ILCOR Advisory Statement

Temperature Management After Cardiac Arrest
An Advisory Statement by the Advanced Life Support Task Force of the International Liaison Committee on Resuscitation and the American Heart Association Emergency Cardiovascular Care Committee and the Council on Cardiopulmonary, Critical Care, Perioperative and Resuscitation

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Abstract—For more than a decade, mild induced hypothermia (32°C–34°C) has been standard of care for patients remaining comatose after resuscitation from out-of-hospital cardiac arrest with an initial shockable rhythm, and this has been extrapolated to survivors of cardiac arrest with initially nonshockable rhythms and to patients with in-hospital cardiac arrest. Two randomized trials published in 2002 reported a survival and neurological benefit with mild induced hypothermia. One recent randomized trial reported similar outcomes in patients treated with targeted temperature management at either 33°C or 36°C. In response to these new data, the International Liaison Committee on Resuscitation Advanced Life Support Task Force performed a systematic review to evaluate 3 key questions: (1) Should mild induced hypothermia (or some form of targeted temperature management) be used in comatose post–cardiac arrest patients? (2) If used, what is the ideal timing of the intervention? (3) If used, what is the ideal duration of the intervention? The task force used Grading of Recommendations Assessment, Development and Evaluation methodology to assess and summarize the evidence and to provide a consensus on science statement and treatment recommendations. The task force recommends targeted temperature management for adults with out-of-hospital cardiac arrest with an initial shockable rhythm at a constant temperature between 32°C and 36°C for at least 24 hours. Similar suggestions are made for out-of-hospital cardiac arrest with a nonshockable rhythm and in-hospital cardiac arrest. The task force recommends against prehospital cooling with rapid infusion of large volumes of cold intravenous fluid. Additional and specific recommendations are provided in the document. (Circulation. 2015;132:2448-2456. DOI: 10.1161/CIR.0000000000000313.)

Key Words: AHA Scientific Statements ■ cardiac arrest ■ duration ■ heat arrest ■ hypothermia ■ resuscitation ■ temperature management ■ timing

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Sudden cardiac arrest is one of the leading causes of death in adults around the world. Although the incidence varies from country to country, cardiac arrest affects several million people annually, with an average survival rate of <10%. In patients who remain comatose after cardiac arrest, the post–cardiac arrest syndrome is a complex set of pathophysiological processes consisting of brain injury, myocardial depression, and systemic ischemia/reperfusion injury, as well as ongoing injury caused by the precipitating cause of the arrest. For more than a decade, mild induced hypothermia (32°C–34°C) has been the cornerstone of post–cardiac arrest care. Mild to moderate hypothermia induced after global brain ischemia or cardiac arrest was initially evaluated in animal models that showed improved neurological function for those receiving induced hypothermia. After 2 human randomized trials published in 2002, the International Liaison Committee on Resuscitation (ILCOR) recommended in 2003 that “unconscious adult patients with spontaneous circulation after out-of-hospital cardiac arrest (OHCA) should be cooled to 32°C to 34°C for 12 to 24 hours when the initial rhythm was [ventricular fibrillation] VF” and that “such cooling may also be beneficial for other rhythms or in-hospital cardiac arrest” (IHCA). Similar recommendations were provided in the “2010 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations.”

Recently, a prospective, randomized trial comparing a targeted temperature of 33°C with 36°C for a large group of patients with OHCA found that both groups had similar mortality (primary end point) and neurological outcome at 180 days. As a result of that trial, there has been debate about the optimal target temperature for post–cardiac arrest patients. To address the evolving science of targeted temperature management (defined as an active therapy to achieve and maintain a specific target temperature for a defined duration), the ILCOR Advanced Life Support (ALS) Task Force conducted an evidence review and created an updated position paper to address 3 key questions about temperature management in the post–cardiac arrest patient:

1. For patients who remain comatose after return of spontaneous circulation (ROSC), should targeted temperature management be used?
2. If targeted temperature management is used, what is the optimal timing of initiation?
3. If targeted temperature management is used, what is the optimal duration of therapy?

To address these questions, the ALS Task Force created formal Population, Intervention, Comparison, and Outcome (PICO) questions and performed a comprehensive literature search. The task force evaluated, compiled, and summarized the evidence by using Grading of Recommendations Assessment, Development and Evaluation (GRADE; www.gradeworkinggroup.org) methodology and performed meta-analyses when appropriate. The task force then created a consensus statement by considering the available evidence and balancing benefits and harms to guide the final recommendations.

Methods

Overview

We conducted a systematic review and, when appropriate, meta-analyses for 3 distinct questions about temperature management (outlined in the Questions Asked section). We completed a bias assessment for all included studies and then used GRADE methodology to evaluate this evidence and to develop treatment recommendations. The outcomes of interest were defined and prioritized by the ILCOR ALS Task Force as part of the evidence review process for the 2015 ILCOR guidelines.

Questions Asked

The literature searches were designed to address the following 3 PICO questions:

1. Among patients with ROSC after cardiac arrest in any setting (P), does inducing mild hypothermia (target temperature, 32°C–34°C; I) compared with no targeted temperature management (C) change survival with favorable neurological/functional outcome at discharge, 30 days, 60 days, 180 days, or 1 year or survival only at discharge, 30 days, 60 days, 180 days, or 1 year (O)?
2. Among patients with ROSC after cardiac arrest in any setting (P), does induction of hypothermia before some time point (eg, 1 hour after ROSC or before hospital arrival; I) compared with induction of hypothermia after that time point (C) change survival with favorable neurological/functional outcome at discharge, 30 days, 60 days, 180 days, or 1 year or survival only at discharge, 30 days, 60 days, 180 days, or 1 year (O)?
3. Among patients with ROSC after cardiac arrest in any setting (P), does induction and maintenance of hypothermia for any duration other than 24 hours (C) compared with induction and maintenance of hypothermia for a duration of 24 hours (I) change survival with favorable neurological/functional outcome at discharge, 30 days, 60 days, 180 days, or 1 year or survival only at discharge, 30 days, 60 days, 180 days, or 1 year (O)?

Selection of Studies

Information specialists searched PubMed, EMBASE, and the Cochrane Library in December 2013 (questions 2 and 3) and January 2014 (question 1) and again in December 2014 by using the search terms outlined in Appendix A in the online-only Data Supplement.

Data Selection and Extraction

Two reviewers independently screened titles and abstracts that resulted from the search for studies that addressed the question posed by each PICO. Inclusion criteria within each question were chosen on the basis of the amount and type of evidence available. The entire task force approved each set of criteria. Disagreement on individual studies was settled via consensus between the reviewers and a facilitator from the task force.

- Question 1: For patient populations in which randomized, controlled trials (RCTs) were available (ie, shockable
OHCA), only RCTs were included. Otherwise, observational studies were included for the 2 patient populations in which there were no RCT data: IHCA and OHCA with an initial nonshockable rhythm. We did not include studies without a comparator group, studies that did not report separate outcomes for shockable and nonshockable rhythms, or studies that only reported unadjusted outcomes. We chose to exclude studies with a pre-post design because of the significant changes in post–cardiac arrest care over the past several years and the consequent danger of significant confounding based on year of arrest.

• Question 2: Only human RCTs were included. Given the number of human RCTs available for review, observational data were excluded.

• Question 3: Given the lack of human RCT data, all studies with a comparator group were included. Case reports/series were not included.

Studies published only in abstract form were excluded from all 3 questions because of the risk of incomplete reporting. There were no exclusions based on language. Articles were initially included on the basis of title or abstract. Subsequently, the text was reviewed to determine whether the article addressed the PICO question and whether all inclusion and no exclusion criteria were met. Inclusion of animal studies was beyond the scope of the present document, although we recognize that animal studies have and will continue to provide valuable preliminary and mechanistic data.

Bias Assessment and GRADE Methodology
All included RCTs were assessed for bias on the basis of criteria from the Cochrane Handbook for Systematic Reviews of Interventions. Briefly, RCTs were assessed on the adequacy of allocation generation, allocation concealment, blinding of participants, blinding of outcome assessors, completeness of follow-up, selectivity of outcome reporting, and a final category for “other” sources of bias. Observational studies were assessed for the presence of appropriate eligibility criteria, clear exposure and outcome definitions, confounding, and completeness of follow-up. The results of the bias assessments are detailed in the appendixes in the online-only Data Supplement.

The overall quality of evidence was summarized by use of the GRADE approach and online tools. Briefly, the GRADE approach assesses the combined quality of the evidence or confidence in the estimates of effect across individual outcomes by evaluation for risk of bias, indirectness, imprecision, and inconsistency, as well as other considerations of the included studies. In each category, the evidence for a given outcome can be rated as being free of serious concerns or downgraded by 1 or 2 levels for serious or very serious concerns, respectively. The quality of evidence across each outcome is rated as very low, low, moderate, or high on the basis of these considerations. RCTs start as high quality and observational studies start as low quality and can then be upgraded or downgraded on the basis of the above criteria. Details of the current GRADE evaluations are provided in the appendixes in the online-only Data Supplement. The GRADE approach, inclusive of definitions and details of the above, is described in extensive detail at www.gradeworkinggroup.org. In this document, for the sake of consistency, we chose to report mortality and poor neurological outcome throughout the article, acknowledging that this differs from the phrasing of the PICO question outcomes in some cases.

Meta-Analysis
Meta-analyses were conducted when the included RCTs were judged to be comparable in terms of patients, interventions, comparisons, and outcomes. To be conservative, we assumed a considerable amount of heterogeneity and used random-effects models for all analyses. All plots and estimates were calculated with RevMan version 5.2, and data are summarized as relative risks (RRs) or odds ratios (ORs) with 95% confidence intervals (CIs).

Development of the Treatment Recommendations
The GRADE approach was used to grade the strength of recommendations and to inform the language of the treatment recommendations. The evidence reviewers drafted a statement of the consensus on science and treatment recommendations, which was then reviewed and revised by the task force through an iterative process. The members of the task force voted on and approved the final advisory statement. A majority rule was applied, although the vote was close to unanimous for all recommendations.

Results and Recommendations
(Consensus on Science)

Question 1: Does Mild Hypothermia Compared Versus No Targeted Temperature Management Improve Outcome?

