



REMAP-CAP

Randomized, Embedded,
Multifactorial Adaptive Platform
trial for Community-Acquired
Pneumonia

Domain-Specific Appendix:
MACROLIDE DURATION DOMAIN

**REMAP-CAP: Randomized, Embedded,
Multifactorial Adaptive Platform trial for
Community-Acquired Pneumonia**

Macrolide Duration Domain-Specific Appendix Version 2 dated 12 December 2017

Summary

In this domain of the REMAP-CAP trial, participants with community-acquired pneumonia admitted to intensive care units will be randomized to receive:

- Short course macrolide (for 3 days)
- Extended course macrolide (for 14 days)

At this participating site the following one intravenous and one enteral macrolide have been selected within this domain:

Intravenous: Azithromycin Clarithromycin

Enteral: Azithromycin Clarithromycin Roxithromycin

SUPERSEDED

REMAP-CAP: Macrolide Duration Domain Summary	
Interventions	<ul style="list-style-type: none"> • Short course macrolide discontinued after 3 days unless there is confirmed or strongly suspected microbiological cause for prolonged administration • Extended course macrolide for 14 days or hospital discharge, whichever occurs first
Strata	Analysis and Response Adaptive Randomization are by strata (shock) to allow for strata-by-intervention interaction
Evaluable Interactions	Intervention-intervention interactions will be evaluated between interventions in this domain and the beta-lactam antibiotic interventions in the Antibiotic Domain and between interventions in this domain and the Corticosteroid Domain.
Timing of Reveal	Randomization with Immediate Reveal and Delayed Initiation (with reveal and initiation only occurring after consent or agreement for participation is obtained)
Inclusions	Patients are eligible for this domain only if they have been allocated a beta-lactam plus macrolide intervention within the Antibiotic Domain.
Domain-Specific Exclusions	Domain exclusions: <ul style="list-style-type: none"> • The treating clinician believes that participation in the domain would not be in the best interests of the patient
Intervention-Specific Exclusions	Nil, not applicable
Outcome measures	Primary REMAP endpoint: all-cause mortality at 90 days. Secondary REMAP endpoints refer to Core Protocol Section 7.6.2 Secondary domain endpoints (censored 90 days from the date of enrollment): <ol style="list-style-type: none"> 1. Serious ventricular arrhythmia (including ventricular fibrillation) or sudden unexpected death in hospital. 2. Serious Adverse Events (SAE) as defined in CORE protocol

SUPERSEDED

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1. ABBREVIATIONS

CAP	Community Acquired Pneumonia
CCU	Coronary Care Unit
COPD	Chronic Obstructive Pulmonary Disease
DC	Direct Current
DSA	Domain-Specific Appendix
DSWG	Domain-Specific Working Group
DSMB	Data Safety and Monitoring Board
ICU	Intensive Care Unit
IDSA	Infectious Diseases Society of America
ITSC	International Trial Steering Committee
IV	Intravenous
O2	Oxygen
PCR	Polymerase Chain Reaction
RAR	Response Adaptive Randomization
RCT	Randomized Controlled Trial
REMAP	Randomized, Embedded, Multifactorial Adaptive Platform trial
REMAP-CAP	Randomized, Embedded, Multifactorial, Adaptive Platform trial for Community-Acquired Pneumonia
RSA	Region-Specific Appendix
SAE	Serious Adverse Event
Severe CAP	Severe Community-Acquired Pneumonia

2. PROTOCOL APPENDIX STRUCTURE

The structure of this protocol is different to that used for conventional trials because this trial is highly adaptive and the description of these adaptations is better understood and specified using a 'modular' protocol design. While, all adaptations are pre-specified, the structure of the protocol is designed to allow the trial to evolve over time, for example by the introduction of new domains or interventions or both (see glossary, Section 1.2 Core Protocol for definitions of these terms) and commencement of the trial in new geographical regions.

The protocol has multiple modules, in brief, comprising a Core Protocol (overview and design features of the study), a Statistical Analysis Appendix (details of the current statistical analysis plan and models) and Simulations Appendix (details of the current simulations of the REMAP), multiple Domain-Specific Appendices (DSA) (detailing all interventions currently being studied in each domain), and multiple Regions-Specific Appendices (RSA) (detailing regional management and governance).

