Oxygen Saturation and Outcomes in Preterm Infants

The BOOST II United Kingdom, Australia, and New Zealand Collaborative Groups

ABSTRACT

BACKGROUND
The clinically appropriate range for oxygen saturation in preterm infants is unknown. Previous studies have shown that infants had reduced rates of retinopathy of prematurity when lower targets of oxygen saturation were used.

METHODS
In three international randomized, controlled trials, we evaluated the effects of targeting an oxygen saturation of 85 to 89%, as compared with a range of 91 to 95%, on disability-free survival at 2 years in infants born before 28 weeks' gestation. Halfway through the trials, the oximeter-calibration algorithm was revised. Recruitment was stopped early when an interim analysis showed an increased rate of death at 36 weeks in the group with a lower oxygen saturation. We analyzed pooled data from patients and now report hospital-discharge outcomes.

RESULTS
A total of 2448 infants were recruited. Among the 1187 infants whose treatment used the revised oximeter-calibration algorithm, the rate of death was significantly higher in the lower-target group than in the higher-target group (23.1% vs. 15.9%; relative risk in the lower-target group, 1.45; 95% confidence interval [CI], 1.15 to 1.84; P = 0.002). There was heterogeneity for mortality between the original algorithm and the revised algorithm (P = 0.006) but not for other outcomes. In all 2448 infants, those in the lower-target group for oxygen saturation had a reduced rate of retinopathy of prematurity (10.6% vs. 13.5%; relative risk, 0.79; 95% CI, 0.63 to 1.00; P = 0.045) and an increased rate of necrotizing enterocolitis (10.4% vs. 8.0%; relative risk, 1.31; 95% CI, 1.02 to 1.68; P = 0.04). There were no significant between-group differences in rates of other outcomes or adverse events.

CONCLUSIONS
Targeting an oxygen saturation below 90% with the use of current oximeters in extremely preterm infants was associated with an increased risk of death. (Fundied by the Australian National Health and Medical Research Council and others; BOOST II Current Controlled Trials number, ISRCTN00842661, and Australian New Zealand Clinical Trials Registry numbers, ACTRN1260500055606 and ACTRN1260500253606.)
The clinically appropriate range for oxygen saturation in preterm infants is unknown. Trials in the 1950s showed that unrestricted oxygen increased the rate of severe retinopathy of prematurity. However, when oxygen was subsequently restricted, increased mortality was observed. The first Benefits of Oxygen Saturation Targeting (BOOST) trial showed that in preterm infants who were still receiving oxygen at 32 weeks’ gestation, targeting a higher oxygen-saturation range prolonged oxygen dependence. Observational studies suggested that higher oxygen-saturation levels may increase rates of retinopathy of prematurity.

In five randomized, masked trials with similar protocols conducted in the United States, Australia, New Zealand, Canada, and the United Kingdom involving infants born before 28 weeks’ gestation, investigators are evaluating the effects of targeting a range of oxygen saturation of 85 to 89%, as compared with a range of 91 to 95%, on survival and neurodevelopmental outcomes at 18 months to 2 years after the expected delivery date. In all five trials, Masimo Radical pulse oximeters were used to measure oxygen saturation.

During the trials, investigators in the United Kingdom found that standard Masimo Radical oximeters returned fewer oxygen-saturation values in the range of 87 to 90% than expected. We investigated this oximeter finding, because such a discrepancy might affect the study groups differently, and we found that there was a shift up in the oximeter-calibration curve between 87% and 90%. This reduced the frequency of displayed oxygen-saturation values ranging from 87 to 90% and caused values ranging from 87 to 96% to read 1 to 2% higher. Masimo supplied software with a revised calibration algorithm that eliminated the problem and was similar to the calibration of other oximeters.