Evidence
The search yielded a total of 5045 studies. Of these, 6 RCTs and 5 observational studies were included for bias assessment (in the online-only Data Supplement). Appendix B shows the study selection flow diagram. Appendix C provides the study overview, and Appendix D describes bias assessment. One small feasibility RCT was not included in the bias assessment because the intervention group received cooling only until the target temperature was reached or for 4 hours, whichever came first. After bias assessment, 1 RCT was not considered further because of a high risk of bias, as outlined in Appendix D of the online-only Data Supplement. We used the remaining 5 RCTs to assess the evidence for temperature management in OHCA. Five observational studies addressed the evidence for targeted temperature management for IHCA and OHCA with an initial nonshockable rhythm. We organized the available evidence into separate but related categories:

1. Evidence to support targeted temperature management versus no targeted temperature management for the following:
   a. Adult patients with ROSC after OHCA with an initially shockable rhythm
   b. Adult patients with ROSC after OHCA with an initially nonshockable rhythm
c. Adult patients with ROSC after IHCA with any initial rhythm

2. In patients for whom targeted temperature management is performed, what is the ideal target temperature?

**OHCA With an Initial Shockable Rhythm**

One RCT and 1 quasi-randomized trial enrolling a total of 352 patients provided overall low-quality evidence for decreased poor neurological outcome in patients with OHCA with ventricular fibrillation or pulseless ventricular tachycardia as an initial rhythm who were cooled to 32°C to 34°C compared with no cooling. The pooled RR was 0.75 (95% CI, 0.61–0.92) for mortality and 0.73 (95% CI, 0.60–0.88) for poor neurological/functional outcome at 6 months or hospital discharge (see Appendix F in the online-only Data Supplement). One additional small RCT of 61 patients evaluated hypothermia in the setting of high-volume hemofiltration and found no increase in survival at 6 months. This study was downgraded for potential confounding because patients received concomitant hemofiltration with high volumes of cold fluid, and this trial was therefore not included in the meta-analysis.

**OHCA With an Initial Nonshockable Rhythm**

Three cohort studies including a total of 1034 patients provided overall very low-quality evidence for no difference in poor neurological outcome in patients with nonshockable OHCA (adjusted pooled OR, 0.90; 95% CI, 0.45–1.82; forest plot in Appendix F of the online-only Data Supplement). One additional retrospective study using a large registry, analyzing 1830 patients, provided very low-quality evidence for an increase in poor neurological outcome in patients with nonshockable OHCA (adjusted OR, 1.44; 95% CI, 1.04–2.01). These data were not pooled with the above studies because of a very high risk of bias (inconsistent results with different analyses reported from the study). One of these studies reported mortality and provided overall very low-quality evidence for decreased mortality at 6 months (adjusted OR, 0.56; 95% CI, 0.34–0.93).

**In-Hospital Cardiac Arrest**

One retrospective cohort study of 8316 IHCA patients with any initial rhythm provided overall very low-quality evidence for no difference in mortality at hospital discharge (adjusted OR, 1.11; 95% CI, 0.81–1.54) or poor neurological outcome (adjusted OR, 1.08; 95% CI, 0.76–1.54).

**Evidence for an Ideal Temperature When Using Targeted Temperature Management?**

One RCT of 939 patients compared target temperatures of 33°C and 36°C in adult patients with OHCA of any initial rhythm except unwitnessed asystole. This study provided moderate-quality evidence for no decrease in mortality at 180 days (RR, 1.01; 95% CI, 0.88–1.16) or poor neurological outcome at 6 months (RR, 1.03; 95% CI, 0.91–1.16) in the 33°C group compared with the 36°C group. One additional small pilot RCT of 36 patients compared 32°C and 34°C in patients with OHCA and an initial shockable rhythm or asystole. This study provides overall very low-quality evidence for decreased mortality with 32°C compared with 34°C (RR, 0.63; 95% CI, 0.40–0.97) but no decrease in poor neurological outcome (RR, 0.64; 95% CI, 0.38–1.09) or increase in survival free from severe dependence (RR, 0.32; 95% CI, 0.08–1.37). However, given the very small sample size, the findings of this study are very imprecise.

**Conclusions**

One RCT and 1 quasi-RCT provide overall low-quality evidence to use targeted temperature management after ROSC from OHCA with an initial shockable rhythm. Although there is no direct evidence supporting this therapy in nonshockable OHCA or IHCA, indirect evidence extrapolated from studies of shockable OHCA may support this strategy. There is no good direct evidence that suggests that 1 target temperature within the 32°C-to-36°C range is superior to another.

**Recommendations**

We recommend targeted temperature management as opposed to no targeted temperature management for adults with OHCA with an initial shockable rhythm who remain unresponsive after ROSC (strong recommendation, low-quality evidence).

We suggest targeted temperature management as opposed to no targeted temperature management for adults with OHCA with an initial nonshockable rhythm (weak recommendation, very low-quality evidence) who remain unresponsive after ROSC.

We suggest targeted temperature management as opposed to no targeted temperature management for adults with IHCA (weak recommendation, very low-quality evidence) with any initial rhythm who remain unresponsive after ROSC.

We recommend selecting and maintaining a constant, target temperature between 32°C and 36°C for those patients in whom temperature control is used (strong recommendation, moderate-quality evidence). Whether certain subpopulations of cardiac arrest patients may benefit from lower (32°C–34°C) or higher (36°C) temperatures remains unknown, and further research may help elucidate this.

**Question 2: Does Early (Prehospital) Induction of Targeted Temperature Management Affect Outcome?**

**Evidence**

Seven RCTs were identified for inclusion from 2286 studies generated from the search (Appendix B in the online-only Data Supplement gives the study selection flow diagram). Five of the 7 studies used cold intravenous fluids after ROSC to induce hypothermia; 1 study used cold intravenous fluid during resuscitation; and 1 study used intra-arrest intranasal cooling. The volume of cold fluid ranged from 20 to 30 mL/kg and up to 2 L, although some patients did not receive the full amount before hospital arrival. One small feasibility trial was not included. All 7 included studies suffered from the unavoidable lack of blinding of the clinical team, and 3 also failed to blind the outcomes assessors (Appendixes C, D, and E in the online-only Data Supplement give the study overview, bias assessments, and GRADE tables).

Five of the studies, enrolling a total of 1867 patients with OHCA, evaluated the outcome of poor neurological outcome. Meta-analysis of these studies showed that initiation of induced
bias assessment). Previous trials for targeted temperature had pulmonary edema. Two small pilot trials found no statistically significant difference between the groups, whereas the larger trial by Kim et al found an increase in pulmonary edema in patients who received prehospital cooling (RR, 1.34; 95% CI, 1.15–1.57). Forest plots are presented in Appendix F of the online-only Data Supplement. When reviewed individually, none of the trials found an effect on either poor neurological outcome or mortality.

Meta-analysis of 4 RCTs that examined the outcome of patients who received prehospital induced hypothermia (RR, 1.22; 95% CI, 1.01–1.46). This result was driven by data from the largest trial. Six trials included pulmonary edema as an outcome. Three of these recorded no pulmonary edema in either group. The remaining 3 trials did record patients who had pulmonary edema. Two small pilot trials found no statistically significant difference between the groups, whereas the larger trial by Kim et al found an increase in pulmonary edema in patients who received prehospital cooling (RR, 1.34; 95% CI, 1.15–1.57). Forest plots are presented in Appendix F of the online-only Data Supplement.

Conclusions
In 7 RCTs providing overall moderate-quality evidence, prehospital induction of mild hypothermia did not reduce poor neurological outcome or mortality after OHCA. The largest study found an increased risk of pulmonary edema and re-arrest with prehospital induction of mild hypothermia using rapid infusion of cold intravenous fluid.

Recommendation
We recommend against routine use of prehospital cooling with rapid infusion of large volumes of cold intravenous fluid immediately after ROSC (strong recommendation, moderate-quality evidence). Other cooling strategies and cooling during cardiopulmonary resuscitation in the prehospital setting have not been studied adequately, and further research in this area is needed.

Question 3: Does the Duration of Targeted Temperature Management Affect Outcome

Evidence
We found no human interventional studies comparing different durations of targeted temperature management after cardiac arrest with ROSC (Appendix B in the online-only Data Supplement gives the study flowchart). One observational study provided overall very low-quality evidence for no difference in duration of hypothermia in those with a good versus a poor neurological outcome, and 1 observational study provided overall very low-quality evidence for no difference in mortality or poor neurological outcome with 24 compared with 72 hours of hypothermia (Appendixes C and D in the online-only Data Supplement give the study overview and bias assessment). Previous trials for targeted temperature management ranged from 12 to 28 hours. One trial (Nielsen et al) provided strict normothermia (<37.5°C) after rewarming until 72 hours after ROSC. However, this intervention was applied to both groups; therefore, treatment effect cannot be assessed.

Conclusion
There are no data that can be used to compare different durations of targeted temperature management in humans.

Recommendation
We suggest that if targeted temperature management is used, duration should be at least 24 hours, as in the 2 largest previous RCTs (weak recommendation, very low-quality evidence).

Discussion and Knowledge Gaps
Although some recent reports suggest modest improvements in outcome over the past decade, cardiac arrest continues to be associated with high morbidity and mortality. The recommendations within this statement should be viewed in light of the very poor prognosis in this patient population and the fact that there are currently very few proven interventions for patients after cardiac arrest. The execution of well-controlled RCTs in post–cardiac arrest patients is challenging because of the complexity, heterogeneity, and high acuity of the patients. Moreover, the inability to blind clinicians to treatments such as temperature management adds another layer of difficulty when weighing the evidence.

The most notable difference between the trials by Bernard et al and the Hypothermia After Cardiac Arrest (HACA) group (both published in 2002) and the trial by Nielsen et al (published in 2013) is that the earlier studies did not adequately control temperature in the control arm. Average temperatures were >37°C in the control groups in the studies by both Bernard et al and the HACA group, whereas tight control was maintained in the 36°C group in the trial by Nielsen et al. Although there is no high-quality evidence, some observational studies have found an association between post–cardiac arrest fever and poor outcome.

The second notable difference between the Bernard et al and HACA trials and the trial by Nielsen et al was the use of a blinded neurological prognosticator instead of reliance on unblinded clinical teams. For both the Bernard et al and the HACA investigations, clinical teams aware of the treatment allocation provided families with the prognostic information that informed decisions about withdrawal of care; moreover, the timing of prognosis and decision making was not controlled for. In contrast, Nielsen et al minimized this bias by having neurologists who were blinded to the treatment allocation evaluate the patient at 72 hours and provide prognostic information at that time. Of note, none of the studies provided information on whether the total dose of preceding sedation was different in the 2 allocation groups at the time of neuroprognostication.

Although the results of the trial by Nielsen et al suggest that controlling temperature at 33°C is not superior to strict temperature control at 36°C, whether this is true for patients who differ from the patient population included in the study is not entirely clear. Patients in the Nielsen et al trial had higher rates of bystander cardiopulmonary resuscitation than were seen in the HACA trial (73% compared with 43%–49%). Median no-flow time in patients receiving bystander cardiopulmonary resuscitation was short in the trial by Nielsen et al, but this parameter was not reported in other.
The possibility remains that some unidentified subgroups of patients may benefit from a specific target temperature. We ultimately recommend targeted temperature management at a constant temperature within the range of 32°C to 36°C (the temperature range used in published studies) for comatose post–cardiac arrest patients. Although we recommend that a constant temperature should be maintained during targeted temperature management, we also recognize that potential side effects may appropriately lead a clinician to adjust from a lower to a higher target temperature despite no direct evidence for this approach. For example, if overt bleeding occurs at a temperature of 32°C, then one may decide to increase the target temperature to theoretically mitigate this potential side effect. The weaknesses in existing studies illustrate potential knowledge gaps and areas for future research. Of note, the recommendation to control temperature after cardiac arrest is distinct from mere prevention or treatment of fever, which has not been studied in any of the RCTs.

