The effect of domiciliary non-invasive ventilation (NIV) on clinical outcomes in stable and recently hospitalized patients with severe obstructive pulmonary disease (COPD)

Dretzke, Janine; Moore, David; Dave, Chirag; Mukherjee, Rahul; Price, Malcolm; Bayliss, Susan; Jordan, Rachel; Turner, Alice

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The effect of domiciliary noninvasive ventilation on clinical outcomes in stable and recently hospitalized patients with COPD: a systematic review and meta-analysis

Janine Dretzke1
David Moore1
Chirag Dave2
Rahul Mukherjee2
Malcolm J Price1
Sue Bayliss1
Xiaoying Wu1
Rachel E Jordan1
Alice M Turner1,2,3

1Institute of Applied Health Research, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, 2Heart of England NHS Foundation Trust, Heartlands Hospital, 3Queen Elizabeth Hospital Research Laboratories, University of Birmingham, Edgbaston, Birmingham, UK

Introduction: Noninvasive ventilation (NIV) improves survival among patients with hypercapnic respiratory failure in hospital, but evidence for its use in domiciliary settings is limited. A patient’s underlying risk of having an exacerbation may affect any potential benefit that can be gained from domiciliary NIV. This is the first comprehensive systematic review to stratify patients based on a proxy for exacerbation risk: patients in a stable state and those immediately post-exacerbation hospitalization.

Methods: A systematic review of nonrandomized and randomized controlled trials (RCTs) was undertaken in order to compare the relative effectiveness of different types of domiciliary NIV and usual care on hospital admissions, mortality, and health-related quality of life. Standard systematic review methods were used for identifying studies (until September 2014), quality appraisal, and synthesis. Data were presented in forest plots and pooled where appropriate using random-effects meta-analysis.

Results: Thirty-one studies were included. For stable patients, there was no evidence of a survival benefit from NIV (relative risk [RR] 0.88 [0.55, 1.43], I²=60.4%, n=7 RCTs), but there was a possible trend toward fewer hospitalizations (weighted mean difference −0.46 [−1.02, 0.09], I²=59.2%, n=5 RCTs) and improved health-related quality of life. For posthospital patients, survival benefit could not be demonstrated within the three RCTs (RR 0.89 [0.53, 1.49], I²=25.1%), although there was evidence of benefit from four non-RCTs (RR 0.45 [0.32, 0.65], I²=0%). Effects on hospitalizations were inconsistent. Post hoc analyses suggested that NIV-related improvements in hypercapnia were associated with reduced hospital admissions across both populations. Little data were available comparing different types of NIV.

Conclusion: The effectiveness of domiciliary NIV remains uncertain; however, some patients may benefit. Further research is required to identify these patients and to explore the relevance of improvements in hypercapnia in influencing clinical outcomes. Optimum time points for commencing domiciliary NIV and equipment settings need to be established.

Keywords: noninvasive ventilation, domiciliary, COPD, hospitalization, systematic review, meta-analysis

Introduction
COPD is a chronic progressive lung disease, characterized by nonreversible airflow obstruction and intermittent exacerbations.1 Treatment for COPD is based on pharmacotherapy, pulmonary rehabilitation, and in some cases, long-term oxygen therapy. Exacerbations are a key cause of increased morbidity, mortality, and poor health status,
and place a considerable burden on the health care system. Approximately 15% of COPD patients per year have exacerbations necessitating hospital admission; between 10% and 25% of patients admitted with hypercapnic respiratory failure due to COPD die in hospital. Reduced exacerbation frequency is therefore an important therapeutic target.

Noninvasive ventilation (NIV) is a method of providing ventilatory support via a mask and is effective in improving survival among patients with acute or acute-on-chronic hypercapnic respiratory failure in hospital. Evidence for domiciliary use of NIV in non-acute COPD patients is more limited despite a number of systematic reviews. As patients immediately posthospitalization are at greater risk of recurrence of exacerbation than those more stable, this difference could influence the effectiveness of NIV in preventing or reducing the impact of these events. This is the first systematic review to stratify data by these two patient groups, and it is the most comprehensive review to date, including evidence from randomized controlled trials (RCTs), non-RCTs, and RCTs comparing different NIV settings, and considering mortality, hospitalizations, and quality of life (QoL) as outcomes. Finally, this is the first systematic review to attempt an analysis, albeit exploratory, of the relationship between hypercapnia and clinical outcomes.