Approximately halfway through the trials, between December 2008 and May 2009, oximeters in the United Kingdom and Australian trials were changed to the new calibration algorithm, and the new algorithm was used for all infants who were subsequently enrolled. The New Zealand trial oximeters were not changed because recruitment had nearly finished. Analysis of oxygen-saturation distributions showed that the revised calibration algorithm improved oxygen-saturation targeting, with clearer separation in oxygen-saturation patterns between the two study groups and more time in the intended oxygen-saturation range (Fig. 1, and Tables S1.1 through S1.4 in the Supplementary Appendix, available with the full text of this article at NEJM.org).

In 2010, in the Surfactant, Positive Pressure, and Pulse Oximetry Randomized Trial (SUPPORT), investigators reported that infants treated with the use of an oxygen-saturation target of 85 to 89%, as compared with a target of 91 to 95%, had decreased rates of retinopathy of prematurity (8.6% vs. 17.9%, P<0.001) but increased rates of death (19.9% vs. 16.2%, P=0.045). At that time, patients were being recruited for the BOOST II trials, and after analyzing data from the original trials, the data and safety monitoring committees did not advise stopping recruitment.

In December 2010, the data and safety monitoring committees in the United Kingdom, Australian, and New Zealand undertook a pooled interim safety analysis, including data from the 2315 infants enrolled in the three BOOST II trials and the 1316 infants enrolled in SUPPORT. The sole outcome that the committees analyzed was survival at 36 weeks’ gestation. Guidelines prespecified that the results would not be released to the investigators unless a difference in survival in all infants or in those recruited after the oximeter-calibration changes exceeded 3 SE (P<0.003). In the three trials reported here, mortality at 36 weeks showed heterogeneity between the original oximeter-calibration algorithm and the revised algorithm (P=0.006 for interaction). Among the 1260 infants for whom the original oximeter algorithm was used, there was no significant between-group difference in mortality. However, in the 1055 infants for whom the revised algorithm was used, infants with an oxygen-saturation target of 85 to 89%, as compared with those with a target of 91 to 95%, had an increased rate of death at 36 weeks (21.8% vs. 13.3%, P<0.001). At that time, recruitment to the present trials in the United Kingdom and Australia was closed. The present New Zealand trial had finished recruiting.

The primary outcome of the Neonatal Oxygenation Prospective Meta-analysis (NeOProM) Collaboration is death or severe neurosensory disability at 18 months to 2 years of age, corrected for prematurity. SUPPORT recently report-
Figure 1. Pooled Frequency Histograms for Time Infants Spent at Each Oxygen-Saturation Level from 80 to 100% While Receiving Supplemental Oxygen.

For trials in the United Kingdom and Australia, separate histograms are provided for infants whose treatment used the original oximeter-calibration algorithm and those whose treatment used the revised algorithm, according to whether they were assigned to receive a higher target of oxygen saturation (91 to 95%) or a lower target (85 to 89%). Revised oximeters were not used in the New Zealand trial.
ed no difference in this composite outcome but an increased rate of death at 18 to 22 months in infants in the group with a lower oxygen-saturation target. Because a finding of increased mortality with a lower oxygen-saturation target could have an influence on clinical practice, we now report a pooled analysis of individual patient data with respect to outcomes at hospital discharge in the United Kingdom, Australian, and New Zealand BOOST II trials.

**METHODS**

**PATIENTS**
The planned study sample sizes were 1200 infants each for the United Kingdom and Australian trials and 340 infants for the New Zealand trial. Infants were enrolled from March 1, 2006, until December 24, 2010. Randomization was performed centrally by computer and separately for each trial. In the United Kingdom, a minimization procedure was used to balance study-group assignment according to sex, gestational age, and center. In Australia and New Zealand, randomization was stratified according to sex, gestational age, center, single birth or multiple births, and whether birth took place in the hospital where enrollment took place. Infants were eligible if they had been born within the past 24 hours and before 36 weeks’ gestation. Infants were excluded if they were considered to be unlikely to survive, had a major congenital abnormality, or would die or were discharged home. If infants were in stable condition while breathing ambient air before 36 weeks, oximetry could be discontinued, but if oximetry resumed before 36 weeks, study oximeters were used. Data regarding oxygen saturation were downloaded and merged with chart data on which staff recorded the inspired oxygen concentration in blocks of either 20 minutes (in the United Kingdom) or 60 minutes (in Australia and New Zealand) to enable assessment of compliance with target ranges.