The Core Protocol contains all information that is generic to the trial, irrespective of the regional location in which the trial is conducted and the domains or interventions that are being tested. The Core Protocol may be amended but it is anticipated that such amendments will be infrequent.

The Core Protocol does not contain information about the intervention(s), within each domain, because one of the trial adaptations is that domains and interventions will change over time. Information about interventions, within each domain, is covered in a DSA. These Appendices are anticipated to change over time, with removal and addition of options within an existing domain, at one level, and removal and addition of entire domains, at another level. Each modification to a DSA will be subject of a separate ethics application for approval.

The Core Protocol does not contain detailed information about the statistical analysis or simulations, because the analysis model will change overtime in accordance with the domain and intervention trial adaptations but this information is contained in the Statistical Analysis and Simulations Appendices. These Appendices are anticipated to change over time, as trial adaptations occur. Each modification will be subject to approval from the International Trial Steering Committee (ITSC) in conjunction with advice from the International Statistics Interest Group (ISIG) and the Data Safety and Monitoring Board (DSMB).

The Core Protocol also does not contain information that is specific to a particular region in which the trial is conducted, as the locations that participate in the trial are also anticipated to increase over time. Information that is specific to each region that conducts the trial is contained within a RSA. This includes information related to local management, governance, and ethical and regulatory aspects. It is planned that, within each region, only that region's RSA, and any subsequent modifications, will be submitted for ethical review in that region.

The current version of the Core Protocol, DSAs, RSAs and the Statistical Analysis Appendix is listed in the Protocol Summary and on the study website (www.remapcap.org).

3. MACROLIDE DURATION DOMAIN-SPECIFIC APPENDIX VERSION

The version of the Macrolide Duration Domain-Specific Appendix is in this document's header and on the cover page.

3.1. Version history

Version 1: Approved by the Macrolide Duration Domain-Specific Working Group (DSWG) on 20 November 2016

Version 1.1: Approved by the Macrolide Duration DSWG on 30 March 2017

Version 2: Approved by the Macrolide Duration DSWG on 12 December 2017

4. MACROLIDE DURATION DOMAIN GOVERNANCE

4.1. Domain members

Chair:

Professor Allen Cheng

Members:

Professor Richard Beasley

Professor Marc Bonten

Dr. Lennie Derde

Dr. Robert Fowler
Associate Professor David Gattas

Associate Professor Peter Kruger
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5. MACROLIDE DURATION DOMAIN-SPECIFIC WORKING GROUP AUTHORIZATION

The Macrolide Duration Domain-Specific Working Group (DSWG) have read the appendix and authorize it as the official Macrolide Duration Domain-Specific Appendix for the study entitled REMAP-CAP. Signed on behalf of the committee,

Chair
Allen Cheng



Date 12th December 2017

6. BACKGROUND AND RATIONALE

6.1. Domain definition

This is a domain within the REMAP-CAP to test the effectiveness of different durations of macrolide administration in patients with severe community-acquired pneumonia (severe CAP) who are admitted to an Intensive Care Unit (ICU).

6.2. Domain-specific background

Antibiotics are an essential component of therapy for all patients with suspected or proven community-acquired pneumonia (CAP). In patients with sepsis (including pneumonia) requiring admission to intensive care with organ dysfunction, guidelines recommend initiation of antibiotics within 60 minutes of presentation. (Dellinger et al., 2013)

6.2.1. Guidelines recommend either macrolides or quinolones to treat “atypical” respiratory pathogens

Macrolide antibiotics include azithromycin (available for intravenous (IV) or enteral administration), clarithromycin (available for IV or oral administration), roxithromycin (available only for enteral administration), and erythromycin (available for IV or oral administration). Erythromycin is an older macrolide the use of which has declined substantially.

