Study protocol for IMPRoVE: a multicentre prospective observational cohort study of the incidence, impact and mechanisms of perioperative right ventricular dysfunction in non-cardiac surgery

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INTRODUCTION
Perioperative myocardial injury (PMI) is common after major non-cardiac surgery, with a recent large international observational study demonstrating an elevated post-operative high-sensitivity troponin level in 19.7% of patients undergoing major non-cardiac surgery.1 Perioperative PMI has also been shown to be associated with poor cardiovascular outcomes in patients undergoing non-cardiac surgery.2 Similarly, natriuretic peptides increase following surgery, and this is associated with an increased risk of cardiovascular complications and mortality.3 Our group has demonstrated that peak postoperative brain natriuretic peptide is associated with postoperative complications and length of hospital stay after thoracic surgery.4 Although

STRENGTHS AND LIMITATIONS OF THIS STUDY
⇒ This is the first study to investigate the incidence of perioperative right ventricular dysfunction (RVD) after major non-cardiac surgery, and the association between RVD and patient outcomes in this group.
⇒ T1-cardiovascular MR substudy to investigate whether inflammation is a mechanism underlying perioperative RVD.
⇒ A large prospective multicentre study with appropriate statistical power analysis.
⇒ It is difficult to predict the incidence of perioperative RVD in surgical groups other than lung resection since there are such limited data.

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an increase in cardiac biomarkers after major non-cardiac surgery in up to 28% of patients.\(^6\) Postoperative RVD may predicate surgery. In the general population, RVD is more prevalent in the elderly, and in people with hypertension, diabetes mellitus, ischaemic heart disease and lung disease; risk factors which are over-represented in the surgical population. As anticipated, in our previous thoracic surgery cohort we found a high prevalence of pre-existing RVD of 50%.\(^8\)

The perioperative period exposes patients to many insults that may contribute to RVD. Excess preload may occur in the form of injudicious intravenous fluid administration, resulting in RV distension and tricuspid regurgitation.\(^6\)\(^,\)\(^8\) Impaired contractility may occur due to myocardial ischaemia. RV afterload may increase by many mechanisms, including:

- Pulmonary thromboembolism: Occurring subclinically in up to 28% of patients undergoing elective intermediate to high-risk non-cardiac surgery.\(^1\)
- Lung injury and inflammation: Due to pre-existing lung disease and the combined deleterious effects of ventilator induced lung injury, systemic inflammation and fluid overload.\(^6\)
- Positive-pressure mechanical ventilation: Especially one-lung ventilation (OLV).\(^6\)
- Lung resection: Recently, we have demonstrated the pulsatile component of RV afterload significantly increases after lung resection.\(^1\)

**Inflammation and PMI**

Although it is widely hypothesised that PMI results predominantly from ischaemia secondary to myocardial oxygen supply/demand imbalance, this hypothesis remains unproven and is challenged by important observations; in excess of 90% of patients with PMI have no ischaemic symptoms to support a diagnosis of myocardial infarction,\(^7\) and the extent and severity of coronary artery disease does not correlate closely with the occurrence of PMI.\(^13\)

The inflammatory response is an important contributor to the myocardial injury seen after myocardial infarction and cardiac surgery, but the extent to which systemic inflammation is involved in the pathogenesis of PMI after non-cardiac surgery is not known. Ackland *et al* recently demonstrated that PMI was associated with an elevated neutrophil-to-lymphocyte ratio, suggesting systemic inflammation may predispose patients to PMI.\(^14\)

Using T1-weighted cardiovascular magnetic resonance (T1-CMR) imaging, our group has described the presence of imaging correlates of perioperative RV (but not LV) myocardial inflammation in patients following lung resection.\(^15\)

In summary, with greater understanding of the incidence, impact and underlying mechanisms of perioperative RVD provided through this investigation, preventative interventions targeted at patients at greatest risk may offer a unique therapeutic opportunity to provide a personalised approach to perioperative management and improve patient outcomes across a wide range of surgical populations.

**Hypotheses**

- RVD after major non-cardiac surgery is a common covert contributor to perioperative morbidity.
- Inflammatory injury to the RV is a significant contributing factor to PMI.

**METHODS AND ANALYSIS**

**Summary:** A multicentre prospective observational cohort study in patients undergoing major non-cardiac surgery in five surgical specialties. Main study: 175 patients to undergo transthoracic echocardiography (TTE) preoperatively and postoperatively (figure 1). Substudy: 50 patients to undergo T1-CMR preoperatively and postoperatively.