**ASSESSMENTS**
Data were recorded on case-report forms at each center and checked centrally. Retinopathy of prematurity was classified according to the International Classification of Retinopathy of Prematurity and is reported if infants were treated according to the Early Treatment for Retinopathy of Prematurity (ETROP) criteria. Necrotizing enterocolitis was listed if it required surgery or caused death. Oxygen treatment at 36 weeks was recorded in all three trials. In the United Kingdom, bronchopulmonary dysplasia was additionally defined as requiring supplemental oxygen at 36 weeks to maintain an actual oxygen saturation of 90%.

When the oximeter-calibration algorithm was revised, infants continued to be treated with the use of the oximeter-calibration version to which they were originally assigned. Clinical staff members were not informed about the nature of the software revision. No further training about oxygen-saturation targeting was provided.

**STUDY OVERSIGHT**
The BOOST II trials were funded and conducted independently, with similar protocols (available at NEJM.org). The Australian trial was funded by the National Health and Medical Research Council, the United Kingdom trial by the Medical Research Council, and the New Zealand trial by the New Zealand Health Research Council. Masimo supplied the oximeters used in the study under lease, but company representatives were not involved in the design of the study, in the analysis of the data, or in the preparation of the manuscript.
A joint analysis plan prespecified that data from the three trials would be pooled and outcomes reported for all infants and for those who underwent randomization before and after the revision of the oximeter-calibration algorithm.

All analyses were performed with the use of Stata SE 11.2 software (StatCorp). All analyses were performed separately by the trial statisticians in the United Kingdom and Australia and were cross-checked. A two-sided P value of less than 0.05 was considered to indicate statistical significance without adjustment for multiple comparisons.

All analyses were performed on the intention-to-treat principle at randomization, regardless of deviations from the protocol. Outcomes were summarized with the use of counts and percentages for categorical variables and of means and standard deviations for normally distributed continuous variables. The magnitude and direction of treatment effects were expressed as relative risks, with 95% confidence intervals adjusted for country. Relative risks were calculated as the event rate in the lower-target group divided by the event rate in the higher-target group. Pre-specified subgroup analyses according to the oximeter-calibration algorithm that was used were performed with a statistical test for interaction.

To compare the oxygen-saturation values, the percentage of time spent at each oxygen-saturation value between 60% and 100% was calculated for each infant and pooled for all infants, for time treated with oxygen and for all time evaluated on the oximeter. Offset readings were adjusted back to the actual oxygen-saturation values. We used quadratic interpolation to estimate the distribution of values affected by the transitioning back to actual values of offset readings in which the measured value was outside the range of 85 to 95%. A post hoc survival analysis was performed with the use of cumulative-hazard plots to compare mortality before discharge in the two target groups.

**R E S U L T S**

**PATIENTS**

A total of 2448 infants were enrolled in the three trials (973 in the United Kingdom, 1135 in Australia, and 340 in New Zealand). Of these infants, 1261 (51.5%) were treated with the use of the original oximeter-calibration algorithm and 1187 (48.5%) with the use of the revised algorithm (Fig. 2). Baseline demographic and clinical characteristics were similar in the two target groups, among the three trials, and in the two algorithm groups (Table 1). Forest plots of pooled outcomes at hospital discharge are shown in Figure 3. Outcome data from the individual trials are provided in Tables S2.1 and S2.2 in the Supplementary Appendix.