With respect to the timing of targeted temperature management, the main confounder for the majority of analyzed RCTs is the rapid uncontrolled infusion of a large volume of cold fluid (as opposed to other cooling methods) immediately after ROSC for OHCA. This method for cooling was used for all of the pooled studies except for 1 relatively small pilot study that provided intranasal cooling. The trials using cold fluid specified amounts up to either 2 L or 20 to 30 mL/kg, although not all patients received the full amount before hospital arrival. The rapid infusion of large amounts of cold fluid immediately after achieving ROSC and in the prehospital setting could theoretically be harmful, as indicated by increased rates of reaerst and pulmonary edema in the largest of the included studies, and could therefore negate any potential benefits of early targeted temperature management. Whether similar issues exist with rapid cold fluid infusion in the in-hospital setting is unknown; however, any potential harm from this therapy may relate specifically to the prehospital setting, where there may be less control over the environment, fewer personnel, and reduced monitoring capabilities. We recommend against the use of rapid infusion of large volumes of cold fluid immediately after ROSC for the induction of hypothermia in the prehospital setting but recognize that other cooling methods were not adequately evaluated and therefore are not discussed. Thus, further investigation of cooling methods and location may be warranted.

Finally, evidence for a specific duration of targeted temperature management is lacking. In the absence of evidence, we believe that choosing a duration of therapy similar to those in previous RCTs of targeted temperature management is the most appropriate approach. Human studies specifically focused on different durations have not been performed, and this remains a knowledge gap.

Many knowledge gaps remain, and we suggest the following key questions for future research:

- Are there subpopulations in which aggressive prevention of fever instead of targeted temperature management (32°C–36°C) is justified?
- Are there subpopulations in which a temperature of 32°C to 34°C is beneficial compared with 36°C? For example, are patients with more severe neurological injury more likely to benefit from a lower target temperature?
- Are there subpopulations in which a temperature of 36°C is beneficial compared with 32°C to 34°C such as patients with hemodynamic instability or bleeding?
- Is there utility in intra-arrest cooling or prehospital cooling (to between 32°C and 36°C) by means other than the rapid infusion of large volumes of cold intravenous fluids immediately after ROSC? Might this be helpful in patients for whom transport time to a hospital is longer than average (ie, patients in rural areas)?
- What is the ideal duration of targeted temperature management and of fever prevention?
- Does the use of targeted temperature management, including various temperature targets, affect long-term neurocognitive and functional outcomes?
- Does the choice of sedation, particularly with respect to different targeted temperatures, affect or influence outcome?
- What are the reasons for the discrepancy between experimental/animal data and human clinical trials of the effects of targeted temperature management?

**Summary Recommendations**

On the basis of the published evidence to date, the ALS Task Force of ILCOR made the following recommendations in February 2015:

- We recommend targeted temperature management as opposed to no targeted temperature management for adults with OHCA with an initial shockable rhythm who remain unresponsive after ROSC (strong recommendation, low-quality evidence).
- We suggest targeted temperature management for adults with OHCA with an initial nonshockable rhythm who remain unresponsive after ROSC (weak recommendation, very low-quality evidence).
- We suggest targeted temperature management for adults with IHCA with any initial rhythm who remain unresponsive after ROSC (weak recommendation, very low-quality evidence).
- We recommend selecting and maintaining a constant target temperature between 32°C and 36°C for those patients in whom targeted temperature management is used (strong recommendation, moderate-quality evidence).
- We recommend against routine use of prehospital cooling with rapid infusion of large volumes of cold intravenous fluid immediately after ROSC (strong recommendation, moderate-quality evidence).
- We suggest that, if targeted temperature management is used, duration should be at least 24 hours as in the 2 largest previous RCTs.

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### Disclosures

#### Writing Group Disclosures

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<td>Joshua C. Reynolds</td>
<td>Michigan State University College of Human Medicine</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<tr>
<td>Jasmeet Soar</td>
<td>Southmead Hospital Department of Anesthesia and Intensive Care</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<tr>
<td>Theodoros Xanthos</td>
<td>Midwestern University of Chicago College of Pharmacy</td>
<td>None</td>
<td>None</td>
<td>None</td>
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</table>

This table represents the relationships of writing group members that may be perceived as actual or reasonably perceived conflicts of interest as reported on the Disclosure Questionnaire, which all members of the writing group are required to complete and submit. A relationship is considered to be “significant” if (a) the person receives $10,000 or more during any 12-month period, or 5% or more of the person’s gross income; or (b) the person owns 5% or more of the voting stock or share of the entity, or owns $10,000 or more of the fair market value of the entity. A relationship is considered to be “modest” if it is less than “significant” under the preceding definition.

*Modest.
†Significant.

#### Reviewer Disclosures

<table>
<thead>
<tr>
<th>Reviewer</th>
<th>Employment</th>
<th>Research Grant</th>
<th>Other Research Support</th>
<th>Speakers’ Bureau/Honoraria</th>
<th>Expert Witness</th>
<th>Ownership Interest</th>
<th>Consultant/Advisory Board</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>Niklas Nielsen</td>
<td>Helsingborg Hospital (Sweden)</td>
<td>Swedish Heart and Lung Foundation†; AFA Insurance Foundation†; Swedish Research Council†</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<tr>
<td>Gavin Perkins</td>
<td>Warwick Medical School and Heart of England NHS Foundation Trust (UK)</td>
<td>Funding from National Institute for Health Research†</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<tr>
<td>Ketil Sundvik</td>
<td>University of Oslo (Norway)</td>
<td>None</td>
<td>None</td>
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*Modest.
†Significant.
References


Temperature Management After Cardiac Arrest: An Advisory Statement by the Advanced Life Support Task Force of the International Liaison Committee on Resuscitation and the American Heart Association Emergency Cardiovascular Care Committee and the Council on Cardiopulmonary, Critical Care, Perioperative and Resuscitation

Michael W. Donnino, Lars W. Andersen, Katherine M. Berg, Joshua C. Reynolds, Jerry P. Nolan, Peter T. Morley, Eddy Lang, Michael N. Cocchi, Theodoros Xanthos, Clifton W. Callaway, Jasmeet Soar and and the ILCOR ALS Task Force

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An erratum has been published regarding this article. Please see the attached page for:

/content/133/1/e13.full.pdf

Data Supplement (unedited) at:

http://circ.ahajournals.org/content/suppl/2015/09/25/CIR.0000000000000313.DC1

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Correction

In the article by Donnino et al, “Temperature Management After Cardiac Arrest: An Advisory Statement by the Advanced Life Support Task Force of the International Liaison Committee on Resuscitation and the American Heart Association Emergency Cardiovascular Care Committee and the Council on Cardiopulmonary, Critical Care, Perioperative and Resuscitation,” which published ahead of print October 4, 2015, and appears in the December 22/29, 2015, issue of the journal (Circulation, 2015;132:2448–2456. DOI: 10.1161/CIR.0000000000000313), several corrections were needed.

1. On page 2449, in the left column, fourth paragraph, first sentence, reference 15 was added to the end of the sentence.
2. On page 2449, in the right column, second paragraph, reference 15 was removed.
3. In the publish-ahead-of-print version of the article, in the Acknowledgments section, the collaborators were incorrectly listed in PubMed (a metadata error) as Aikin RP, Böttiger BW, Callaway CW, Castren MK, Eisenberg MS, Kleinman ME, Kloeck DA, Kloeck WG, Mancini ME, Neumar RW, Ornato JP, Paiva EF, Peberdy MA, Soar J, Rea T, Sierra AF, Stanton D, and Zideman DA. This has been corrected in the metadata of the article, with the collaborators correctly listed in PubMed as Mayuki Aibiki, Bernd W. Böttiger, Steven C. Brooks, Charles D. Deakin, Saul Drajer, Walter Kloeck, Laurie J. Morrison, Robert W. Neumar, Tonia C. Nicholson, Brian J. O’Neil, Edison F. Paiva, Michael Parr, Tzong-Luen Wang, and Jonathan Witt.

These corrections have been made to the print version and to the current online version of the article, which is available at http://circ.ahajournals.org/content/132/25/2448.full.
Appendix A: Search Strategies

Question #1:

*PubMed: (Search Completed: January 2015)*


*Embase: (Search Completed: January 2015)*

("heart arrest'/exp OR "cardiac arrest":ti,ab OR "cardiac arrests":ti,ab OR "cardiovascular arrest":ti,ab OR "cardiovascular arrests":ti,ab OR "heart arrest":ti,ab OR "heart arrests":ti,ab OR "asystole":ti,ab OR "pulsless electrical activity":ti,ab OR "cardiopulmonary arrest":ti,ab OR "cardiopulmonary arrests":ti,ab OR 'heart ventricle fibrillation'/exp OR “out of hospital cardiac arrest”:ti,ab OR “out-of-hospital cardiac arrest”:ti,ab OR ‘return of spontaneous circulation'/exp OR "return of spontaneous circulation":ti,ab OR ROSC:ti,ab OR 'resuscitation'/exp OR resuscitat*:ti,ab OR "advanced cardiac life support":ti,ab OR "ACLS":ti,ab OR CPR:ti,ab OR 'heart massage'/exp) AND (hypothermia:ti,ab OR "targeted temperature management":ti,ab OR "whole body cooling":ti,ab OR "whole-body cooling":ti,ab OR cool*:ab,ti OR 'induced hypothermia'/exp OR "paramedic cooling":ti,ab OR ((cool*:ti,ab OR cold:ti,ab OR ‘cooling’/de OR 'body temperature'/exp OR "body temperature":ti,ab) AND (‘brain injury'/de OR "brain injury":ti,ab OR "brain injuries":ti,ab OR “neurological status”:ti,ab OR neuroprotect*:ti,ab OR 'hypoxic ischemic encephalopathy'/exp OR “hypoxic-ischemic encephalopathy”:ti,ab OR
"neurological outcome":ti,ab OR "neurological outcomes":ti,ab OR “functional outcome”:ti,ab OR “functional outcomes”:ti,ab OR 'cognitive defect'/exp OR "cognitive impairment":ti,ab OR “cognitive impairments”:ti,ab OR “cognitive function”:ti,ab OR "treatment outcome'/exp OR 'Glasgow outcome scale'/exp)) NOT ('animal'/exp NOT 'human'/exp) NOT ([editorial]/lim OR [letter]/lim OR 'case report'/de) AND [Embase]/lim

Cochrane: (Search Completed: January 2015)

