to allocation concealment and masking of intervention for practical reasons.

Study design
In the routine strategy, all mechanically ventilated patients had a daily chest radiograph, irrespective of their clinical status. Such radiographs are usually done during morning rounds. In the on-demand strategy, mechanically ventilated patients were given a chest radiograph by permanent staff at morning rounds if warranted by the findings of the morning clinical examination. In both strategies, additional unscheduled chest radiographs could be requested by the permanent staff or residents at any time. We expected that the on-demand strategy would lead to fewer chest radiographs during morning rounds than the routine strategy, but this reduction could be balanced by an increase in unscheduled chest radiographs with the on-demand strategy. We tested the hypothesis that the mean number of chest radiographs per day would be lower with the on-demand strategy than with the routine strategy (null hypothesis of no difference), with no measurable change in key outcome measures to suggest reduced quality of care.

Chest radiographs done at admission to the intensive care unit were not included in analyses. We examined the distribution of chest radiographs for a range of periods throughout the day.

In most intensive care units worldwide, all medical staff in a given unit use the same strategy to decide when to do patients’ chest radiographs. For comparison of two of these strategies, a cluster-randomised design3—in which randomisation is done at the level of the intensive care unit rather than the patient—is appropriate since the design is indicative of usual practice in the unit. However, interpretation of results could be difficult if the number of clusters is small because differences in outcome might be due to the
treatment used or to other differences between the clusters. In an effort to overcome these problems, we used a cluster-randomised crossover design in which all participating clusters received both methods of treatment during two periods (one period for each method). The two methods were compared with a matched-pair approach, each cluster provided an estimate for both treatment methods. Randomisation of the order by which the treatment methods were given ensured that differences recorded between the routine and on-demand strategies within a given intensive care unit were not caused by the effect of switching or secular trends.

The two treatment periods were separated by a 1-week washout period during which the intensive care unit was free to choose any strategy to order chest radiographs. Each treatment period ended either when the last mechanically ventilated patient to remain in the intensive care unit was extubated, or up to 30 days after enrolment of the last mechanically ventilated patient to remain in the unit.

We planned to recruit the same number of patients from every intensive care unit to better account for variability between units. Consequently, the duration of the study varied between units dependent on baseline recruitment and case-mix.

The primary outcome measure was the mean number of chest radiographs per patient-day of mechanical ventilation. This outcome was calculated for every patient as the ratio of the total number of radiographs to duration of mechanical ventilation. The mean was then calculated across all 21 intensive care units and for both treatment periods. The reason for doing each chest radiograph was recorded, along with any new findings leading to diagnostic procedures or therapeutic interventions. During monitoring, chest radiographs recorded in patients’ report forms were checked against the local picture archiving and communication system, which was available in 20 of the 21 intensive care units. We also assessed key secondary outcome measures: days of mechanical ventilation, length of stay in the intensive care unit, and mortality of patients during their stay in the unit.

Statistical analysis
We calculated the number of patients needed to provide 80% statistical power to show a 20% difference between routine and on-demand strategies for use of chest radiographs in a bilateral test with a type 1 error of 5% (webappendix p 1). This calculation took into account the matched-pair design and correlation between patients in a given intensive care unit. The clinical type values used for the sample size calculation were based on previous annual reports of the Cub-Rea network. With 20 participating intensive care units and a mean of 1-2 (SD 0-55) chest radiographs per patient-day during the routine strategy, 100 patients (5 patients per intensive care unit) would have to be enrolled in each strategy to detect a difference of 20% (δ=1·2×0·2), in a bilateral test with a type 1 error of 5% and a power of 80%. To detect substantial differences in mortality or mean duration of mechanical ventilation, we decided that every intensive care unit would enrol 20 patients for each strategy, which was equivalent to a total of 800 patients. With a type 1 error of 5% and statistical power of 80%, such a sample size would detect a difference of 10% in mortality (we postulated that baseline mortality would be 33%), and a difference of 3 days in mean duration of mechanical ventilation (we postulated for mechanical ventilation SD 15-3) between strategies.

Analysis was by intention to treat. We compared the mean number of chest radiographs per patient-day between the two strategies using a paired t test. A permutation test was used to calculate p values (webappendix p 2) for all comparisons between the two strategies except for two cases. First, a Wilcoxon-Mann-
Whitney test was used to assess if the difference in chest radiographs per patient-day in a given intensive care unit between the routine and on-demand strategies was dependent on the strategy applied during the first treatment period. Second, the difference in mortality between the two strategies was tested with the Mantel-Haenszel \(\chi^2\) test stratified by intensive care unit. Simplified acute physiology score II of patients and corresponding predicted hospital mortality were assessed according to Le Gall and colleagues. R statistical software (version 2.9.0) was used for all analyses.

This study is registered with ClinicalTrials.gov, number NCT00893672.