All international guidelines for the empiric treatment of severe CAP recommend treatment with either a macrolide or a fluoroquinolone to provide antimicrobial treatment for “atypical” respiratory pathogen such as legionella ([see Table 1](#)). All of these guidelines recommend adjustment of prescribing when a causative organism is identified which, if the causative organism is an ‘atypical’ pathogen (comprising legionella, *Mycoplasma pneumonia*, *Chlamydophila (Chlamydia) pneumonia*, or *Chlamydophila (Chlamydia) psittaci*) is a prolonged (minimum of 14 days) course of either a macrolide antibiotic or a fluoroquinolone.

Table 1: Empiric antibiotic treatments recommendations for patients with severe pneumonia (without risk factors for pseudomonas) requiring intensive care

Guideline	First line	Second line
British Thoracic Society (Lim et al., 2009)	1. Co-amoxiclav AND macrolide (clarithromycin)	1. Cefuroxime or ceftriaxone AND clarithromycin
United States Infectious Diseases Society of America (IDSA)/ the American Thoracic Society (ATS) (Mandell et al., 2007)	1. Cefotaxime, ceftriaxone, or ampicillin-sulbactam AND either (a) azithromycin or (b) a respiratory fluoroquinolone	1. Respiratory fluoroquinolone AND aztre onam
Australia (Antibiotic Expert Groups, 2014)	1. Ceftriaxone AND azithromycin	1. Moxifloxacin
Canada (Mandell et al., 2000)	1. Moxifloxacin or levofloxacin	1. Cefuroxime, ceftriaxone or beta-lactam/beta-lactamase inhibitor AND IV macrolide
Swedish guidelines (Spindler et al., 2012)	1. Cephalosporin AND macrolide 2. Benzylpenicillin AND respiratory fluoroquinolone	
Europe European Society of Clinical Microbiology and Infectious Diseases / European Respiratory Society (Woodhead et al., 2011)	1. Non-antipseudomonal 3rd generation cephalosporin AND macrolide 2. Non-antipseudomonal 3rd generation cephalosporin AND either (a) Moxifloxacin or (b) Levofloxacin	
Netherlands Dutch Working Party on Antibiotic Policy / Dutch Association of Chest Physicians (Wiersinga et al., 2012)	1. Moxifloxacin or levofloxacin 2. Penicillin (or amoxicillin) AND ciprofloxacin 3. 2nd or 3rd generation cephalosporin AND macrolide.	

The IDSA guidelines recommend administration of azithromycin for between 3 and 5 days but other guidelines do not provide any recommendation regarding the duration of administration of macrolide antibiotics. A survey of Australian and New Zealand ICU specialists indicated that more than 85% administer azithromycin, a macrolide antibiotic, to cover atypical organisms and that just over half of specialists cease azithromycin after 3 days if there is no microbiological evidence of infection with atypical organisms. Studies suggest a wide diversity of antibiotic regimens are used for pneumonia in Europe; the most common antibiotics used included penicillin/beta-lactamase

inhibitors, macrolides, quinolones and third generation cephalosporins, broad spectrum penicillins and second generation cephalosporins but there is little information available about the duration of macrolide therapy when macrolides are used. (Ansari et al., 2009, Torres et al., 2014)

As such, all patients with severe CAP, both in usual practice or within this REMAP, will receive either a macrolide or a fluoroquinolone antibiotic. If a macrolide is included in the choice of empiric antibiotics it is typically continued if an 'atypical' cause of pneumonia is identified. It usually requires several days for the results of microbiological tests to be available and so usual practice is to continue a macrolide antibiotic, for several days, until the results of such tests are available and to then cease the macrolide unless 'atypical' pneumonia is confirmed or strongly suspected.