**RATE OF DEATH**

Among the 1187 infants for whom the revised oximeter-calibration algorithm was used, those in the lower-target group had a higher rate of death than those in the higher-target group before hospital discharge (23.1% vs. 15.9%; relative risk in the lower-target group, 1.45; 95% confidence interval [CI], 1.15 to 1.84; P=0.002). These findings mean that 14 infants would need to be treated with a higher oxygen-saturation target in order to prevent 1 death. Among the 1261 infants for whom the original oximeter-calibration algorithm was used, there were no significant between-group differences in outcomes at hospital discharge. There was heterogeneity between the rates of death among infants whose treatment used the original oximeter-calibration algorithm, as compared with the revised algorithm (P=0.006 for interaction), but not for other outcomes.

In all data combined, there was no significant difference in rate of death in the lower-target
Oxygen Saturation and Outcomes in Preterm Infants

3041 Patients were assessed for eligibility
2454 Were in Australia
587 Were in New Zealand

1566 Were excluded
1319 Were in Australia
247 Were in New Zealand
275 Did not meet inclusion criteria
226 Were in Australia
49 Were in New Zealand
443 Declined to participate
384 Were in Australia
59 Were in New Zealand
848 Had other reasons
709 Were in Australia
139 Were in New Zealand

2448 Underwent randomization
1135 Were in Australia
340 Were in New Zealand
973 Were in the United Kingdom

1224 Were assigned to lower-target oxygen saturation (83–89%)
568 Were in Australia
170 Were in New Zealand
486 Were in the United Kingdom
1211 Received assigned intervention
560 Were in Australia
169 Were in New Zealand
482 Were in the United Kingdom
1 in the UK was randomized in error
12 Did not receive assigned intervention
8 Were in Australia
1 Was in New Zealand
3 Were in the United Kingdom

1224 Were assigned to higher-target oxygen saturation (91–95%)
567 Were in Australia
170 Were in New Zealand
487 Were in the United Kingdom
1212 Received assigned intervention
561 Were in Australia
169 Were in New Zealand
482 Were in the United Kingdom
1 in the UK was randomized in error
11 Did not receive assigned intervention
6 Were in Australia
1 Was in New Zealand
4 Were in the United Kingdom

1 in Australia was lost to follow-up
20 Discontinued intervention
3 Were in Australia
17 Were in the United Kingdom
43 Discontinued intervention at trial closure
14 Were in Australia
29 Were in the United Kingdom

1222 Were included in the intention-to-treat analysis
567 Were in Australia
170 Were in New Zealand
485 Were in the United Kingdom

1223 Were included in the intention-to-treat analysis
567 Were in Australia
170 Were in New Zealand
486 Were in the United Kingdom

15 Discontinued intervention
1 Was in Australia
1 Was in New Zealand
13 Were in the United Kingdom
43 Discontinued intervention at trial closure
16 Were in Australia
29 Were in the United Kingdom

and an increased rate of necrotizing enterocolitis requiring surgery or causing death (10.4% vs. 8.0%; relative risk, 1.31; 95% CI, 1.02 to 1.68; P=0.04). Although significantly fewer infants in the lower-target group were treated with oxygen at 36 weeks in the three trials, there was no
significant between-group difference in the rate of bronchopulmonary dysplasia, as defined physiologically in the United Kingdom trial. There were more deaths in the lower-target group, but no single cause dominated the difference (Table S3 in the Supplementary Appendix). Figure 4 shows cumulative hazard plots for mortality before discharge, according to which version of the oximeter-calibration algorithm was used. The difference in the proportions of infants surviving in the two groups accumulated gradually after the first week after birth.

**EFFECT OF OXIMETER RECALIBRATION**

Figure 1 summarizes pooled distributions of oxygen saturation during the administration of supplemental oxygen (Fig. S1 and Tables S1.1 through S1.4 in the Supplementary Appendix). With the original oximeter-calibration algorithm, there were fewer oxygen-saturation values between 87% and 90% in the two target groups and little separation between the peaks of the oxygen-saturation distributions. With the revised algorithm, the dip in oxygen-saturation values between 87% and 90% was eliminated, and there was clearer separation between the two target groups.