Methods
A protocol detailing the methodology was registered with PROSPERO (CRD42012003286). A summary of the methods is presented here. Search strategies incorporated a combination of text words and index terms relating to NIV and COPD. Bibliographic databases (MEDLINE, MEDLINE In-Process, Embase, Cochrane CENTRAL, CINAHL, and Science Citation Index Expanded (ISI)), the British Library’s ZETOC and ISI Conference Proceedings Citation Index, and clinical trial registers were searched from 1980 until September 2014. No study design or language restrictions were imposed. Citation checking of included studies was undertaken, and experts in the field were consulted to identify further studies. The search strategy for MEDLINE is shown in the Supplementary material.

Studies were eligible for inclusion if they met the criteria shown in Table 1.

<table>
<thead>
<tr>
<th>Study design</th>
<th>Patients</th>
<th>Intervention</th>
<th>Comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCTs (parallel or crossover)</td>
<td>Adult COPD patients</td>
<td>Any form of domiciliary NIV</td>
<td>Usual care or another form of NIV</td>
</tr>
<tr>
<td>Nonrandomized controlled studies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systematic reviews (for identifying further primary studies)</td>
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</tbody>
</table>

Abbreviations: RCTs, randomized controlled trials; NIV, noninvasive ventilation.
walk distance) were not pooled due to between-study heterogeneity but are presented in forest plots in order to show the overall direction of effect and uncertainty.

Exploratory post hoc analyses of study-level data were performed to determine if baseline hypercapnia could predict response to NIV, or whether change in hypercapnia correlated with any effect of NIV on mortality and hospitalizations.

Guidelines of Preferred Reporting Items for Systematic Reviews and Meta-Analyses were adhered to.\textsuperscript{16}

Results

Main study characteristics

Screening of the 7,405 records identified by the searches yielded 21 RCTs (18 NIV vs usual care; three NIV vs another form of NIV) and ten nonrandomized controlled studies (five prospective, five retrospective; Figure 1). Table 2 shows the main characteristics of these studies.

All patients had Global Initiative for Chronic Obstructive Lung Disease stage III and/or IV COPD, or were described as...
Table 2 Main study and intervention characteristics