("paramedic cooling":ti,ab OR "field hypothermia":ti,ab OR [mh "hypothermia, induced"] OR "targeted temperature management":ti,ab OR "therapeutic hypothermia":ti,ab OR "hypothermia therapy":ti,ab OR "whole body cooling":ti,ab OR "target temperature":ti,ab OR [mh "body temperature"] OR “body temperature”:ti,ab) AND ([mh "brain injuries"] OR "brain injury":ti,ab OR “brain injuries”:ti,ab OR “neurological status”:ti,ab OR “neurological outcome”:ti,ab OR “neurological outcomes”:ti,ab OR “functional outcome”:ti,ab OR “functional outcomes”:ti,ab OR neuroprotect*:ti,ab OR [mh "hypoxia-ischemia, brain"] OR "hypoxic-ischemic encephalopathy":ti,ab OR “cognitive impairment”:ti,ab OR “cognitive impairments”:ti,ab OR “cognitive function”:ti,ab OR [mh "outcome and process assessment (health care)"] OR [mh "treatment outcome"] OR [mh "Glasgow Outcome Scale"]) AND ([mh "out-of-hospital cardiac arrest"] OR “out of hospital cardiac arrest”:ti,ab OR "return of spontaneous circulation":ti,ab OR ROSC:ti,ab OR [mh "heart arrest"] OR "cardiac arrest":ti,ab OR "cardiac arrests":ti,ab OR "cardiovascular arrest":ti,ab OR "cardiovascular arrests":ti,ab OR "heart arrest":ti,ab OR "heart arrests":ti,ab OR "asystole":ti,ab OR "pulseless electrical activity":ti,ab OR "cardiopulmonary arrest":ti,ab OR "cardiopulmonary arrests":ti,ab OR [mh "advanced cardiac life support"] OR "advanced cardiac life support":ti,ab OR "ACLS":ti,ab OR [mh "ventricular fibrillation"] OR [mh "cardiopulmonary resuscitation"] OR "cardiopulmonary resuscitation":ti,ab OR CPR:ti,ab OR [mh "heart massage"]

Question #2:

PubMed: (Search Completed: January 2015)

early OR earlie* OR late OR later OR length OR prolong* OR hour* OR hrs OR minute* OR rapid* OR fast* OR quick* OR slow* OR time OR timing OR speed OR rate OR delay*) NEAR/5 (hypothermia OR "targeted temperature management" OR "whole body cooling" OR "whole-body cooling" OR cool*):ti,ab NOT ('animal'/exp NOT 'human'/exp) NOT ([editorial]/lim OR [letter]/lim OR 'case report'/de) AND [Embase]/lim

**Cochrane:** (Search Completed: January 2015)

("paramedic cooling":ti,ab OR "field hypothermia":ti,ab OR [mh "hypothemia, induced"]) OR "targeted temperature management":ti,ab OR "therapeutic hypothermia":ti,ab OR "hypothermia therapy":ti,ab OR "whole body cooling":ti,ab OR "whole-body cooling":ti,ab AND ([mh "brain injuries"] OR "brain injury":ti,ab OR "brain injuries":ti,ab OR "neurological status":ti,ab OR neuroprotect*:ti,ab OR [mh "hypoxia-ischemia, brain"] OR "hypoxic-ischemic encephalopathy":ti,ab OR impair*:ti,ab OR impaire*:ti,ab) AND ([mh "heart arrest"] OR "cardiac arrest":ti,ab OR "cardiac arrests":ti,ab OR "cardiovascular arrest":ti,ab OR "cardiovascular arrests":ti,ab OR "heart arrest":ti,ab OR "heart arrests":ti,ab OR "asystole":ti,ab OR "pulseless electrical activity":ti,ab OR "cardiopulmonary arrest":ti,ab OR "cardiopulmonary arrests":ti,ab OR [mh "advanced cardiac life support"] OR "advanced cardiac life support":ti,ab OR "ACLS":ti,ab OR [mh "ventricular fibrillation"] OR [mh "cardiopulmonary resuscitation"] OR "cardiopulmonary resuscitation":ti,ab OR CPR:ti,ab OR [mh "heart massage"] AND (initiat*:ti,ab OR induc*:ti,ab OR early:ti,ab OR earlie*:ti,ab OR late:ti,ab OR later:ti,ab OR length:ti,ab OR prolong*:ti,ab OR hour*:ti,ab OR hrs:ti,ab OR minute*:ti,ab OR rapid*:ti,ab OR fast*:ti,ab OR quick*:ti,ab OR slow*:ti,ab OR time:ti,ab OR timing:ti,ab OR speed:ti,ab OR rate:ti,ab OR [mh "time factors"] OR [mh "time-to-treatment"] OR delay*:ti,ab OR [mh "emergency medical technicians"] OR "emergency medical":ti,ab OR "EMS":ti,ab OR "EMT":ti,ab OR "pre-hospital":ti,ab OR prehospital:ti,ab OR paramedic*:ti,ab OR "out-of-hospital":ti,ab OR "out of hospital":ti,ab)

**Question #3:**

**PubMed:** (Search Completed: January 2015)

Online-Only Data Supplement

**Embase: (Search Completed: January 2015)**

('dose time effect relation'/exp OR 'time'/exp OR “thermal dose”:ab,ti OR ((duration* OR hour* OR hr* OR prolong* OR short* OR long*) NEAR/10 (hypotherm* OR cool*)):ab,ti) AND ('induced hypothermia'/exp OR "targeted temperature management":ab,ti OR "therapeutic hypothermia":ab,ti OR "hypothermia therapy":ab,ti OR "whole body cooling":ab,ti OR "whole-body cooling":ab,ti OR ((cool*:ab,ti OR cold:ab,ti) AND ('brain injury'/exp OR 'neuroprotection'/exp OR neuroprotection:ab,ti OR 'hypoxic ischemic encephalopathy'/exp OR “hypoxic-ischemic encephalopathy”:ab,ti))) AND ('out of hospital cardiac arrest'/exp OR 'heart arrest'/exp OR "heart arrests":ab,ti OR "cardiac arrest":ab,ti OR "cardiovascular arrest":ab,ti OR "cardiovascular arrests":ab,ti OR "asystole":ab,ti OR "pulseless electrical activity":ab,ti OR "cardiopulmonary arrest":ab,ti OR "cardiopulmonary arrests":ab,ti OR 'cardiopulmonary arrest'/exp OR 'resuscitation'/exp OR "cardiopulmonary resuscitation":ab,ti OR CPR:ab,ti OR 'heart stimulation'/exp) NOT ([editorial]/lim OR [letter]/lim OR 'case report'/de) AND [Embase]/lim

**Cochrane: (Search Completed: January 2015)**

([mh "hypothermia, induced"] OR "targeted temperature management":ab,ti OR "therapeutic hypothermia":ab,ti OR "hypothermia therapy":ab,ti OR "whole body cooling":ab,ti OR "whole-body cooling":ab,ti OR ((cool*:ab,ti OR cold:ab,ti) AND ([mh "brain injuries/prevention and control"] OR neuroprotection:ab,ti OR [mh "hypoxia-ischemia, brain/prevention and control"] OR “hypoxic-ischemic encephalopathy":ab,ti))) AND ([mh "heart arrest"] OR "cardiac arrest":ab,ti OR "cardiac arrests":ab,ti OR "cardiovascular arrest":ab,ti OR "cardiovascular arrests":ab,ti OR "heart arrest":ab,ti OR "heart arrests":ab,ti OR "asystole":ab,ti OR "pulseless electrical activity":ab,ti OR "cardiopulmonary arrest":ab,ti OR "cardiopulmonary arrests":ab,ti OR [mh "advanced cardiac life support"] OR "advanced cardiac life support":ab,ti OR "ACLS":ab,ti OR [mh "ventricular fibrillation"] OR [mh "cardiopulmonary resuscitation"] OR "cardiopulmonary resuscitation":ab,ti OR CPR:ab,ti OR [mh "heart massage"]) AND (prolong*:ab,ti OR hour*:ab,ti OR hrs:ab,ti OR duration*:ab,ti OR [mh "time factors"])
**Appendix B: Selection of Articles**

**Question #1:**

- **Records identified through database search** (n = 6241)
- **Additional records identified through other sources** (n = 0)
- **Records after duplicates removed** (n = 5045)
- **Additional records identified through other sources** (n = 0)
- **Records screened** (n = 5045)
- **Records excluded** (n = 5025)
- **Full-text articles assessed for eligibility** (n = 20)
- **Full-text articles excluded:**
  - (n = 1 subjects cooled for <4 hours[2])
  - (n = 8 pre-post studies[3-10])
- **Studies included in qualitative synthesis** (n = 11)
- **Studies included in quantitative synthesis (meta-analysis)**
  - (n = 2 for survival & neurologic outcome in shockable OHCA)
  - (n = 3 for neurologic outcome in nonshockable OHCA)

OHCA indicates out-of-hospital cardiac arrest; RCT: randomized controlled trial.
Question #2:

Records identified through database search (n = 3015)

Additional records identified through other sources (n = 0)

Records after duplicates removed (n = 2286)

Records screened (n = 2286)

Records excluded (n = 2278)

Full-text articles assessed for eligibility (n = 8)

Full-text articles excluded (n = 1 small feasibility trial[1])

Studies included in qualitative synthesis (n = 7)

Studies included in quantitative synthesis (meta-analysis)
  (n = 7 for survival)
  (n = 5 for good neurologic outcome)
  (n = 5 for rearrest)
  (n = 6 for pulmonary edema)
Question #3:

Records identified through database search (n = 1594)

Additional records identified through other sources (n = 0)

Records after duplicates removed (n = 1253)

Records screened (n = 1253)

Records excluded (n = 1251)

Full-text articles assessed for eligibility (n = 2)

Full-text articles excluded (n = 0)

Studies included in qualitative synthesis (n = 2)

Studies included in quantitative synthesis (meta-analysis) (n = 0)
### Appendix C: Overview of Studies