**PER-PROTOCOL ANALYSIS AND ADVERSE EVENTS**

The results of a per-protocol analysis that excluded 23 infants who did not receive the intended intervention were similar to the findings in the intention-to-treat analysis. The few adverse events that were reported are listed in full in Table S4 in the Supplementary Appendix.

**DISCUSSION**

The present trials were closed early when a pooled interim safety analysis showed that infants in the group treated with an oxygen-saturation target of 85 to 89%, as compared with 91 to 95%, had an increased rate of death at 36 weeks. This report includes outcomes for all infants until hospital discharge. A substantial difference in mortality persisted, and other important outcomes were influenced significantly by the targeted oxygen-saturation range. The between-group difference in the rate of death accrued over many weeks of the intervention and was not attributable to any single cause of death. It is unclear why the rate of death was

---

### Table 1. Baseline Characteristics of the Infants, According to Trial and Study Group.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Australia</th>
<th>New Zealand</th>
<th>United Kingdom</th>
<th>Combined Trials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male sex — no./total no. (%)</td>
<td>293/568 (51.6)</td>
<td>295/566 (52.1)</td>
<td>90/170 (52.9)</td>
<td>258/465 (55.3)</td>
</tr>
<tr>
<td>Birth weight — g</td>
<td>817±177</td>
<td>833±190</td>
<td>873±202</td>
<td>884±186</td>
</tr>
<tr>
<td>Gestational age — wk</td>
<td>26.0±1.19</td>
<td>26.1±1.23</td>
<td>26.1±1.23</td>
<td>26.1±1.19</td>
</tr>
<tr>
<td>Multiple births — no./total no. (%)</td>
<td>138/568 (24.3)</td>
<td>135/567 (23.8)</td>
<td>46/170 (27.1)</td>
<td>31/170 (18.2)</td>
</tr>
<tr>
<td>Birth outside enrollment hospital — no./total no. (%)</td>
<td>26/568 (4.6)</td>
<td>25/567 (4.4)</td>
<td>5/170 (2.9)</td>
<td>3/170 (1.8)</td>
</tr>
<tr>
<td>Use of antenatal glucocorticoids — complete regimen — no./total no. (%)</td>
<td>303/568 (53.1)</td>
<td>329/567 (58.2)</td>
<td>94/170 (55.3)</td>
<td>301/465 (64.9)</td>
</tr>
<tr>
<td>Admission temperature — °C</td>
<td>36.0±0.93</td>
<td>36.8±0.93</td>
<td>36.7±0.91</td>
<td>36.6±0.91</td>
</tr>
</tbody>
</table>

*Plus-minus values are means ±SD. The oxygen-saturation targets were 85 to 89% (lower-target group) or 91 to 95% (higher-target group).
higher in the lower-target group than in the higher-target group. Detailed post hoc analysis of the oxygen-saturation patterns of infants who survived and died will be required to further explore this issue. Interpretation of the results is complicated by the change in oximeter calibration approximately halfway through the trials. This modification rectified an artifact in the original oximeters that appeared to decrease the interpretation approximately halfway through the trials. This modification rectified an artifact in the original oximeters that appeared to decrease the oxygen-saturation patterns of infants who survived and died will be required to further explore this issue. Interpretation of the results is
patterns. The revised Masimo oximeter-calibration algorithm may be more relevant to future clinical practice because it resembles the calibration in other commonly used oximeters; the original calibration algorithm is no longer available.

There was significant heterogeneity in treatment effect between the original oximeter-calibration algorithm and the revised algorithm with respect to mortality but not retinopathy of prematurity or necrotizing enterocolitis. This may be because each of these outcomes may be influenced at different oxygen saturations. The oxygen-saturation histograms in Figure 1 show that when the oximeter-calibration algorithm was revised, there was no increase in the proportion of time spent with oxygen-saturation values below 85% in the lower-target group. This suggests that the increase in mortality cannot be attributed to an increase in the time spent with very low oxygen-saturation values.