### Results

Table 1 shows characteristics of the 21 participating intensive care units. None of the participating units cared for neurosurgery or cardiac surgery patients, but all other types of patients are represented in the patient sample. Overall and in order, the ten most common diagnoses of patients admitted to the units in 2006 were: acute respiratory failure without underlying pulmonary disease, coma, septic shock, acute kidney failure, acute respiratory failure with underlying pulmonary disease, pulmonary oedema, cardiac arrest, acute respiratory distress syndrome, haemorrhagic shock, and need for postoperative care. Because of differences in the case-mix and total number of beds, the study duration was a median of 131 days (IQR 107–173) in a given intensive care unit.

Figure 1 shows the study profile. Overall, 425 patients were assigned to have chest radiographs by a routine strategy and 424 by an on-demand strategy. Table 2 shows patient characteristics at baseline. 7755 chest radiographs were done during both treatment periods under both strategies (table 3). The mean number of chest radiographs per patient-day of ventilation was significantly lower with the on-demand strategy than the routine strategy (table 3), which corresponded to a decrease of 32% (95% CI 25–38).

The range of mean numbers of chest radiographs per patient-day in the 21 intensive care units was 0.85–1.24 with the routine strategy, and 0.48–1.08 with the on-demand strategy (figure 2 and webappendix p 3). Despite this large variability, the on-demand strategy was associated with fewer chest radiographs than was the routine strategy in all 21 intensive care units (figure 2). The size of this decrease was not dependent on the

### Role of the funding source

The sponsor of the study had no role in study design, data collection, data analysis, data interpretation, writing of the report, or the decision to submit for publication. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

### Table 1: Overview of participating intensive care units

<table>
<thead>
<tr>
<th>On-demand strategy (n=425)</th>
<th>Routine strategy (n=424)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>61 (51–74)</td>
</tr>
<tr>
<td>SAPS II score; predicted hospital mortality*</td>
<td>52 (40–66); 51·0%</td>
</tr>
<tr>
<td>Men</td>
<td>257 (61%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Postoperative care</td>
<td>42 (10%)</td>
</tr>
<tr>
<td>Thoracic diseases</td>
<td>171 (40%)</td>
</tr>
<tr>
<td>ARDS or ALI</td>
<td>55 (32%)</td>
</tr>
<tr>
<td>Pneumonia (without ARDS or ALI criteria)</td>
<td>42 (25%)</td>
</tr>
<tr>
<td>Acute respiratory failure with chronic respiratory insufficiency</td>
<td>29 (17%)</td>
</tr>
<tr>
<td>Cardiogenic oedema</td>
<td>14 (8%)</td>
</tr>
<tr>
<td>Acute respiratory failure with immunodeficiency</td>
<td>17 (10%)</td>
</tr>
<tr>
<td>Acute asthma</td>
<td>7 (4%)</td>
</tr>
<tr>
<td>Other</td>
<td>7 (4%)</td>
</tr>
<tr>
<td>Extrathoracic diseases</td>
<td>209 (49%)</td>
</tr>
<tr>
<td>Shock</td>
<td>104 (50%)</td>
</tr>
<tr>
<td>Coma (excluding coma due to intoxication)</td>
<td>64 (31%)</td>
</tr>
<tr>
<td>Other</td>
<td>7 (3%)</td>
</tr>
<tr>
<td>Postoperative care</td>
<td>42 (10%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2 (1%)</td>
</tr>
</tbody>
</table>

Data are median (IQR), percentage, or number (%). SAPS II=simplified acute physiology score II. ALI=acute lung injury. *Percentage derived from the mean of all patients’ probabilities of predicted hospital mortality, therefore number of patients is not given.

### Table 2: Patient characteristics at baseline

<table>
<thead>
<tr>
<th>Routine strategy (n=424)</th>
<th>On-demand strategy (n=425)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest radiographs per patient-day of mechanical ventilation (total number; mean [95% CI])*</td>
<td>4607; 1 09 (1·05–1·14)</td>
<td>3148; 0 75 (0·67–0·83)</td>
</tr>
<tr>
<td>Morning rounds†</td>
<td>3779; 0 90 (0·86–0·93)</td>
<td>2224; 0 54 (0·47–0·60)</td>
</tr>
<tr>
<td>Unscheduled†</td>
<td>780; 0 18 (0·15–0·22)</td>
<td>893; 0 20 (0·16–0·25)</td>
</tr>
<tr>
<td>Days of mechanical ventilation (total number; mean [SD]; median [IQR])*</td>
<td>4172; 9 82 (8·24); 7 (4–13)</td>
<td>4226; 9 94 (8·75); 7 (3–14)</td>
</tr>
<tr>
<td>Length of stay (days; mean [SD]; median [IQR])</td>
<td>13·96 (11·61); 10 (5–19)</td>
<td>13·21 (11·01); 10 (5–19)</td>
</tr>
<tr>
<td>Mortality</td>
<td>131 (31%)</td>
<td>136 (32%)</td>
</tr>
</tbody>
</table>

Data are number (%) unless otherwise indicated. *Data were censored to 30 days of mechanical ventilation; patients with more than 30 days of mechanical ventilation were regarded as having 30 days of mechanical ventilation in all calculations. †For 48 chest radiographs done for patients on the routine strategy and 31 done for those on the on-demand strategy (p=0·9), whether the chest radiograph was done during the morning round or was unscheduled was not recorded.
strategy allocated for the first treatment period (p=0.20). The reduction was 10–56% across the 21 units: 10–20% in five centres, 20–40% in 11 centres, and more than 40% in five centres (figure 2).