<table>
<thead>
<tr>
<th>Study</th>
<th>N (n, % male)</th>
<th>Length of follow-up</th>
<th>Stable or posthospital/post-exacerbation population and proportion on LTOT</th>
<th>Hypercapnia</th>
<th>NIV target</th>
<th>Comparator</th>
<th>Main outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bhatt et al, USA</td>
<td>30 (20/27, 74%)</td>
<td>6 months</td>
<td>Stable: no exacerbations in 4 weeks prior to study LTOT: no details</td>
<td>Patients described as normocapnic. Pressure Inclusion criterion: PaCO$_2$ &lt;52 mmHg (or &lt;6.93 kPa)</td>
<td>Usual care</td>
<td>QoL, adherence, FEV, % predicted, FVC % predicted, PaCO$_2$, and PaO$_2$</td>
<td></td>
</tr>
<tr>
<td>Casanova et al, Spain</td>
<td>52 (43/44, 98%)</td>
<td>12 months</td>
<td>Stable: no acute exacerbation in previous 3 months LTOT: 93%</td>
<td>No details, but stated in the discussion that: &quot;The number of hypercapnic patients in our series was small&quot;. Mean (SD) PaCO$_2$ in NIV group 50.7 (7.9) (or 6.76) kPa and usual care group 53.2 (8.6) (or 7.09) kPa</td>
<td>Pressure</td>
<td>Usual care</td>
<td>Survival, exacerbations, hospitalizations, adherence, FEV, % predicted, FVC % predicted, PaCO$_2$, and PaO$_2$</td>
</tr>
<tr>
<td>Clin et al, Italy</td>
<td>90 (69/86, 80%)</td>
<td>24 months</td>
<td>Stable clinical condition, as assessed by an arterial pH &gt;7.35, and free from exacerbation in the 4 weeks preceding recruitment LTOT: 100%</td>
<td>Inclusion criterion: PaCO$_2$ &gt;6.6 kPa</td>
<td>Pressure</td>
<td>Usual care</td>
<td>Survival, hospitalizations, QoL, adherence, FEV, % predicted, PaCO$_2$, PaO$_2$, 6MWD</td>
</tr>
<tr>
<td>Duiverman et al, the Netherlands</td>
<td>72 (35/66, 53%)</td>
<td>3 months</td>
<td>Stable clinical condition (no exacerbation in the 4 weeks prior to study participation together with a pH of &gt;7.35) LTOT: 45% (first study period) and 57% (second study period)</td>
<td>Inclusion criterion: PaCO$_2$ &gt;6.0 kPa</td>
<td>Blood gases</td>
<td>Usual care + 12-week multidisciplinary rehabilitation program</td>
<td>QoL, FEV, % predicted, PaCO$_2$, PaO$_2$, 6MWD</td>
</tr>
<tr>
<td>Duiverman et al, the Netherlands</td>
<td>24 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Usual care + home-based rehabilitation program</td>
<td>Survival, exacerbations, hospitalizations, adherence, FEV, % predicted, PaCO$_2$, PaO$_2$, and 6MWD</td>
</tr>
<tr>
<td>Garrod et al, UK</td>
<td>45 (28/45, 62%)</td>
<td>3 months</td>
<td>Stable severe COPD. Patients had no reported exacerbations in the past 4 weeks LTOT: 4%</td>
<td>Patients described as normocapnic. Pressure NIV group mean PaCO$_2$ 44.2 (6.68) (or 5.89) kPa. Usual care mean PaCO$_2$ 46.1 (9.07) (or 6.15) kPa</td>
<td>Usual care + pulmonary rehabilitation program during part of the RCT</td>
<td>Exacerbations, QoL, adherence, FEV, % predicted, FVC, PaCO$_2$, and PaO$_2$</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>nIV Size</td>
<td>nIV Duration</td>
<td>Description</td>
<td>Inclusion Criterion</td>
<td>Pressure</td>
<td>Usual care</td>
<td>Other Measures</td>
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<tr>
<td>Gay et al., USA</td>
<td>13 (10/13, 77%)</td>
<td>3 months</td>
<td>Clinically stable, severe COPD. No major changes in FEV₁, PaCO₂, hospitalization, or change in medications over a 6-week period</td>
<td>Inclusion criterion: PaCO₂ &gt; 45 mmHg (or 6.0 kPa)</td>
<td>Pressure</td>
<td>Usual care</td>
<td>Adherence, FEV₁ % predicted, PaCO₂, PaO₂, and 6MWD</td>
</tr>
<tr>
<td>Kamiński et al., Poland</td>
<td>19 (16/19, 84%)</td>
<td>3 months</td>
<td>Stable: exacerbation of COPD during last 3 months was an exclusion criterion</td>
<td>Inclusion criterion: PaCO₂ &gt; 50 mmHg (or 6.6 kPa)</td>
<td>Blood gases</td>
<td>Usual care</td>
<td>Survival, hospitalizations, adherence, FEV₁, FVC, PaCO₂, PaO₂, and 6MWD</td>
</tr>
<tr>
<td>Köhnlein et al., Germany</td>
<td>195 (121/195, 62%)</td>
<td>12 months</td>
<td>Stable: no exacerbations in 4 weeks prior to study</td>
<td>Yes (PaCO₂) of ≥ 7 kPa (51.9 mmHg)</td>
<td>Blood gases</td>
<td>Usual care</td>
<td>Survival, hospitalizations, QoL, adherence, FEV₁, FVC, PaCO₂, PaO₂, and 6MWD</td>
</tr>
<tr>
<td>McEvoy et al., Australia</td>
<td>144 (94/144, 65%)</td>
<td>12 months</td>
<td>Stable hypercapnic COPD LTOT: 100%</td>
<td>All described as hypercapnic. PaCO₂ &gt; 46 mmHg (or 6.13 kPa) at least twice in the previous 6 months during periods of clinical stability</td>
<td>Pressure</td>
<td>Usual care</td>
<td>Survival, hospitalizations, QoL, adherence, FEV₁, FVC, PaCO₂, PaO₂, and 6MWD</td>
</tr>
<tr>
<td>Meecham-Jones et al., UK Crossover RCT</td>
<td>18 (15/18, 83%)</td>
<td>3 months</td>
<td>Stable clinical state for at least 1 month prior to entry into the study, with no recent deterioration in clinical state, spirometric values, or resting blood gases LTOT: 100%</td>
<td>Inclusion criterion: PaCO₂ &gt; 45 mmHg (or 6.0 kPa)</td>
<td>Pressure</td>
<td>Usual care</td>
<td>QoL, adherence, FEV₁, FVC, PaCO₂, PaO₂, and 6MWD</td>
</tr>
<tr>
<td>Sin et al., Canada</td>
<td>23 (10/21*, 48%)</td>
<td>3 months</td>
<td>Advanced stable COPD (no further details) LTOT: proportion unclear</td>