Infants in the lower-target group had a significant decrease in the rate of treatment for retinopathy of prematurity, a finding that is consistent with the results of trials conducted in the 1950s and SUPPORT.6,11 Because treatment for this condition is usually effective, blindness was rare, with similar rates in the two target groups in SUPPORT.11 However, retinopathy of prematurity causes other structural and functional eye abnormalities that can be visually disabling,14 and these may become more common if the reported survival advantage with a higher oxygen saturation influences clinical practice. Treatment for retinopathy of prematurity was more frequent in the two target groups in the United Kingdom than in Australia and New Zealand, suggesting that treatment thresholds may have differed even though the same criteria were used.15

In the pooled data, the lower oxygen-saturation target significantly increased the rate of necrotizing enterocolitis requiring surgery or causing death. This definition excludes milder cases of necrotizing enterocolitis with more subjective features. It is plausible that a lower oxygen saturation might influence bowel ischemia.

The increased proportion of infants receiving oxygen at 36 weeks in the higher-target group probably reflects, in part, the increased oxygen needed to achieve the target. As in SUPPORT,6 when bronchopulmonary dysplasia was defined on the basis of a physiological test in the United Kingdom trial, there was no significant between-group difference in this diagnosis.

With the original oximeters in the present trials, the peak median oxygen-saturation values while infants were receiving supplemental oxygen were approximately 89% in the lower-target group and 92% in the higher-target group, as compared with 91% and 94%, respectively, in SUPPORT.6 Although the same intended targets

---

**Figure 4. Cumulative Hazard Estimates for Death before Hospital Discharge.**

Data from the three BOOST II trials have been pooled and are plotted separately for infants who were treated with the use of the original oximeter-calibration algorithm (Panel A) or the revised algorithm (Panel B). Cumulative hazard values were calculated with the use of the Nelson–Aalen estimator.
were used, quite different oxygen-saturation patterns were achieved in our studies, as compared with those in SUPPORT. When the oximeter-calibration algorithm was revised, the lower-target groups in the present trials spent more time in the intended range, and mortality in these groups increased. With greater or lesser adherence to the intended range, the effect of oxygen-saturation targets on mortality may vary, so the best estimate of the effect of oxygen saturation on mortality is unknown. Other interventions that influence oxygen targeting may influence mortality and should also be researched carefully.16

Monitoring of oxygen saturation has largely replaced the practice of monitoring the arterial partial pressure of oxygen (PaO\textsubscript{2})\textsuperscript{17,18} and has effectively lowered the range of PaO\textsubscript{2} for preterm infants, as compared with previously recommended PaO\textsubscript{2} targets.\textsuperscript{19,20} Infants in the lower-target group may have had times when the PaO\textsubscript{2} was below 40 mm Hg.\textsuperscript{19} The optimal measure of oxygenation to guide clinical practice is not known.

Without the pooled interim safety analysis,\textsuperscript{10} continued recruitment to the present trials might have resulted in potentially avoidable deaths in the lower-target group. Consensus is needed about the roles of data and safety monitoring committees of simultaneous, similar, independent trials in respect to patient safety. The use of an interim analysis carries a statistical risk that, by chance, the observed effect might not represent the true effect that would have been shown if the trial had continued.\textsuperscript{21} Thus, the prespecified criteria for unmasking the results of the interim safety analysis\textsuperscript{11} required a difference in survival of 3 SE (99.73% confidence interval).

The clinically appropriate oxygen-saturation range for extremely preterm infants is unknown and may vary with advancing gestational and postnatal age. The present trials and the SUPPORT trial suggest that targeting a range of 91 to 95% is safer than targeting a range of 85 to 89%, but other ranges have not been investigated. The follow-up results from SUPPORT show no significant difference in rates of later disability.\textsuperscript{11} The ongoing NeOProM Collaboration\textsuperscript{7} will eventually provide follow-up data on approximately 5000 infants and may further inform clinical practice.