**Centres:** Three hospitals in the West of Scotland (Golden Jubilee National Hospital (GJNH), Queen Elizabeth University Hospital and Glasgow Royal Infirmary) and one London hospital (Royal London Hospital).
Study status: Grant funding was secured on 12th February 2021, with ethical approval on 12th January 2023 (REC reference 22/SC/0442). Recruitment commenced in May 2023 with an anticipated study duration of 36 months.

Selection of study subjects

Inclusion criteria

► Patient aged >18 years.
► Patient undergoing planned elective primary hip or knee joint replacement under spinal anaesthesia, major colorectal, major vascular surgery or major surgery requiring OLV with or without lung resection.
► Provision of informed consent.

Main study exclusion criteria

► Pregnancy.
► Ongoing participation in any investigational research which could undermine the scientific basis of the study.
► Major surgery within previous 3 months.
► Previous participation in the IMPRoVE study.
► Inadequate comprehension of English resulting in inability to comply with instructions while undergoing interventions required for main study and substudy.

Risk factors for RVD are likely to be over-represented in patients presenting for surgery and participants with pre-existing RVD could represent an important population that may face greater consequences of acute perioperative insults to the RV. For this reason, although not a specific inclusion or exclusion criteria, patients with pre-existing RVD, including when identified on preoperative echocardiography will be included in the study.

T1-CMR substudy exclusion criteria

► Contraindication to T1-CMR (see online supplemental material).
► Atrial fibrillation at baseline.
► Acute or chronic kidney disease.
► Allergy to intravenous contrast.

Study conduct

Recruitment

Patients will be identified from hospital waiting lists. Patients will be informed of the study, offered a patient information sheet and invited to participate at the earliest possible opportunity after they have been informed of their decision for surgery. Following appropriate time to consider participation, informed consent will be obtained by a member of the research team.

Consent

Written informed consent will be obtained, following a face-to-face discussion about the study by a member of the study team. Signing of consent form and preoperative blood sampling and imaging may take place at any time in the 30 days prior to surgery or on the day of surgery.
Medical management

Medical management will be according to the standard of care at each treating site and is not influenced by this study protocol.

Study interventions

Table 1 shows the general schedule of assessments/study interventions that patients will undergo.

Echocardiography conduct and analysis

TTE will be performed on all 175 patients by a British Society of Echocardiography (BSE) accredited echocardiographers preoperatively and between postoperative days 2 and 4. Echocardiography will acquire the minimum BSE image dataset. In addition to this minimum image dataset, we will acquire an RV focused apical four chamber view for RV free-wall peak longitudinal strain (FWLS) analysis (optimising feasibility as per consensus guidelines). All echocardiography study images will be sent centrally for offline analysis: anonymised images will be transferred via routine clinical imaging systems to the GJNH. A full echocardiography data set will be used to assess for RVD (the primary outcome) and LVD. Offline RV and LV two-dimensional (2D) speckle tracking strain analysis will be performed using Tomtec 2D Cardiac Performance Analysis software. Twenty echocardiography scans will be randomly selected and re-reported by the same reporter a minimum of 2 weeks after initial reporting, and reported by a second reporter, to allow assessment of intraobserver and interobserver agreement. Reproducibility will be assessed by intraclass correlation coefficient using two-way mixed effects with absolute agreement and Bland-Altman plots.

T1-CMR conduct

A subcohort of 50 patients (10 from each surgical group) will undergo a preoperative T1-CMR scan and a single postoperative scan (between postoperative days 2–4). Replicating our previous protocol, CMR will be undertaken on a 1.5 or 3.0 Tesla scanner, by band 7 Health and Care Professions Council accredited radiographers. T1-weighted scans will be performed pretraveous and postintravenous gadolinium administration.