#### Question #1:

<table>
<thead>
<tr>
<th>Study</th>
<th>No. of Patients Analyzed</th>
<th>No. of Patients Screened</th>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
<th>Experimental Intervention</th>
<th>Control Group</th>
<th>Primary Outcome</th>
<th>Main Clinical Results (Intervention vs Control)</th>
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<tbody>
<tr>
<td>Randomized controlled trials</td>
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<tr>
<td>HACA (2002)[11]</td>
<td>275</td>
<td>3551</td>
<td>Age 18–75 y, OHCA, witnessed arrest, initial shockable rhythm, presumed cardiac origin, collapse-to-CPR interval &gt;5 to &lt;15 min, collapse-to-ROSC interval &lt;60 min</td>
<td>Initial temperature &lt;30°C, pre–cardiac arrest coma, pregnancy, following commands, hypotension &gt;30 min, severe hypoxia &gt;15 min, pre–cardiac arrest terminal illness, unlikely to follow up, concomitant enrollment in another study, EMS-witnessed arrest, preexisting coagulopathy</td>
<td>Surface cooling to 32°C to 34°C within 4 h of ROSC, maintenance for 24 h, then passive rewarming</td>
<td>Normothermia (not otherwise defined)</td>
<td>Good neurologic status at 6 mo (CPC 1–2)</td>
<td>55% vs 39% (P=0.009) Adjusted RR 1.47 (95% CI, 1.09–1.82)</td>
</tr>
<tr>
<td>Bernard et al. (2002)[12]</td>
<td>77</td>
<td>84</td>
<td>OHCA, initial shockable rhythm, persistent coma</td>
<td>Female age &lt;50 y and male age &lt;18 y, systolic blood pressure &lt;90 mm Hg despite vasopressor support, other possible causes of coma, unavailable ICU bed at hospital</td>
<td>Prehospital initiation of surface cooling to 33°C after ROSC, maintenance for 12 h, then active rewarming for 6 h</td>
<td>Target core temperature of 37°C, passive rewarming if spontaneously hypothermic</td>
<td>Good functional status at hospital discharge (discharge to home or acute rehabilitation)</td>
<td>49% vs 26% (P=0.046) Adjusted OR 5.25 (95% CI, 1.47–18.76)</td>
</tr>
<tr>
<td>Laurent et al. (2005)[13]</td>
<td>61</td>
<td>244</td>
<td>Age 18–75 y, OHCA, initial shockable or asystolic rhythm, collapse-to-CPR &lt;10 min, collapse-to-ROSC &lt;50 min, presumed cardiac origin</td>
<td>Pregnancy, following commands, preexisting terminal illness</td>
<td>Hemofiltration plus active cooling with replacement fluid to 32°C to 33°C for 24 h, then passive rewarming</td>
<td>Hemofiltration with replacement fluid set to 37°C</td>
<td>Mortality at 6 mo</td>
<td>32% vs 45% (P=0.28)</td>
</tr>
<tr>
<td>Zhang et al. (2005)[14]</td>
<td>16</td>
<td>Not reported</td>
<td>Received CPR for cardiac arrest</td>
<td>Previous history of cardiac arrest, trauma</td>
<td>Surface cooling to 33°C for 72 h, then rewarming at 1°C/h</td>
<td>No temperature management</td>
<td>Secondary outcome: functional status at 3 mo</td>
<td>Barthel Index score: 86±6 vs 52±12 (P&lt;0.01)</td>
</tr>
<tr>
<td>Study</td>
<td>n</td>
<td>n (%)</td>
<td>Age &gt;18 y, OHCA, witnessed arrest, presumed cardiac cause, initial shockable or asystolic rhythm, collapse-to-ROSC ≤ 60 min</td>
<td>GCS &gt;8, pregnancy, initial PEA rhythm, preceding terminal illness, other possible causes of coma, shock despite 30 min of administration of inotropes</td>
<td>Induction with ice-cold crystalloid and maintenance of 32°C with endovascular device for 24 h, then rewarming at 0.1°C to 0.3°C/h</td>
<td>Induction with ice-cold crystalloid and maintenance of 34°C with endovascular device for 24 h, then rewarming at 0.1°C to 0.3°C/h</td>
<td>Good functional status at 6 mo (Barthel Index score ≥60)</td>
<td>% vs % (P = )</td>
</tr>
<tr>
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<tr>
<td>Lopez-de-Sa et al. (2012)[15]</td>
<td>36</td>
<td>73</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>44% vs 11% (P = 0.12)</td>
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<tr>
<td>Nielsen et al. (2013)[16]</td>
<td>939</td>
<td>1431</td>
<td>OHCA, any initial rhythm, GCS &lt;8</td>
<td>Obvious or suspected pregnancy, known bleeding diathesis, suspected or confirmed acute intracranial bleeding or acute stroke, unwitnessed cardiac arrest with initial rhythm asystole, known limitations in therapy and do-not-resuscitate order, known disease that would make 180-d survival unlikely, known prearrest CPC 3 or 4, &gt;4 h from ROSC to screening, systolic blood pressure &lt;80 mm Hg in spite of fluid loading/vasopressor and/or inotropic medication/ intra-aortic balloon pump, temperature on admission &lt;30°C</td>
<td>Cooling via any method as rapidly as possible to 33°C, maintenance for 28 h, then rewarming at maximum 0.5°C/h to 37°C, then active fever prevention until 72 h after the cardiac arrest</td>
<td>Cooling via any method as rapidly as possible to 36°C, maintenance for 28 h, then rewarming at maximum 0.5°C/h to 37°C, then active fever prevention until 72 h after the cardiac arrest</td>
<td>All-cause mortality through the end of the trial</td>
<td>50% vs 48% (P = 0.51)</td>
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</table>

**Observational studies**

<table>
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<tr>
<th>Study</th>
<th>n</th>
<th>n (%)</th>
<th>Age &gt;18 y, nontraumatic OHCA in a registry, witnessed, initial nonshockable rhythm</th>
<th>Died &lt;24 h after ROSC, GCS &gt;8, prearrest CPC 3–5, CVA cause of arrest, initial temperature &lt;30°C</th>
<th>Cooling via any method to 32°C to 34°C for 24 h</th>
<th>No temperature management</th>
<th>Good functional status at 6 mo (CPC 1–2)</th>
<th>% vs % (P = )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testori et al. (2011)[17]</td>
<td>374</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>35% vs 23% (P = 0.02)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Adjusted OR 1.84 (95% CI, 1.08–3.13)</td>
</tr>
<tr>
<td>Dumas et al. (2011)[18]</td>
<td>437</td>
<td>N/A</td>
<td>OHCA patients in a registry, initial nonshockable rhythm</td>
<td>Trauma</td>
<td>Surface cooling to 32°C to 34°C for 24 h, then passive rewarming for additional 24 h</td>
<td>No temperature management</td>
<td>Good functional status at hospital discharge (CPC 1–2)</td>
<td>15% vs 17% (P = 0.48)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Adjusted OR 0.71 (95% CI, 0.37–1.36)</td>
</tr>
<tr>
<td>Study</td>
<td>N</td>
<td>Data Source</td>
<td>Age and OHCA Criteria</td>
<td>Temperature Management Details</td>
<td>Functional Status Outcome After Discharge</td>
<td>Odds Ratio (95% CI)</td>
<td></td>
<td></td>
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<tr>
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<tr>
<td>Vaaher-salo et al. (2013)[19]</td>
<td>223</td>
<td>N/A</td>
<td>Age &gt;18 y, OHCA, initial nonshockable rhythm, admitted to the ICU</td>
<td>Noncomatose patients, Cooling to 33°C, primarily via endovascular devices although not mandated</td>
<td>Poor functional status (CPC 3, 4, or 5, or death) 1 y after discharge</td>
<td>77% vs 82%</td>
<td></td>
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</tr>
<tr>
<td>Nichol et al. (2013)[20]</td>
<td>8316</td>
<td>N/A</td>
<td>IHCA on general inpatient ward in a registry, index event</td>
<td>Trauma, unknown time of arrest, Coded as “induced hypothermia” in registry. Cooling methods not described</td>
<td>Survival to hospital discharge</td>
<td>27% vs 31% (P=0.29)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mader et al. (2014)[21]</td>
<td>1830</td>
<td>N/A</td>
<td>CARES registry; Age &gt; 18 y, OHCA, initial nonshockable rhythm, presumed cardiac etiology</td>
<td>Missing data on temperature management or outcome, cardiac arrest at long-term care facility, EMS-witnessed</td>
<td>Poor functional status at hospital discharge (CPC 3-5)</td>
<td>85% vs. 78% (P&lt;0.0001)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CARES indicates Cardiac Arrest registry to Enhance Survival; CI, confidence interval; CPC, cerebral performance category; CPR, cardiopulmonary resuscitation; CVA, cerebrovascular accident; EMS, emergency medical service; GCS, Glasgow Coma Scale; ICU, intensive care unit; IHCA, in-hospital cardiac arrest; N/A, not applicable; OHCA, out-of-hospital cardiac arrest; OR, odds ratio; PEA, pulseless electrical activity; ROSC, return of spontaneous circulation; RR, risk ratio.
**Question #2:**