<td>Based on mean PaCO₂ NIV 43.1 (4.9) mmHg (or 5.7 kPa) and usual care 45.2 (13.5) mmHg (or 6.0 kPa); a proportion of patients with hypercapnia</td>
<td>Pressure</td>
<td>Usual care</td>
<td>Adherence, FEV₁, PaCO₂, and 6MWD</td>
</tr>
<tr>
<td>Strumpf et al., USA Crossover RCT</td>
<td>19 (19/23*, 83%)</td>
<td>3 months</td>
<td>Severe, stable COPD. No exacerbation of airway disease within the previous month LTOT: 86% (completers only)</td>
<td>Mean PaCO₂ 49 (2) mmHg, range 35–67 (range 4.7–8.9 kPa). Likely to include a proportion of patients with hypercapnia</td>
<td>Blood gases</td>
<td>Usual care</td>
<td>Hospitalizations, exacerbations, adherence, FEV₁, FVC, PaCO₂, and PaO₂</td>
</tr>
<tr>
<td>Zhou et al., People's Republic of China</td>
<td>36 (29/36, 81%)</td>
<td>12 months</td>
<td>Stable. No exacerbations within the last month LTOT: 100% usual care arm no details for NIV arm</td>
<td>Baseline PaCO₂ NIV 57.42 (7.64) (or 7.6) kPa and usual care 56.89 (8.26) (or 7.6) kPa. Likely to include proportion of patients with hypercapnia</td>
<td>Pressure</td>
<td>Usual care</td>
<td>Survival, exacerbations, hospitalizations, adherence, PaCO₂, PaO₂, and pH</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Study</th>
<th>N (n, % male)</th>
<th>Length of follow-up</th>
<th>Stable or posthospital/post-exacerbation population and proportion on LTOT</th>
<th>Hypercapnia</th>
<th>NIV target</th>
<th>Comparator</th>
<th>Main outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheung et al,31 People's Republic of China</td>
<td>47 (43/47, 91%)</td>
<td>12 months</td>
<td>Posthospital: patients who were admitted with a severe exacerbation with persistent respiratory acidosis despite initial treatment with bronchodilators, corticosteroids, and antibiotics, and who required treatment with NIV. Those who survived after treatment with acute NIV were the target study population</td>
<td>Inclusion criterion: PaCO₂ ≥ 6 kPa</td>
<td>Volume</td>
<td>Usual care</td>
<td>Survival, exacerbations, hospitalizations, adherence, and PaCO₂</td>
</tr>
<tr>
<td>De Backer et al,34 Belgium</td>
<td>15 (10/15, 67%)</td>
<td>6 months</td>
<td>Posthospital: hospitalized due to a hypercapnic exacerbation</td>
<td>Inclusion criterion: PaCO₂ ≥ 45 mmHg (or 6.0 kPa)</td>
<td>Blood gases</td>
<td>Usual care</td>
<td>FEV₁, PaCO₂, and 6MWD</td>
</tr>
<tr>
<td>Murphy et al,35 UK Interim results</td>
<td>36 (no details)</td>
<td>3 months</td>
<td>Posthospital: patients admitted for acute hypercapnic respiratory failure due to an exacerbation of COPD with persistent hypercapnia (PaCO₂ ≥ 7 kPa) 2–4 weeks following resolution of the acute episode</td>
<td>PaCO₂ ≥ 7 kPa</td>
<td>Pressure</td>
<td>Usual care</td>
<td>Adherence</td>
</tr>
<tr>
<td>Struijk et al,32 the Netherlands</td>
<td>201 (83/201, 41%)</td>
<td>12 months</td>
<td>Posthospital: patients included after episode of acute respiratory failure</td>
<td>Yes (PaCO₂ ≥ 6.0 kPa)</td>
<td>Pressure</td>
<td>Usual care</td>
<td>Survival, hospitalizations, exacerbations, QoL, adherence, FEV₁, FVC, PaCO₂, and PaO₂</td>
</tr>
<tr>
<td>Xiang et al,33 People's Republic of China</td>
<td>40 (31/40, 77%)</td>
<td>24 months</td>
<td>Posthospital: after discharge from hospital. All admitted with acute exacerbation and type II respiratory failure. Discharged once stable</td>
<td>Inclusion criterion: PaCO₂ ≥ 55 mmHg (or 7.33 kPa)</td>
<td>Pressure</td>
<td>Usual care</td>
<td>Survival, hospitalizations, FEV₁, FVC, PaCO₂, PaO₂, dyspnea, and 6MWD</td>
</tr>
<tr>
<td>Study Authors</td>
<td>Country</td>
<td>Duration</td>
<td>Enrollment Details</td>
<td>PaCO\textsubscript{2} (mmHg or kPa)</td>
<td>Blood Gases Details</td>
<td>QoL, Adherence, FEV\textsubscript{1}, PaCO\textsubscript{2}, and 6MWD</td>
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<tr>
<td>Dreher et al\textsuperscript{28}</td>
<td>Germany</td>
<td>6 weeks</td>
<td>Stable. Patients enrolled during stable phase of disease. Excluded if weaned from invasive ventilation or intubated during the last 3 months</td>
<td>PaCO\textsubscript{2} &gt;45 mmHg (or 6.0 kPa)</td>
<td>Blood gases. High intensity: high pressure with respiratory rates beyond the spontaneous breathing frequency</td>
<td>QoL, adherence, FEV\textsubscript{1}, PaCO\textsubscript{2}, and 6MWD</td>
<td></td>
</tr>
<tr>
<td>Murphy et al\textsuperscript{40}</td>
<td>UK</td>
<td>6 weeks</td>
<td>Stable (no details on length of time without exacerbations)</td>
<td>PaCO\textsubscript{2} &gt;6.0 kPa</td>
<td>Pressure. High intensity: high pressure and high back-up rate (2 bpm)</td>
<td>QoL, adherence, and PaCO\textsubscript{2}</td>
<td></td>
</tr>
<tr>
<td>Oscroft et al\textsuperscript{39}</td>
<td>UK</td>
<td>8 weeks</td>
<td>Stable (no exacerbations in preceding 4 weeks; clinical stability confirmed during overnight assessment)</td>
<td>PaCO\textsubscript{2} &gt;7.5 kPa</td>
<td>Pressure. Volume assured: set to enable adjustment of inspiratory pressure up to 25 mmHg, the maximum possible with this ventilator</td>
<td>QoL, adherence, FEV\textsubscript{1}, FVC, and PaCO\textsubscript{2}</td>
<td></td>
</tr>
</tbody>
</table>