The difference in the total number of routine and on-demand chest radiographs was not significant when the analysis was restricted to chest radiographs with new findings that led or contributed to diagnostic procedures or therapeutic interventions. 728 routine chest radiographs led or contributed to 824 therapeutic or diagnostic interventions in 264 patients, whereas 729 on-demand chest radiographs led or contributed to 834 interventions in 265 patients (p=0.77). The types of interventions done were similar between strategies, except for change in ventilator settings (figure 3).

Table 3 and webappendix p 4 indicate that the on-demand strategy was associated with a large and significant decrease in chest radiographs during morning rounds, with a small increase in unscheduled chest radiographs that was not significant. Importantly, no change was recorded in any secondary outcome measures—days of mechanical ventilation, length of stay in the intensive care unit, or mortality—between the routine and on-demand strategies (table 3).

Discussion

Results from our study show a substantial reduction in use of chest radiographs with the on-demand strategy in all 21 participating intensive care units, corresponding to a 32% decrease overall compared with the routine strategy. Between the strategies, we recorded similar numbers of chest radiographs that led or contributed to therapeutic or diagnostic interventions, duration of mechanical ventilation and stay in the intensive care unit, and mortality.

We noted that although the routine protocol specified that a chest radiograph should be done at morning rounds every day, 393 (9%) fewer chest radiographs were done at morning rounds than were patient-days available. However, had routine chest radiographs been done for every day of mechanical ventilation, the difference in the number of chest radiographs between the two strategies would have been greater than our results have shown.

Six studies have compared routine and on-demand strategies: one in a cardiothoracic ward for patients after intensive care,11 one in a paediatric intensive care unit,17 and four in mixed intensive care units.10,12,13,16 Three studies included any patients from intensive care units,11–13 and three focused on intubated patients only.10,16,17 All these single-centre studies favoured the on-demand strategy, but only two—of 519 chest radiographs in 94 patients16 and 977 chest radiographs in 165 patients10—specifically focused on adult patients who had been mechanically ventilated for at least 2 days. Our study of 7755 chest radiographs in almost 850 patients has strengths compared with previous studies.
reports. Notably, our study was multicentre and the cluster-randomised crossover design accounted for variation between the intensive care units. In the 21 intensive care units, the mean decrease of 32% in chest radiographs with the on-demand strategy is in keeping with that reported from results of single-centre studies: 35%, 45%, 35%, and 39%, although one study showed a reduction of 90%.

Our study is limited by the fact that routine chest radiographs are done to ensure that important findings are not missed; as underscored by Lessnau, many intensivists are not yet comfortable with obtaining fewer chest radiographs in the absence of extensive published evidence. Although we did not investigate whether the on-demand strategy was associated with missed findings that resulted in adverse events or delay in treatment, we did show that the on-demand strategy did not change the number of chest radiographs that led or contributed to diagnostic or therapeutic interventions, duration of mechanical ventilation or stay in intensive care unit, or mortality.

Second, opinions from medical personnel participating in the study about the routine versus on-demand strategies were not recorded before, during, and after the study. This information is potentially important—for example, the physicians’ workloads are increased by individual assessment of every patient early in the morning to decide whether a chest radiograph is necessary instead of ordering systematic morning chest radiographs for all mechanically ventilated patients. Such considerations could restrict implementation of the on-demand strategy in daily practice. Third, results were obtained in closed intensive care units in France, which have a specific organisation and patient case-mix (webappendix p 5). Therefore, extrapolation to different settings with other organisation and patient case-mix (webappendix p 5). Therefore, extrapolation to different settings with other case-mix or management should be done with caution. Nevertheless, our results can be generalised to many general intensive care units sharing similar characteristics to the intensive care units included in our study.

Results from our study strongly support the adoption of an on-demand strategy in preference to a routine strategy to decrease the number of chest radiographs done in mechanically ventilated adult patients without a reduction in patient safety. In view of the large number of patients who undergo mechanical ventilation, these results could substantially benefit clinical practice.

Contributors


Conflicts of interest

We declare that we have no conflicts of interest.

Acknowledgments

We thank the research clinical assistants, and especially Louise Anemet, Linda Gimeno, Xavier Lepage; the radiology departments of the 18 hospitals participating in the study; and David Yeung for editorial assistance. This study was funded by a grant (SCR06006) devoted to research on standard care procedures from Assistance Publique-Hôpitaux de Paris (Direction Régionale de la Recherche Clinique Ile de France).

References


Steering Committee