<table>
<thead>
<tr>
<th>Study</th>
<th>No. of Patients Analyzed</th>
<th>No. of Patients Screened</th>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
<th>Experimental Intervention</th>
<th>Control Intervention</th>
<th>Clinical Outcome</th>
<th>Main Clinical Results (Intervention vs Control)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim et al. (2007)[22]</td>
<td>125</td>
<td>559</td>
<td>OHCA with ROSC, intubation, IV access, esophageal temperature probe (temperature ≥34°C), unresponsive, any initial rhythm</td>
<td>Traumatic arrest, age &lt;18 y</td>
<td>Prehospital rapid infusion of up to 2 L of 4°C normal saline</td>
<td>Standard of care (60/97 admitted patients in the combined group received surface cooling in the hospital)</td>
<td>Survival to hospital discharge</td>
<td>21/63 (33%) vs 18/62 (29%)</td>
</tr>
<tr>
<td>Kamarainen et al. (2009)[23]</td>
<td>37</td>
<td>44</td>
<td>OHCA with ROSC, &gt;9 min until ROSC, age ≥18 y, GSC ≤5, any initial rhythm</td>
<td>Pregnancy, traumatic arrest, arrest due to intoxication, persistent initial hypotension after ROSC</td>
<td>Prehospital rapid infusion of 4°C Ringer’s acetate at a rate of 100 mL/min (10 of 19 received in-hospital TTM)</td>
<td>13 of 18 received in-hospital TTM</td>
<td>Hospital survival and good neurologic outcome at discharge (CPC 1–2)</td>
<td>Hospital survival: 8/19 (42%) vs 8/18 (44%) CPC 1–2: 42% vs 44%</td>
</tr>
<tr>
<td>Castren et al. (2010)[24]</td>
<td>194</td>
<td>Unknown</td>
<td>OHCA, ≥18 y, witnessed, CPR initiated by EMS within 20 min, any initial rhythm</td>
<td>Trauma, drug overdose, cerebrovascular accident, known coagulopathy, asphyxia or known requirement for supplemental oxygen, electrocution, hypothermia, do-not-attempt-resuscitation order, and intranasal obstruction. ROSC before randomization</td>
<td>Prehospital intra-arrest transnasal cooling</td>
<td>In-hospital cooling (modality according to “institutional standards,” not otherwise specified)</td>
<td>ROSC rate, survival to discharge, good neurologic outcome at discharge (CPC 1–2)</td>
<td>ROSC: 35/94 (38%) vs 43/101 (43%) (P=0.48) Survival to discharge in those admitted alive: 14/32 (44%) vs 13/42 (31%) (P=0.26) CPC 1–2 in those admitted alive: 11/32 (34%) vs 9/42 (21%) (P=0.21)</td>
</tr>
<tr>
<td>Bernard et al. (2010)[25]</td>
<td>234</td>
<td>6730</td>
<td>OHCA with ROSC, ventricular fibrillation, systolic blood pressure &gt;90 mm Hg, cardiac arrest time &gt;10 min, age ≥15 y, and IV access</td>
<td>Not intubated, poor prearrest functional status, hypothermic, or pregnant</td>
<td>Prehospital rapid infusion of up to 2 L of ice-cold lactated Ringer’s solution</td>
<td>In-hospital rapid infusion of 40 mL/kg ice-cold lactated Ringer’s solution</td>
<td>Good functional status at hospital discharge (discharge to home or to rehabilitation)</td>
<td>56/118 (48%) vs 61/116 (53%) (P=0.43)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
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<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Bernard et al. (2012)[26]</td>
<td>163</td>
<td>6730</td>
<td>OHCA with ROSC, PEA or asystole, systolic blood pressure &gt;90 mm Hg, cardiac arrest time &gt;10 min, age ≥15 y, and IV access available</td>
<td>Not intubated, poor prearrest functional status, hypothermic, pregnant, or traumatic arrest</td>
<td>Prehospital rapid infusion of 40 mL/kg (up to 2 L) ice-cold Hartmann’s solution</td>
<td>In-hospital cooling with rapid infusion of 40 mL/kg ice-cold Hartmann’s solution, and surface cooling</td>
<td>Good functional status at hospital discharge (discharge to home or to rehabilitation)</td>
<td>10/82 (12%) vs 7/81 (9%) (P=0.50)</td>
</tr>
<tr>
<td>Kim et al. (2014)[27]</td>
<td>1359</td>
<td>5696</td>
<td>OHCA with ROSC, intubation, IV access, esophageal temperature probe (temperature ≥34°C), unresponsive, any initial rhythm</td>
<td>Traumatic arrest, age &lt;18 y,</td>
<td>Prehospital rapid infusion of up to 2 L of 4°C normal saline (224 of 292 patients with VF received in-hospital cooling; no information provided for non-VF patients)</td>
<td>Standard of care (224 of 291 patients with VF received in-hospital cooling; no information provided for non-VF patients)</td>
<td>Hospital mortality and good neurologic outcome at discharge</td>
<td>Survival to discharge: VF: 63% vs 64% (P=0.69) Non-VF: 19% vs 16% (P=0.30) Good neurologic outcome: VF: 58% vs 62% (P=0.59) Non-VF: 14% vs 13% (P=0.74)</td>
</tr>
<tr>
<td>Debaty et al. (2014)[28]</td>
<td>245</td>
<td>1559</td>
<td>OHCA, &gt; 18 y, eligible for resuscitation</td>
<td>Trauma, hemorrhage, asphyxia, hypothermia, pregnant, ROSC before randomization</td>
<td>Intra-arrest up to 2 L &lt;8°C saline at 100mL/min with pressure bag and gel pads surface cooling. Aim for 32-34°C.</td>
<td>In-hospital TTM with cold saline infusion, cooling mattress, cold air circulation or extra corporeal life support</td>
<td>Survival at 30 days</td>
<td>5.7% vs 4.1% (P=0.58)</td>
</tr>
</tbody>
</table>

CPC indicates cerebral performance category; EMS, emergency medical service; GCS, Glasgow Coma Scale; IV, intravenous; OHCA, out-of-hospital cardiac arrest; PEA, pulseless electrical activity; ROSC, return of spontaneous circulation; TTM, targeted temperature management; VF, ventricular fibrillation.
### Question 3:

<table>
<thead>
<tr>
<th>Study</th>
<th>No. of Patients Analyzed</th>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
<th>Intervention</th>
<th>Clinical Outcomes</th>
<th>Results Related to Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yokoyama et al.</td>
<td>452</td>
<td>OHCA, receiving temperature management, age &gt;18 y, stable hemodynamics, comatose, presumed cardiac cause of arrest</td>
<td>Pregnancy, aortic dissection, pulmonary embolism, drug addiction, poor daily activity before onset</td>
<td>Various durations of targeted temperature management</td>
<td>Neurologic outcome at 30 d</td>
<td>Duration of cooling in CPC 1–2: 24 (24–42) h vs CPC 3–5: 26 (24–45) h (Nonsignificant P value, exact P value not reported)</td>
</tr>
<tr>
<td>Lee et al. (2014)[30]</td>
<td>79</td>
<td>OHCA, unconscious asphyxia (i.e. preceding respiratory failure)</td>
<td>&lt; 18 y, preexisting terminal illness, trauma, exsanguination, toxin other than tetrodotoxin</td>
<td>24 h at 33°C ± 1°C compared to 72 h at 32°C ± 1°C</td>
<td>Survival and good neurologic outcome (CPC 1-2) at 30 days</td>
<td>Survival: 49% vs. 47% (P=0.61) Good neurological outcome: 3% vs. 3% (P=1.00)</td>
</tr>
</tbody>
</table>

CPC indicates cerebral performance category; OHCA, out-of-hospital cardiac arrest.
Appendix D: Bias Assessment

Question #1:

<table>
<thead>
<tr>
<th>Study</th>
<th>Allocation: Generation</th>
<th>Allocation: Concealment</th>
<th>Blinding: Participants</th>
<th>Blinding: Assessors</th>
<th>Outcome: Complete</th>
<th>Outcome: Selective</th>
<th>Other Bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>HACA (2002)[11]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Unclear†</td>
</tr>
<tr>
<td>Bernard et al. (2002)[12]</td>
<td>High‡</td>
<td>High‡</td>
<td>High*</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Unclear†</td>
</tr>
<tr>
<td>Laurent et al. (2005)[13]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>High§</td>
<td>Low</td>
<td>Low</td>
<td>Unclear†‖</td>
</tr>
<tr>
<td>Zhang et al. (2005)[14]</td>
<td>High§</td>
<td>High§</td>
<td>High*</td>
<td>High§</td>
<td>Low</td>
<td>High¶</td>
<td>High†#</td>
</tr>
<tr>
<td>Lopez-de-Sa et al. (2012)[15]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Unclear†**</td>
</tr>
<tr>
<td>Nielsen et al. (2013)[16]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
</tbody>
</table>

*Study participants and clinical teams not blinded.
†Clinician performing neurologic prognostication not blinded.
‡Allocation by day of week.
§Not described in manuscript.
‖All subjects received 8 hours of hemofiltration.
¶Did not report survival.
#Very limited patient information/baseline data provided.
**Some baseline imbalance between groups.
## b. Bias Assessment: Observational Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Eligibility Criteria</th>
<th>Exposure/Outcome</th>
<th>Confounding</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testori et al. (2011)[17]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>Low</td>
</tr>
<tr>
<td>Dumas et al. (2011)[18]</td>
<td>Unclear†</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Nichol et al. (2013)[20]</td>
<td>High†</td>
<td>High‡</td>
<td>High§</td>
<td>Low</td>
</tr>
<tr>
<td>Vaahersalo et al. (2013)[19]</td>
<td>Unclear†</td>
<td>Low</td>
<td>High*</td>
<td>Low</td>
</tr>
<tr>
<td>Mader et al. (2014)[21]</td>
<td>Unclear**†</td>
<td>High§</td>
<td>High*</td>
<td>Low</td>
</tr>
</tbody>
</table>

*High risk of residual confounding.
†Patients with traditional targeted temperature management exclusion criteria not excluded before analysis.
‡Less than 3% of subjects received hypothermia, and inclusion criteria rely solely on coding in the registry.
§Independent documentation of therapeutic temperature was available for only 40% of patients cooled and was not always consistent with reaching target temperature for those reportedly cooled. Less than 3% of patients received the intervention, which causes high concern for confounding by indication.
**Limited data on how decision to use hypothermia was made
*No actual temperature data; exclusion criteria rely solely on coding in the registry
**Question #2:**

### a. Bias Assessment: RCTs

<table>
<thead>
<tr>
<th>Study</th>
<th>Allocation: Generation</th>
<th>Allocation: Concealment</th>
<th>Blinding: Participants</th>
<th>Blinding: Assessors</th>
<th>Outcome: Complete</th>
<th>Outcome: Selective</th>
<th>Other Bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim et al. (2007)[22]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Kamarainen et al. (2009)[23]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>High†</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Castren et al. (2010)[24]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>High‡</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Bernard et al. (2010)[25]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Bernard et al. (2012)[26]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Kim et al. (2014)[27]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Debaty et al. (2014)[28]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>High†</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
</tbody>
</table>

*Study participants and clinical teams not blinded.
†Outcome assessors not blinded.
‡According to the study, “assessment may not always have been performed by an individual blinded to the treatment group.”
**Question #3:**

### a. Bias Assessment: Observational Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Eligibility Criteria</th>
<th>Exposure/Outcome</th>
<th>Confounding</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yokoyama et al. (2011)[29]</td>
<td>Low</td>
<td>Low</td>
<td>High*</td>
<td>Low</td>
</tr>
<tr>
<td>Lee et al. (2014)[30]</td>
<td>Low</td>
<td>Low</td>
<td>High†</td>
<td>Low</td>
</tr>
</tbody>
</table>

*No adjustment for any potential confounders.
†High risk of residual confounding, pre/post study, different temperature target
Appendix E: GRADE Tables

Question #1:

TABLE: TTM compared with no TTM in adults with OHCA with an initial shockable rhythm who remain unresponsive after ROSC

<table>
<thead>
<tr>
<th>No. of Patients, No. of Studies, Follow-Up Period</th>
<th>Quality Assessment</th>
<th>Summary of Findings</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Risk of Bias</td>
<td>Inconsistency</td>
<td>Indirectness</td>
</tr>
<tr>
<td>Mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>352 patients 2 RCTs[11, 12] 6 mo/hospital discharge</td>
<td>Serious§</td>
<td>Not serious</td>
<td>Not serious</td>
</tr>
<tr>
<td>42 patients 1 RCT[13] 6 mo</td>
<td>Serious§</td>
<td>Not serious</td>
<td>Serious#</td>
</tr>
<tr>
<td>Poor neurologic/functional outcome**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>350 patients 2 RCTs[11, 12] 6 mo/hospital discharge</td>
<td>Serious§</td>
<td>Not serious</td>
<td>Not serious</td>
</tr>
</tbody>
</table>

CI indicates confidence interval; OHCA, out-of-hospital cardiac arrest; RCT, randomized controlled trial; ROSC, return of spontaneous circulation; RR, risk ratio; TTM, targeted temperature management.