Table 1 Schedule of assessments for all patients enrolled into IMPRoVE study

<table>
<thead>
<tr>
<th>Visit window</th>
<th>Preoperative (day 0)</th>
<th>POD1</th>
<th>POD2</th>
<th>Discharge</th>
<th>30 days</th>
<th>3 months</th>
<th>12 months</th>
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<tbody>
<tr>
<td>Informed consent</td>
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<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Baseline demographics and risk scoring</td>
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<td>BNP/hsTn</td>
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<td>x</td>
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<td>NT-proBNP</td>
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<td>Immediate perioperative data</td>
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<td>Laboratory data</td>
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<td>x</td>
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<td>x</td>
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<tr>
<td>T1-CMR</td>
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<td>x</td>
<td>x</td>
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<td>x</td>
<td>x</td>
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<td>QoR-15</td>
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<td>x</td>
<td>x</td>
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<td>x</td>
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<tr>
<td>Organ-specific complications (Clavien-Dindo ≥2)</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<td>x</td>
<td>x</td>
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<tr>
<td>Unplanned ICU admission</td>
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<tr>
<td>Length of hospital stay</td>
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<tr>
<td>Length of ICU/HDU stay</td>
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<td>x</td>
<td>x</td>
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<tr>
<td>Mortality</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>DAH30</td>
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<tr>
<td>Hospital readmission</td>
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<td>x</td>
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<tr>
<td>EQ-5D-5L</td>
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<td>x</td>
<td>x</td>
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<td>WHODAS 2.0</td>
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</tbody>
</table>

*Ten patients from each of the five surgical groups (50 in total).

BNP, brain natriuretic peptide; DAH30, days alive and at home at 30 days; EQ-5D-5L, EuroQol-5 Dimension-5 Level; HDU, high-dependency unit; hsTn, high sensitivity troponin; ICU, intensive care unit; IMPRoVE, Incidence, impact and Mechanisms of Perioperative Right Ventricular dysfunction; NT-proBNP, N-terminal prohormone of BNP; POD, Post operative day; QoR-15, quality of recovery-15 score; T1-CMR, T1 cardiovascular magnetic resonance; WHODAS 2.0, WHO Disability Assessment Schedule 2.0.
Postprocessing will be protocolised and dual reported by blinded observers.

**Laboratory sampling**
Where possible samples will be drawn contemporaneously with routine clinical blood tests. Cardiac biomarkers will be batch analysed at University of Glasgow Laboratories.

**DAH<sub>30</sub> conduct**
Days alive and at home at 30 days postoperatively (DAH<sub>30</sub>) will be assessed by telephone on postoperative day 30 (up to +5 days). A script will be used to ensure that DAH<sub>30</sub> is reliably and consistently recorded.

Data collection will be performed by the local study team on case report forms (CRFs), which will be filed and securely stored at participating sites. The data will be anonymised at site and a unique numeric study number allocated. Completed CRFs will be entered onto a secure online database in a linked anonymised form. Electronic data will be stored in an encrypted and anonymised format for 15 years following the completion of the trial. At the end of this period, the dataset will be destroyed according to DoD 5220.22-M standards. All data will be held in accordance with the General Data Protection Regulation (2018).

**Laboratory data**
Laboratory data (full blood count, urea and electrolytes, liver function tests and C reactive protein) will be obtained from the local biochemistry and haematology laboratory reporting systems perioperatively, on the day of echocardiography and if clinically indicated, at follow-up.

**Clinical data**
Baseline demographic information will be collected including chronic comorbidities. We will specifically gather information on sleep apnoea status and previous COVID-19 infection since these may affect baseline RV function. Preoperative data will include previous pulmonary function tests, cardiopulmonary exercise testing, CT thorax imaging (for coronary artery calcium scoring), American College of Surgeons National Surgical Quality Improvement Programme risk scoring, and baseline questionnaires (Duke Activity Status Index, quality of recovery-15, EuroQol-5 Dimension-5 Level (EQ-5D-5L) and WHO Disability Assessment Schedule 2.0 (WHODAS 2.0)). Immediate perioperative data will include the operation performed, duration of surgery and anaesthesia, duration of OLV (if applicable), and use of vasopressor/inotropic support.

**Study outcomes**

- **Incidence of postoperative RVD**
- **Coprimary outcomes**
- **Study outcomes**
- **Exploratory outcomes**
- **Statistical considerations**
- **Clinical impact of perioperative RV**
- **Clinical impact of postoperative RVD**

**Incidence of postoperative RVD**

- Days alive and at home at 30 days postoperatively (DAH<sub>30</sub>). DAH<sub>30</sub> is a continuous number between 0 and 30 which reflects, out of the 30 days following surgery, the total number of those days that a patient spends alive and at home. If a patient dies within those 30 days, their value is set to 0.