6.2.2. Macrolide antibiotics have anti-inflammatory properties

Azithromycin has well-described immunomodulatory effects including inhibiting the production of inflammatory cytokines and neutrophils. (Kanoh and Rubin, 2010) These effects are consistent in cell culture, animal studies in patients with chronic pulmonary inflammatory diseases, and appear to be multiphasic, with an initial inflammatory effect followed by a sustained decrease in cytokine production. Other non-antimicrobial effects of macrolides include a reduction in mucus secretion (Rubin et al., 1997), downregulation of adhesion molecules and chemoattractants (Tamaoki, 2004), and inhibition of neutrophil reactive oxygen species. (Levert et al., 1998)

6.2.3. Severe CAP is intertwined with the host systemic inflammatory response

The clinical manifestation of pneumonia is a product of the interaction between an infective pathogen and the local and systemic inflammatory responses of the host. Interestingly, a more pronounced and aggressive inflammatory response has been shown in several studies to be associated with treatment failure and increased rates of mortality. (Antunes et al., 2002) In support of this hypothesis that an over-active immune response is deleterious, higher levels of pro-inflammatory cytokines and chemokines (i.e. IL-6 and IL-8) have been detected in patients with severe CAP and associated with increased rates of mortality. (Antunes et al., 2002) It has been postulated that a potential dampening of this 'abnormal' immune response to infection could improve outcomes. The immunomodulatory properties of macrolide antibiotics provide a rationale for why an extended course may be superior to usual practice, in patients who do not have a microbiological reason (i.e. identification of an 'atypical' organism) to continue the macrolide. High profile reviews have identified the role of extended administration of azithromycin in patients with CAP as a high priority research question. (Dellinger et al., 2013, Wilkinson and Woodhead, 2004)

6.2.4. Macrolides have been associated with improved clinical outcomes in inflammatory lung diseases in some studies

Additional supportive evidence of the potentially beneficial effects of macrolides, that are believed to be mediated by their immunomodulatory properties, comes from trials of macrolides in patients with various forms of chronic inflammatory lung disease. Clinical evidence for an anti-inflammatory effect of macrolides was first noted in patients with diffuse panbronchiolitis, a rare disease found exclusively in Japan. (Schultz, 2004) In Randomized Controlled Trials (RCTs), long term azithromycin has been resulted in improved outcomes in patients with Chronic Obstructive Pulmonary Disease (COPD) (Albert et al., 2011, Uzun et al., 2014), non-cystic fibrosis associated bronchiectasis (Altenburg et al., 2013, Valery et al., 2013), and to prevent or treat bronchiolitis obliterans or chronic rejection in patients who have undergone lung transplantation. (Corris et al., 2015, Vos et al., 2011)

6.2.5. The use of macrolide antibiotics has been associated with improved outcomes in CAP even when the causative organism is resistant to macrolides.

A further rationale for a potential beneficial immunomodulatory effect of macrolide therapy in patients with severe CAP is that outcome may be better for patients with CAP who are treated with macrolide antibiotics, even when the organism that is responsible for causing pneumonia is resistant to macrolides. This evidence is less strong, being derived from observational studies. (Restrepo et al., 2013, Yanagihara et al., 2009).

Clinical trials adding a macrolide to beta-lactams, compared with a beta-lactam alone, for CAP have not demonstrated clinical benefit. One trial found that the addition of clarithromycin to a beta-lactam (cefuroxime or amoxicillin-clavulanate) was associated with a shorter time to clinical stability in patients with moderately severe CAP, although the difference in this small trial was not statistically significant. (Garin et al., 2014) A recent cluster randomized trial of patients with CAP that required hospitalization did not find any differences in mortality or hospital length of stay but did not include patients with severe CAP. (Postma et al., 2015)

6.2.6. Macrolide antibiotics safety profile

The safety profile of macrolide antibiotics is well established. However, there are also safety concerns regarding macrolides with reports of life-threatening cardiac rhythm disorders, although this is rare. (Juurlink, 2014, Svanstrom et al., 2013)

7. DOMAIN OBJECTIVES

The objective of this domain is to determine the effectiveness of short course versus extended course macrolide treatment, in patients co-treated with a beta-lactam antibiotic, in the treatment of severe CAP.

The interventions that will be compared are:

- Short course macrolide discontinued after 3 days unless there is confirmed or strongly suspected microbiological cause for prolonged administration
- Extended course macrolide for 14 days or hospital discharge, whichever occurs first

Azithromycin is the preferred macrolide but at sites where azithromycin is not available, the use of other macrolides will be permitted ([see Section 8.3](#)).