*Includes assessment of publication bias, magnitude of the effect, dose-response gradient, and plausible residual confounding leading to spurious effect when no effect was observed or reduction of a demonstrated effect.
†The risk ratios represent the risk of the outcome in the treatment group (targeted temperature management) compared to the control group (no targeted temperature management) such that a risk ratio <1 indicates the outcome being less common in the intervention group. When more than 1 trial is included the pooled risk ratio is reported. See appendix F for forest plots.
‡Absolute effect is calculated as the absolute difference in the outcome between the treatment group (targeted temperature management) and the control group (no targeted temperature management) expressed as number of patients per 1000 patients treated. For the confidence interval, positive numbers reflect more patients and negative numbers fewer patients with the outcome.
§Neurological prognosticators and clinical team not blinded.
IOne of the included trials used quasi-randomization (alternating days).[12] We did not consider this to introduce enough additional concern to increase the overall risk of bias to “very serious”.
*Optimal information size not achieved. Based on a conservative alpha of 0.01, beta of 0.2, a control outcome rate of 55% and a relative risk reduction of 10% the optimal information size was calculated at 3,922 total patients.
#Simultaneous hemofiltration.
**Poor neurological/functional outcome defined as a cerebral performance category score of 3, 4 or 5 or dead[11] or not being discharged home or to rehabilitation.[12]
<table>
<thead>
<tr>
<th>No. of Patients, No. of Studies, Follow-Up Period</th>
<th>Quality Assessment</th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Risk of Bias</td>
<td>Inconsistency</td>
</tr>
<tr>
<td>Mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>374 patients 1 observational[17] 6 mo</td>
<td>Serious§</td>
<td>Not serious</td>
</tr>
<tr>
<td>Poor neurologic outcome¶</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1034 patients 3 observational[17-19] 6 mo/1 y</td>
<td>Serious§</td>
<td>Not serious</td>
</tr>
<tr>
<td>Poor neurologic outcome¶</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1830 patients 1 observational[21] Hospital discharge</td>
<td>Very serious**</td>
<td>Not serious</td>
</tr>
</tbody>
</table>

CI, confidence interval; NA, not available; NE, not estimable; OHCA, out-of-hospital cardiac arrest; OR, odds ratio; ROSC, return of spontaneous circulation; TTM, targeted temperature management.

*Include assessment of publication bias, magnitude of the effect, dose-response gradient, and plausible residual confounding leading to spurious effect when no effect was observed or reduction of a demonstrated effect.
†Adjusted ORs are reported for mortality. For the outcome of poor neurologic outcome the pooled OR was used (see Appendix F for forest plot). The ORs represent the risk of the outcome in the treatment group (TTM) compared with the control group (no TTM) adjusted for various confounders.
‡Absolute effect is calculated as the absolute difference in the outcome between the treatment group (TTM) and the control group (no TTM) calculated based on the control group risk and the adjusted OR, expressed as number of patients per 1000 patients treated. For the CI, positive numbers reflect more patients and negative numbers fewer patients with the outcome.
§High risk of residual confounding.
¹Optimal information size not achieved. Based on a conservative α of 0.01, a β of 0.2, a control outcome rate of 75%, and a relative risk reduction of 10%, the optimal information size was calculated at 1748 total patients.
¶Poor neurologic outcome defined as a cerebral performance category score of 3, 4, or 5 or dead.
#CI cannot exclude clinically relevant benefit or harm.
**Very high risk of residual confounding
††Study reported multiple analyses with inconsistent results
<table>
<thead>
<tr>
<th>No. of Patients</th>
<th>No. of Studies</th>
<th>Follow-Up Period</th>
<th>Quality Assessment</th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No. of Patients TTM</td>
</tr>
<tr>
<td>Mortality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8316 patients</td>
<td>1 observational[20]</td>
<td>Hospital discharge</td>
<td>Very serious§</td>
<td>Not serious</td>
</tr>
<tr>
<td>Poor neurologic outcome¶</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8316 patients</td>
<td>1 observational[20]</td>
<td>Hospital discharge</td>
<td>Very serious§</td>
<td>Not serious</td>
</tr>
</tbody>
</table>

CI, confidence interval; IHCA, in-hospital cardiac arrest; OR, odds ratio; ROSC, return of spontaneous circulation; TTM, targeted temperature management.

*Includes assessment of publication bias, magnitude of the effect, dose-response gradient, and plausible residual confounding leading to spurious effect when no effect was observed or reduction of a demonstrated effect.
†Adjusted ORs are reported for all relative effect measures. The ORs represent the risk of the outcome in the treatment group (TTM) compared with the control group (no TTM) adjusted for various confounders.
‡Absolute effect is calculated as the absolute difference in the outcome between the treatment group (TTM) and the control group (no TTM) calculated based on the control group risk and the adjusted OR, expressed as number of patients per 1000 patients treated. For the CI, positive numbers reflect more patients and negative numbers fewer patients with the outcome.
§High risk of residual confounding, high risk of selection bias, and unclear exposure.
‖CI cannot exclude clinically relevant benefit or harm.
¶Poor neurologic outcome defined as a cerebral performance category score of 3, 4, or 5 or dead.
33°C compared with 36°C for adults with OHCA who remain unresponsive after ROSC and receive TTM

<table>
<thead>
<tr>
<th>No. of Patients, No. of Studies, Follow-Up Period</th>
<th>Risk of Bias</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Other*</th>
<th>Overall Quality of Evidence</th>
<th>Summary of Findings</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality§</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No. of Patients</td>
<td>Relative† (95% CI)</td>
</tr>
<tr>
<td>939 patients 1 RCT[16] 180 d</td>
<td>Not serious</td>
<td>Not serious</td>
<td>Not serious</td>
<td>Serious¶</td>
<td>None</td>
<td>Moderate</td>
<td>226/473 (48%)</td>
<td>RR 1.01 (0.88–1.16)</td>
</tr>
<tr>
<td>Poor neurologic outcome#</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>220/466 (47%)</td>
<td></td>
</tr>
<tr>
<td>933 patients 1 RCT[16] 180 d</td>
<td>Not serious</td>
<td>Not serious</td>
<td>Not serious</td>
<td>Serious¶</td>
<td>None</td>
<td>Moderate</td>
<td>251/469 (54%)</td>
<td>RR 1.03 (0.91–1.16)</td>
</tr>
</tbody>
</table>

CI indicates confidence interval; OHCA, out-of-hospital cardiac arrest; RCT, randomized controlled trial; ROSC, return of spontaneous circulation; RR, risk ratio; TTM, targeted temperature management.

*Includes assessment of publication bias, magnitude of the effect, dose-response gradient, and plausible residual confounding leading to spurious effect when no effect was observed or reduction of a demonstrated effect.

†The RRs represent the risk of the outcome in the 33°C group compared with the 36°C group.

‡Absolute effect is calculated as the absolute difference in the outcome between the treatment group (TTM) and the control group (no TTM) calculated based on the control group risk and the risk ratio, expressed as number of patients per 1000 patients treated. For the CI, positive numbers reflect more patients and negative numbers fewer patients with the outcome.

§The authors also reported the results of a time-to-event analysis (hazard ratio, 1.06 [95% CI, 0.89–1.28]).

‖Although clinicians and patients were not blinded, we do not consider this to introduce enough bias to downgrade the evidence, because the neurologic prognosticators were blinded.

¶CI cannot exclude clinically relevant benefit or harm.

#Poor neurologic outcome defined as a cerebral performance category score of 3, 4, or 5 or dead. The authors also reported poor neurologic outcome, defined as a modified Rankin scale score of 4 to 6 (RR 1.01 [95% CI, 0.89–1.14]).
### Summary of Findings: 32°C compared with 34°C for adults with OHCA who remain unresponsive after ROSC and receive targeted temperature management

<table>
<thead>
<tr>
<th>No. of Patients</th>
<th>No. of Studies</th>
<th>Follow-Up Period</th>
<th>Risk of Bias</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Other*</th>
<th>Overall Quality of Evidence</th>
<th>Summary of Findings</th>
<th>Effect</th>
<th>Absolute‡</th>
<th>Relative† (95% CI)</th>
<th>Absolute‡ (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>36 patients</td>
<td>1 RCT[15]</td>
<td>Very serious§</td>
<td>Not serious</td>
<td>Not serious</td>
<td>Serious†</td>
<td>None</td>
<td>Very low</td>
<td>10/18 (56%)</td>
<td>16/18 (89%)</td>
<td>RR 0.63 (0.40–0.97)</td>
<td>233 fewer per 1000 (−533 to −23)</td>
<td></td>
</tr>
<tr>
<td>Poor neurologic outcome‡</td>
<td>36 patients</td>
<td>1 RCT[15]</td>
<td>Very serious§</td>
<td>Not serious</td>
<td>Not serious</td>
<td>Serious#</td>
<td>None</td>
<td>Very low</td>
<td>9/18 (50%)</td>
<td>14/18 (78%)</td>
<td>RR 0.64 (0.38–1.09)</td>
<td>278 fewer per 1000 (−482 to 66)</td>
<td></td>
</tr>
</tbody>
</table>

CI, confidence interval; OHCA, out-of-hospital cardiac arrest; RCT, randomized controlled trial; ROSC, return of spontaneous circulation; RR, risk ratio.

*Includes assessment of publication bias, magnitude of the effect, dose-response gradient, and plausible residual confounding leading to spurious effect when no effect was observed or reduction of a demonstrated effect.

†The RRs represent the risk of the outcome in the 32°C group compared with the 34°C group.

‡Absolute effect is calculated as the absolute difference in the outcome between the treatment group (targeted temperature management) and the control group (no targeted temperature management) calculated based on the control group risk and the adjusted odds ratio, expressed as number of patients per 1000 patients treated. For the CI, positive numbers reflect more patients and negative numbers fewer patients with the outcome.

§Neurologic prognosticators not blinded, and risk of confounding caused by unbalanced groups.

‖Optimal information size not achieved. See calculations above.

¶Poor neurologic outcome, defined as the best cerebral performance category score being 3, 4, or 5. The authors also reported death or severe dependence, defined as a Barthel score <60 (RR 0.32 [95% CI, 0.08–1.37]).

#CI cannot exclude clinically relevant benefit or harm.
**Question #2:**

Prehospital targeted temperature management compared with no prehospital targeted temperature management in adults with OHCA who remain unresponsive after ROSC

<table>
<thead>
<tr>
<th>No. of Patients</th>
<th>No. of Studies Follow-Up Period</th>
<th>Risk of Bias</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Other*</th>
<th>Overall Quality of Evidence</th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prehospital</td>
<td>No Prehospital</td>
</tr>
<tr>
<td>Mortality</td>
<td>2237 patients</td>
<td>Serious§</td>
<td>Not serious</td>
<td>Not serious</td>
<td>Not serious</td>
<td>None</td>
<td>Moderate</td>
<td>RR 0.98 (0.92–1.04)</td>
</tr>
<tr>
<td></td>
<td>7 RCTs[22-28] Hospital discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor neurologic/functional outcome</td>
<td>1867 patients</td>
<td>Serious§</td>
<td>Not serious</td>
<td>Not serious</td>
<td>Not serious</td>
<td>None</td>
<td>Moderate</td>
<td>RR 1.00 (0.95–1.06)</td>
</tr>
<tr>
<td></td>
<td>5 RCTs[23-27] Hospital discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rearrest</td>
<td>1719 patients</td>
<td>Serious§</td>
<td>Serious#</td>
<td>Not serious</td>
<td>Not serious</td>
<td>None</td>
<td>Low</td>
<td>RR 1.27 (1.10–1.47)</td>
</tr>
<tr>
<td></td>
<td>5 RCTs[22, 23, 25-27] Prehospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary edema**</td>
<td>1860 patients</td>
<td>Serious§</td>
<td>Serious#</td>
<td>Not serious</td>
<td>Not serious</td>
<td>None</td>
<td>Low</td>
<td>††††</td>
</tr>
<tr>
<td></td>
<td>6 RCTs[22, 23, 25-28] Prehospital/arrival</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CI indicates confidence interval; OHCA, out-of-hospital cardiac arrest; RCTs, randomized controlled trials; ROSC, return of spontaneous circulation; RR, risk ratio.