In conclusion, preterm infants born before 28 weeks' gestation with a target oxygen saturation of 85 to 89% had a significantly higher rate of death than those with a target of 91 to 95% in a subgroup whose treatment involved an oximeter-calibration algorithm similar to that in current use.\textsuperscript{8} Our findings strongly favor the avoidance of targeting an oxygen saturation of less than 90% among such infants, according to readings on current oximeters.\textsuperscript{6,10,11,22}

Supported by the National Health and Medical Research Council (project grant 352386, to the Australian trial), the Medical Research Council (grant number 73460, to the United Kingdom trial), and the New Zealand Health Research Council (project grant number 05-145, to the New Zealand trial); and by a grant from the United Kingdom's Biomedical Research Centre of the National Institute for Health Research (to Dr. Marlow), Masimo supplied the study oximeters under lease. Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

We thank the many parents and clinicians who participated in these studies; the late Dr. Edmund Hey, for his contribution to study development; and Masimo for providing the modified calibration algorithms and for technical support.

APPENDIX

Members of the writing committee (Ben J. Stenson, M.D., Neonatal Unit, Royal Infirmary of Edinburgh, Department of Child Life and Health, University of Edinburgh, Edinburgh; William O. Tarnow-Mordi, M.B., Ch.B., Westmead International Network for Neonatal Education and Research (WINNER) Centre, National Health and Medical Research Council (NHMRC) Clinical Trials Centre, University of Sydney, Westmead Hospital, Sydney; Brian A. Darkow, M.D., University of Otago, Christchurch, New Zealand; John Simes, M.D., NHMRC Clinical Trials Centre, University of Sydney, Sydney; Edmund Juszczak, M.Sc., Clinical Trials Unit, National Perinatal Epidemiology Unit (NPEU), University of Oxford, Oxford, United Kingdom; Lisa Askie, Ph.D., NHMRC Clinical Trials Centre, University of Sydney, Sydney; Malcolm Barton, M.D., Newborn Services, Auckland City Hospital and Department of Paediatrics, University of Auckland, Auckland, New Zealand; Ursula Bowler, NPEU Clinical Trials Unit, University of Oxford, Oxford, United Kingdom; Roland Broadbent, M.B., Ch.B., Department of Women's and Children's Health, Dunedin School of Medicine, University of Otago, Dunedin, New Zealand; Pamela Cairns, M.D., University Hospitals Bristol National Health Service (NHS) Trust, Bristol, United Kingdom; Peter Graham Davis, M.D., Royal Melbourne Hospital and the Department of Obstetrics and Gynaecology, University of Melbourne, VIC, Australia; Sanjeev Deshpande, M.B., B.S., Shrewsbury and Telford Hospitals NHS Trust, Shrewsbury, United Kingdom; Mark Donoghoe, B.Sc., NHMRC Clinical Trials Centre, University of Sydney, Sydney; Lex Doyle, M.D., the Royal Women's Hospital, University of Melbourne, Murdoch Children's Research Institute, Melbourne, VIC, Australia; Brian W. Fleck, M.D., NHS Lothian, Princess Alexandra Eye Pavilion, Edinburgh; Alpana Ghadge, Ph.D., NHMRC Clinical Trials Centre, University of Sydney, Sydney; Wendy Hague, Ph.D., NHMRC Clinical Trials Centre, University of Sydney, Sydney; Jeffrey Halliday, M.D., Queen's University, Belfast, United Kingdom; Michael Hewson, M.B., Ch.B., Neonatal Intensive Care Unit, Wellington Hospital, Wellington, New Zealand; Andrew King, B.A., NPEU Clinical Trials Unit, University of Oxford,
REFERENCES


Copyright © 2013 Massachusetts Medical Society.