We hypothesize that the probability of all-cause mortality at 90 days will differ depending on the duration of administration of a macrolide.

We hypothesize that the treatment effect of extended macrolide duration is different depending on the presence or absence of shock at the time of enrollment (strata-by-intervention interaction).

We hypothesize that the treatment effect extended macrolide duration is different depending on the different empiric beta-lactam antibiotic that is administered. This is an intervention by intervention interaction between this domain and the beta-lactam antibiotic options in the Antibiotic Domain (i.e. the macrolide duration domain is nested within the beta-lactam antibiotic interventions in the Antibiotic Domain).

We hypothesize that the treatment effect of extended macrolide duration is different depending on whether corticosteroids are administered. This is an intervention by intervention interaction between the Macrolide Duration Domain and the Corticosteroid Domain.

8. TRIAL DESIGN

This domain will be conducted as part of a REMAP trial for severe CAP (see Core Protocol Section 7). Treatment allocation will be adaptive, as described in the Core Protocol Section 7.5.2.

8.1. Population

The REMAP enrolls patients with severe CAP admitted to ICU (see Core Protocol Section 7.3).

8.2. Eligibility criteria

Participants are included in the platform if they have all the REMAP-level inclusions and none of the REMAP-level exclusion criteria (see Core Protocol Section 7.4). Eligibility criteria for this domain can only be understood in conjunction with knowledge of the entry criteria for the Antibiotic Domain.

8.2.1. Inclusion criteria for this domain

Patients are eligible for this domain only if they have been allocated a beta-lactam plus macrolide intervention within the Antibiotic Domain.

In this regard, the Macrolide Duration Domain is nested solely within the beta-lactam plus macrolide interventions within the Antibiotic Domain. It should be noted that to be eligible for this domain it is not necessary to be randomized to a beta-lactam plus macrolide intervention, just allocated to receive a beta-lactam plus macrolide intervention (i.e. a patient allocated to receive a beta-lactam plus macrolide intervention within the Antibiotic Domain because that is the only intervention for which the patient is eligible, because of intervention-level exclusions, is still eligible for randomization in this domain). Patients allocated to receive moxifloxacin or levofloxacin in the Antibiotic Domain are not eligible for this domain.

8.2.2. Exclusion criteria from this domain

Patients will be excluded from this domain, at the time of randomization, if:

- The treating clinician believes that participation in the domain would not be in the best interests of the patient

Patients with suspected legionella or other atypical organisms are eligible for inclusion but if the diagnosis is confirmed after enrollment this influences the implementation of the intervention. It should be noted that patients with known Legionella, at the time of first enrollment in the Platform, are not eligible for the Antibiotic Domain (because specific antimicrobial therapy is indicated) and patients with known intolerance to macrolides have an intervention-level exclusion to receive beta-lactam plus macrolide interventions within the Antibiotic Domain.

8.3. Interventions

8.3.1. Macrolide Intervention

Patients will be randomly assigned to intention to receive one of the following study interventions.

- Short course macrolide discontinued after 3 days unless there is confirmed or strongly suspected microbiological cause for prolonged administration
- Extended course macrolide for 14 days or hospital discharge, whichever occurs first

The dosing of and route of administration of macrolide antibiotics are not specified in the protocol but the following guidance is provided:

- Initial IV administration of a macrolide is strongly preferred
- The preferred IV macrolide is azithromycin, but IV clarithromycin may be substituted.
- The preferred enteral macrolide is azithromycin, but enteral clarithromycin or roxithromycin may be substituted.
- Sites where erythromycin is the only available macrolide will not be able to participate in this domain.

The following doses (Table 2) are provided as guidance and may be modified according to local guidelines or practice. The dose of all macrolides is the same for IV and enteral administration and no dose adjustment is required for alterations in renal function including if the patient is receiving renal replacement therapy. A switch from IV to enteral macrolide is permitted once the patient is clinically improving as determined by the treating clinician.