*Includes assessment of publication bias, magnitude of the effect, dose-response gradient, and plausible residual confounding leading to spurious effect when no effect was observed or reduction of a demonstrated effect.

†Pooled RRs are reported for all relative effect measures. The RRs represent the risk of the outcome in the treatment group (prehospital targeted temperature management) compared with the control group (no prehospital targeted temperature management). The corresponding forest plots are presented in Appendix F.

‡Absolute effect is calculated as the absolute difference in the outcome between the treatment group (prehospital targeted temperature management) and the control group (no prehospital targeted temperature management) calculated based on the control group risk and the pooled RR, expressed as number of patients per 1000 patients treated. For the CI, positive numbers reflect more patients and negative numbers fewer patients with the outcome.

§Neurologic prognosticators and clinical team not blinded.

‖Poor neurologic outcome defined as a cerebral performance category score of 3, 4, or 5 or not being discharged home or to rehabilitation

¶Clinical team and outcome assessors not blinded.

#Very large variability in reported incidences.
**Pulmonary edema was assessed with initial radiography[22, 27] or “oxygen desaturation <90% with froth visible in the endotracheal tube” prehospital.[25, 26] Two studies did not report details related to assessment of pulmonary edema.[23, 28]
†† No pooled estimate was calculated. See Appendix F.
Appendix F: Forest Plots (meta-analyses)

Question #1:

A. Forest Plot – Outcome: Mortality

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>TTM Events</th>
<th>TTM Total</th>
<th>Control Events</th>
<th>Control Total</th>
<th>Weight</th>
<th>Risk Ratio M-H, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bernard, 2002</td>
<td>22</td>
<td>43</td>
<td>23</td>
<td>34</td>
<td>31.2%</td>
<td>0.76 [0.52, 1.10]</td>
</tr>
<tr>
<td>HACA, 2002</td>
<td>56</td>
<td>137</td>
<td>76</td>
<td>138</td>
<td>68.8%</td>
<td>0.74 [0.58, 0.95]</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>180</td>
<td>172</td>
<td>100.0%</td>
<td></td>
<td></td>
<td>0.75 [0.61, 0.92]</td>
</tr>
</tbody>
</table>

Total events 78 99
Heterogeneity: Tau² = 0.00; Chi² = 0.01, df = 1 (P = 0.93); I² = 0%
Test for overall effect: Z = 2.75 (P = 0.006)

B. Forest Plot – Outcome: Poor Neurologic/Functional Outcome

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>TTM Events</th>
<th>TTM Total</th>
<th>Control Events</th>
<th>Control Total</th>
<th>Weight</th>
<th>Risk Ratio M-H, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bernard, 2002</td>
<td>22</td>
<td>43</td>
<td>25</td>
<td>34</td>
<td>29.6%</td>
<td>0.70 [0.49, 0.99]</td>
</tr>
<tr>
<td>HACA, 2002</td>
<td>61</td>
<td>136</td>
<td>83</td>
<td>137</td>
<td>70.4%</td>
<td>0.74 [0.59, 0.93]</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>179</td>
<td>171</td>
<td>100.0%</td>
<td></td>
<td></td>
<td>0.73 [0.60, 0.88]</td>
</tr>
</tbody>
</table>

Total events 83 108
Heterogeneity: Tau² = 0.00; Chi² = 0.08, df = 1 (P = 0.77); I² = 0%
Test for overall effect: Z = 3.24 (P = 0.001)
C. Forest Plot – Nonshockable rhythm. Outcome: Poor Neurologic Outcome*

*Adjusted odds ratios and inverse variance weighting were used to calculate the pooled odds ratio. The study by Mader et al.[21] was not included in the meta-analysis given the very high risk of bias.
Question #2:

For the study by Castren et al.[24] only patients who had return of spontaneous circulation were included in the meta-analysis. The exclusion of the studies that initiated temperature management during cardiopulmonary resuscitation (Castren et al.[24] and Debaty et al.[28]) did not meaningfully change the pooled risk ratios for any of the outcomes (data not shown).

A. Forest Plot – Outcome: Poor Neurologic Outcome

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Pre-hospital TTM</th>
<th>No Pre-hospital TTM</th>
<th>Risk Ratio M.H, Random, 95% CI</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karnarainen, 2009</td>
<td>11</td>
<td>19</td>
<td>1.04 [0.59, 1.83]</td>
<td>2009</td>
</tr>
<tr>
<td>Castren, 2010</td>
<td>21</td>
<td>32</td>
<td>0.84 [0.62, 1.12]</td>
<td>2010</td>
</tr>
<tr>
<td>Bernard, 2010</td>
<td>62</td>
<td>118</td>
<td>1.11 [0.86, 1.43]</td>
<td>2010</td>
</tr>
<tr>
<td>Bernard, 2012</td>
<td>72</td>
<td>82</td>
<td>0.96 [0.87, 1.07]</td>
<td>2012</td>
</tr>
<tr>
<td>Kim, 2014</td>
<td>463</td>
<td>688</td>
<td>1.03 [0.95, 1.11]</td>
<td>2014</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>930</td>
<td>928</td>
<td>1.00 [0.95, 1.06]</td>
<td></td>
</tr>
<tr>
<td>Total events</td>
<td>629</td>
<td>612</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: Tau² = 0.00; Chi² = 3.31, df = 4 (P = 0.51); I² = 0%
Test for overall effect: Z = 0.06 (P = 0.95)
## B. Forest Plot – Outcome: Mortality

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Pre-hospital TTM</th>
<th>No Pre-hospital TTM</th>
<th>Weight</th>
<th>Risk Ratio M-H, Random, 95% CI</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim, 2007</td>
<td>42</td>
<td>63</td>
<td>44</td>
<td>62</td>
<td>6.5%</td>
</tr>
<tr>
<td>Kamarainen, 2009</td>
<td>11</td>
<td>19</td>
<td>10</td>
<td>18</td>
<td>1.1%</td>
</tr>
<tr>
<td>Castren, 2010</td>
<td>18</td>
<td>32</td>
<td>26</td>
<td>42</td>
<td>2.7%</td>
</tr>
<tr>
<td>Bernard, 2010</td>
<td>62</td>
<td>118</td>
<td>54</td>
<td>116</td>
<td>5.3%</td>
</tr>
<tr>
<td>Bernard, 2012</td>
<td>71</td>
<td>82</td>
<td>74</td>
<td>81</td>
<td>30.7%</td>
</tr>
<tr>
<td>Debeye, 2014</td>
<td>7</td>
<td>123</td>
<td>5</td>
<td>122</td>
<td>0.3%</td>
</tr>
<tr>
<td>Kim, 2014</td>
<td>429</td>
<td>688</td>
<td>422</td>
<td>671</td>
<td>33.4%</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>1125</strong></td>
<td><strong>1112</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>0.98 [0.92, 1.04]</strong></td>
<td></td>
</tr>
</tbody>
</table>

Total events: 840, 638

Heterogeneity: Tau² = 0.00; Chi² = 3.30, df = 6 (P = 0.77); I² = 0%

Test for overall effect: Z = 0.74 (P = 0.46)

## C. Forest Plot – Outcome: Rearrest

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Pre-hospital TTM</th>
<th>No Pre-hospital TTM</th>
<th>Weight</th>
<th>Risk Ratio M-H, Random, 95% CI</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim, 2007</td>
<td>15</td>
<td>63</td>
<td>13</td>
<td>62</td>
<td>7.8%</td>
</tr>
<tr>
<td>Kamarainen, 2009</td>
<td>2</td>
<td>19</td>
<td>3</td>
<td>18</td>
<td>12%</td>
</tr>
<tr>
<td>Bernard, 2010</td>
<td>0</td>
<td>118</td>
<td>0</td>
<td>116</td>
<td>Not estimable</td>
</tr>
<tr>
<td>Bernard, 2012</td>
<td>7</td>
<td>82</td>
<td>7</td>
<td>81</td>
<td>3.3%</td>
</tr>
<tr>
<td>Kim, 2014</td>
<td>176</td>
<td>668</td>
<td>138</td>
<td>671</td>
<td>67.6%</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>968</strong></td>
<td><strong>948</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>1.22 [1.01, 1.46]</strong></td>
<td></td>
</tr>
</tbody>
</table>

Total events: 200, 161

Heterogeneity: Tau² = 0.00; Chi² = 0.86, df = 3 (P = 0.83); I² = 0%

Test for overall effect: Z = 2.11 (P = 0.03)
D. Forest Plot – Outcome: Pulmonary Edema*

* Given that only three studies with high heterogeneity had pulmonary edema events reported no pooled analysis was performed. For the Debaty et al.[28] study only patients who survived to hospital admission were included.

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Pre-hospital Cooling</th>
<th>No Pre-hospital Cooling</th>
<th>Risk Ratio (95% CI)</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Events</td>
<td>Total</td>
<td>Events</td>
<td>Total</td>
</tr>
<tr>
<td>Kim, 2007</td>
<td>24</td>
<td>54</td>
<td>27</td>
<td>49</td>
</tr>
<tr>
<td>Kamarainen, 2009</td>
<td>0</td>
<td>19</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Bernard, 2010</td>
<td>0</td>
<td>118</td>
<td>0</td>
<td>116</td>
</tr>
<tr>
<td>Bernard, 2012</td>
<td>0</td>
<td>62</td>
<td>0</td>
<td>81</td>
</tr>
<tr>
<td>Debaty, 2014</td>
<td>7</td>
<td>41</td>
<td>8</td>
<td>36</td>
</tr>
<tr>
<td>Kim, 2014</td>
<td>258</td>
<td>631</td>
<td>104</td>
<td>69</td>
</tr>
</tbody>
</table>

Total (95% CI) | 945 | 909 |

Total events: 287 | 219 |

Heterogeneity: Chi² = 6.77, df= 2 (P = 0.03); P = 70%

Test for overall effect: Z = 3.14 (P = 0.002)
References