**Justification for coprimary outcomes**

- **Incidence of postoperative RVD**
- **Clinical impact of perioperative RV**
- **Clinical impact of postoperative RVD**

**Analysis of coprimary outcomes**

- **Incidence of perioperative RVD**

The identified incidence of postoperative RVD will be compared with the null hypothesis that the incidence equals zero using a one-sample binomial test; 95% CIs for the incidence will be defined using the Clopper-Pearson method. In addition, we will perform sensitivity analyses to identify the incidence of patients that develop new postoperative RVD, and identify the incidence of those that have pre-existing RVD maintained through to the postoperative period. Subgroup analyses will estimate the incidence rate of postoperative LVD and RVD within surgical subgroups and compare the incidence in patients with chronic obstructive pulmonary disease (COPD) versus no COPD, in operations involving mechanical ventricle function in the context of clinical trials. However, recent work (by our group and others) has demonstrated the superiority and increased reproducibility of RVFWLS in identifying RVD compared with ‘conventional indices’.

**Clinical impact of perioperative RV**

- Days alive and at home at 30 days postoperatively (DAH<sub>30</sub>) is a novel, well-validated clinical endpoint describing all facets of the perioperative experience and has been recommended as a patient-centred outcome by the Standardising Endpoints in Perioperative (StEP) Medicine initiative. DAH<sub>30</sub> is sensitive to prolonged stay due to complications, discharge to a rehabilitation or nursing care facility, readmission to hospital after discharge and mortality thus integrating efficacy, quality and safety.

**Exploratory outcomes**

- Exploratory outcomes that we will investigate are shown in table 2.

**Statistical considerations**

- All statistical analyses will be performed in conjunction with the Robertson Centre for Biostatistics at the University of Glasgow.

**Analysis of coprimary outcomes**

- **Incidence of perioperative RVD**

The identified incidence of postoperative RVD will be compared with the null hypothesis that the incidence equals zero using a one-sample binomial test; 95% CIs for the incidence will be defined using the Clopper-Pearson method. In addition, we will perform sensitivity analyses to identify the incidence of patients that develop new postoperative RVD, and identify the incidence of those that have pre-existing RVD maintained through to the postoperative period. Subgroup analyses will estimate the incidence rate of postoperative LVD and RVD within surgical subgroups and compare the incidence in patients with chronic obstructive pulmonary disease (COPD) versus no COPD, in operations involving mechanical
Table 2  Exploratory outcomes

<table>
<thead>
<tr>
<th>Left ventricular dysfunction</th>
<th>Defined by two-dimensional echocardiography derived biplane ejection fraction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac biomarkers</td>
<td>NT-proBNP, BNP, hsTn</td>
</tr>
<tr>
<td>Clinical outcomes informed by STEP trials consensus definitions:</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular outcomes27</td>
<td>Myocardial infarction</td>
</tr>
<tr>
<td></td>
<td>Myocardial injury</td>
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<tr>
<td></td>
<td>Cardiac death</td>
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<td></td>
<td>Non-fatal cardiac arrest</td>
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<td></td>
<td>Coronary revascularisation</td>
</tr>
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<td></td>
<td>Major adverse cardiac event</td>
</tr>
<tr>
<td>Pulmonary outcomes28</td>
<td>Pneumonia</td>
</tr>
<tr>
<td></td>
<td>Atelectasis</td>
</tr>
<tr>
<td></td>
<td>Acute respiratory distress syndrome</td>
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<tr>
<td></td>
<td>Pulmonary aspiration</td>
</tr>
<tr>
<td>Renal outcomes29</td>
<td>Acute kidney injury</td>
</tr>
<tr>
<td></td>
<td>Need for renal replacement therapy</td>
</tr>
<tr>
<td>Infection outcomes30</td>
<td>Fever</td>
</tr>
<tr>
<td></td>
<td>Clinical suspicion of infection</td>
</tr>
<tr>
<td>Neurological outcomes31</td>
<td>Delirium</td>
</tr>
<tr>
<td></td>
<td>Stroke</td>
</tr>
<tr>
<td>Major complications</td>
<td>Sequential Organ Failure Assessment Score</td>
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<tr>
<td>Clinical indicators</td>
<td>Need for unplanned HDU or ICU admission</td>
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<tr>
<td></td>
<td>Requirement for new invasive or non-invasive ventilation</td>
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<tr>
<td></td>
<td>Length of postoperative critical care and hospital stay</td>
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<td></td>
<td>Mortality at 30 days</td>
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<tr>
<td>Patient quality of recovery</td>
<td>QoR-15</td>
</tr>
<tr>
<td>Patient-centred outcomes</td>
<td>EQ-5D-5L, WHODAS 2.0 (assessed at 30 days, 3 months and 12 months postoperatively)</td>
</tr>
<tr>
<td>T1-CMR</td>
<td>Preoperative and postoperative T1-CMR. T1 weighted CMR preintravenous and postintravenous gadolinium to calculate T1 signal and extracellular volume (imaging correlates of myocardial inflammation)</td>
</tr>
</tbody>
</table>