Table 2: Minimum doses of intravenous or enteral macrolide

Agent	Dose
Azithromycin	500mg daily
Clarithromycin	500mg daily
Roxithromycin	150mg q12hr

If, within the first 3 days, there is confirmed diagnosis (or a strong clinical suspicion) of legionellosis or other microbiological diagnosis of an 'atypical' organism, then effective treatment for 'atypical' organisms must be continued. This can be either prolonged macrolide treatment or substitution with a fluoroquinolone or other active agent. Patients in whom legionellosis or another 'atypical'

organism is diagnosed after day 3, can re-start or continue macrolide or commence treatment with a fluoroquinolone or other active agent.

The Macrolide should be discontinued if the patient experiences a serious adverse event (SAE) that is thought to be related to the study drug and may be discontinued at the discretion of the treating clinician if continued treatment is not in the best interests of the patient. In this regard, consideration should be given to evaluation of the QT interval, particularly at the time of discharge from the ICU.

8.3.2. Timing of initiation of intervention

The intervention is identical administration of macrolide, for the first 3 days after enrollment. Microbiological tests are usually available before the fourth day to determine if, in patients randomized to short duration of macrolide, whether there is a microbiological reason for why the macrolide (or suitable alternative antibiotic) should be continued for a prolonged course.

8.3.3. Duration of administration of macrolide

The duration of macrolide therapy is the primary research question in this domain. In the short course intervention, patients will receive 3 days of macrolide therapy unless there is confirmed or strongly suspected cause to continue. In the extended course therapy intervention, patients will continue to receive the macrolide for 14 days or until discharge from hospital, if hospital discharge occurs before 14 days have elapsed.

For patients who are discharged from the ICU before 14 days, it is the responsibility of ICU staff to prescribe the macrolide for administration for a total of 14 days. However, it is not the responsibility of ICU medical or research staff to ensure continuation of the study drug after discharge from the ICU.

8.4. Concomitant care

The use of low dose erythromycin (up to 250mg q6h) to promote gastric emptying is permitted.

Any subsequent change of other antibiotics (other than macrolides), based on availability of microbiological data, will be permitted at the treating clinician's discretion. However, the duration of macrolide therapy will not be affected by macrolide susceptibility or resistance in any pathogens isolated from participants.

8.5. Endpoints

8.5.1. Primary endpoint

The primary endpoint for this domain is the REMAP primary outcome (all-causes mortality at 90 days) as specified in Core Protocol Section 7.6.1.

8.5.2. Secondary endpoints

All secondary endpoints as specified in the Core Protocol Section 7.6.2.

The domain-specific secondary outcome measures (occurring during the index hospitalization, censored at 90 days after enrollment) in addition to the Antibiotic Domain will be:

- Serious ventricular arrhythmia (including ventricular fibrillation) or sudden unexpected death in hospital SAE as defined in CORE Protocol

9. TRIAL CONDUCT

9.1. Microbiology

Isolates will be tested for susceptibility to macrolide antibiotics using routine clinical testing. Specific isolates may be referred to a reference laboratory according to current clinical practice.

9.2. Domain-specific data collection

9.2.1. Clinical data collection

In addition to Domain-specific data required as a consequence of participation in the Antibiotic Domain, patients who are randomized in this domain will have the following data collected:

- Serious ventricular arrhythmia (including ventricular fibrillation) or sudden unexpected death in hospital. SAE as defined in Core Protocol

Refer to Core Protocol Section 8.9 for other data collection fields and processes.

9.3. Criteria for discontinuation

Refer to Core Protocol Section 8.7 for discontinuation criteria for the participation in REMAP-CAP.

9.4. Blinding

9.4.1. Blinding

All antibiotics will be administered on an open-label basis.

9.4.2. Unblinding

Not relevant.

10. STATISTICAL CONSIDERATIONS

10.1. Domain-specific stopping rules

If a Platform Conclusion of equivalence in the primary endpoint is demonstrated the DSMB and the ITSC may consider continuation of randomization if clinically relevant differences in secondary endpoints have not been demonstrated and it is considered plausible that clinically relevant differences in one or more secondary endpoints may be capable of being demonstrated. In all other respects the stopping rules for this domain are those outlined in the Core Protocol Sections 7.8.6 to 7.8.9.