BNP, brain natriuretic peptide; EQ-5D-5L, EuroQol-5 Dimension-5 Level; HDU, high-dependency unit; HS-Tn, high sensitivity troponin; ICU, intensive care unit; NT-proBNP, N-terminal prohormone of BNP; QoR-15, quality of recovery-15; STEP, Standardised Endpoints in Perioperative; WHODAS 2.0, WHO Disability Assessment Schedule 2.0.

Exploratory outcomes

LVD will be analysed analogously to RVD as a secondary analysis.

Secondary outcomes from the postoperative period will be used to compare their incidence in patients with and without the primary outcome (RVD). We will assess for association between RVD and PMI (via cardiac biomarkers), cardiovascular complications, major complications, patient recovery, length of intensive care unit and hospital stay. Analysis of intraoperative data will be used with the aim to identify mechanisms by which RVD may have arisen. Where appropriate, multivariate analysis will be used.

We will use 30-day mortality as our primary survival endpoint and will assess for association with RVD via appropriate survival analyses.
We will also assess the intermediate-term and long-term impact of RVD on patients by assessing association between RVD and health-related quality of life (via EQ-5D-5L) and functional status (via WHODAS 2.0) at 30-day, 3-month and 1-year postoperatively.

Preoperative and postoperative T1-CMR will explore for association between imaging correlates of myocardial inflammation (T1 and extracellular volume) and both RVD and PMI. This substudy will also aim to confirm our previous findings of elevated

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**Figure 2** Simulated power analysis for impact of RVD on days alive and at home at 30 days. Assuming for 1% of the patients DAH$_{30}$=0, for the remainder DAH$_{30}$ follows a negative binomial distribution with parameters chosen such that the median DAH$_{30}$ is 24/25 in one group and 27 in the other group and the shape of the distribution is similar to that seen in the validation cohorts. The simulated DAH$_{30}$ was then compared between groups using negative binomial regression (repeated) in 1000 samples. The figures show the resulting estimated power for incidences of postoperative RVD from 15% to 50%*, and for a clinical effect size of 2 (A) or 3 (B) days difference in DAH$_{30}$. In our previous work the incidence of postoperative RVD was 50% in thoracic surgical patients but may be significantly less in, for example, an orthopaedic population. In Chou et al’s study preoperative RV dysfunction prolonged hospital length of stay by over 50%, but this cohort was a very high-risk vascular surgical population. DAH$_{30}$, days alive and at home at 30 days postoperatively; RVD, right ventricular dysfunction.
postoperative T1/extracellular volume in patients after thoracic surgery, and replicate this in other surgical groups.

Patient and public involvement
Our programme of work was presented to the Society of Cardiothoracic Surgeons‘ RESOLVES Patient and Public Involvement (PPI) group with very positive feedback. This PPI group was unanimously in favour of our research and its obvious benefits to patients.

Ethics and dissemination
The study will be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki and the Good Clinical Practice Guidelines. UK wide ethical approval was obtained from the South Central- Oxford C Research Ethics Committee (REC reference 22/SC/0442) and will comply with all applicable UK legislation. Local research and development approval was obtained from each participating site. All local site Standardised Operating Procedures (SOPs) will be followed.

All publications and presentations relating to this study will be authorised by the trial chief investigator (BS). Authorship will be determined according to the international committee of medical journal editors‘ recommendations. The results of the study will be first reported to study collaborators. Subsequently, we will communicate our results by reporting them to the funder and presentation at national meetings, with publication in appropriate peer-reviewed journals. Further details about the trial results and final report will be available on request to the scientific community in a timely manner.

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Contributors All authors contributed significantly to the submitted work. TK and JM wrote the initial draft of the protocol. BS and PM conceived the study and BS is the grant holder. CB contributed to study design and initial funding application. RK and SM are co-principal investigators at Glasgow Royal Infirmary and contributed to study design. MW is principal investigator and IR co-investigator at the Queen Elizabeth University Hospital, both contributed to study design. GA is co-investigator at the Royal London Hospital and contributed to study design. KER is a co-investigator and lead interventional cardiologist for the study and was involved in study design. NG advised on statistical analyses for the study. All authors read and approved the final manuscript.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

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