10.2. Strata

Both analysis of the treatment effect and the Response Adaptive Randomization (RAR) will utilize the stratum of shock in this domain.

10.3. Timing of revealing of randomization status

The timing of the revealing of allocation status and administration of interventions is as specified to be Randomization with Immediate Reveal and Delayed Initiation with reveal not occurring until after consent or some other form of agreement has been obtained (see section 7.8.3.4 in Core Protocol).

10.4. Interactions with interventions in other domains

An *a priori* interaction with the Corticosteroid Domain is considered possible and will be incorporated into the statistical models used to analyze this domain.

An *a priori* interaction with the beta-lactam specified in the Antibiotic Domain is considered possible and will be incorporated into the statistical models used to analyze this domain. No interaction is

evaluable between this domain and administration of moxifloxacin or levofloxacin in the Antibiotic Domain.

No interaction is evaluable between the Ventilation Domain and this domain

10.5. Post-trial Sub-groups

Domain-specific post-hoc sub-groups will be used in analysis following the conclusion of one or more interventions within the domain. The *a priori* sub-groups of interest include:

- Patients in whom a microbiological diagnosis has been made on the basis of culture or other investigations such as antigen detection or polymerase chain reaction (PCR)
 - Patients with pneumococcal pneumonia
 - Patients without *Legionella* spp or other 'atypical' pneumonia
- Elderly (≥ 65 years) and non-elderly (< 65 years) patients
- Chronic Obstructive Pulmonary Disease (COPD)
- Azithromycin versus other macrolides

11. ETHICAL CONSIDERATIONS

11.1. Data Safety and Monitoring Board

The DSMB should be aware that the superiority, inferiority, or equivalence of different interventions with respect to the primary endpoint is possible, and if equivalence is demonstrated, the optimal treatment may be based on secondary endpoints, such as the incidence of cardiovascular endpoints.

11.2. Potential domain-specific adverse events

The antibiotics used in this domain have a known toxicity profile and adverse events are rare.

Domain-specific harms related to macrolide therapy include:

- Cardiac arrhythmia (particularly torsades de pointes)
- Gastrointestinal intolerance
- Hypersensitivity
- Abnormal liver function

Please refer to Core Protocol (section 8.12) for information about safety monitoring and reporting.

11.3. Domain-specific consent issues

Azithromycin is approved and is in common use in many countries for CAP. Most international guidelines do not specify the duration of treatment where a specific diagnosis (e.g. legionella) has not been diagnosed.

The use of prolonged courses of azithromycin is widely used for specific types of pneumonia (e.g. legionellosis). Sites will be able to opt out of this domain for all patients at that site if they believe that this intervention is not part of reasonable care of patients with pneumonia, or are not approved for use in the country or conflict with antimicrobial stewardship considerations. Additionally, clinicians may choose not to enroll individual patients if they feel that participation is not in the patient's best interests.

As all severe CAP patients receive at least 3 days of macrolide treatment as standard of care, and because extended duration macrolide therapy is not part of the spectrum of standard care, initiation of the intervention, before the fourth day after enrollment, will not occur until consent is obtained from the participant or agreement is obtained from an authorized representative.

Pregnant women are susceptible to pneumonia and azithromycin is widely used safely in this population. Azithromycin and roxithromycin are preferred to clarithromycin in pregnant women.

12. GOVERNANCE ISSUES

12.1. Funding of domain

The REMAP trial is funded by an Australian National Health and Medical Research Council project grant (APP1101719), a European Union 7th Framework Programme for Research and Technological Development grant (602525) and a Health Research Council New Zealand Programme grant (16/631).

12.1. Funding of domain interventions

The macrolide will be provided by participating hospitals on the basis that, in the absence of the REMAP, a proportion of patients with severe CAP would otherwise have received a macrolide. In New Zealand HRC funding will be available to reimburse sites for up to two doses per patient of IV azithromycin (see ANZ RSA Section 9.2.1).

12.2. Domain-specific declarations of interest

All investigators involved in REMAP-CAP maintain a registry of interests on the REMAP-CAP website.

These are updated periodically and publicly accessible on the study website.

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