Controlled studies: stable disease

<table>
<thead>
<tr>
<th>Study Authors</th>
<th>Country</th>
<th>Duration</th>
<th>Enrollment Details</th>
<th>PaCO\textsubscript{2} (mmHg or kPa)</th>
<th>Blood Gases Details</th>
<th>QoL, Adherence, FEV\textsubscript{1}, FVC, PaCO\textsubscript{2}, and PaO\textsubscript{2}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clini et al\textsuperscript{28}</td>
<td>Italy</td>
<td>Mean (SD) 35 (7) months</td>
<td>Stable clinical state, ie, stability in blood gas values and pH (7.35), and lack of exacerbation in the preceding 4 weeks</td>
<td>Inclusion criterion: PaCO\textsubscript{2} &gt;6 kPa</td>
<td>Volume</td>
<td>Usual care</td>
</tr>
<tr>
<td>Clini et al\textsuperscript{23}</td>
<td>Italy</td>
<td>18 months</td>
<td>Stable: noninvasive mechanical ventilation was initiated during a preliminary hospital trial when patients were in a stable state</td>
<td>Inclusion criterion: PaCO\textsubscript{2} &gt;6.7 kPa</td>
<td>Volume</td>
<td>Usual care + “home supervision program”</td>
</tr>
<tr>
<td>Paone et al\textsuperscript{30}</td>
<td>Italy</td>
<td>24 months</td>
<td>Stable. Patients enrolled 3 months after discharge from hospital (for exacerbation); free from exacerbations for at least 4 weeks</td>
<td>Yes (PaCO\textsubscript{2} &gt;50 mmHg) (6.6 kPa)</td>
<td>Volume</td>
<td>Usual care</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Study</th>
<th>N (n, % male)</th>
<th>Length of follow-up</th>
<th>Stable or posthospital/post-exacerbation population and proportion on LTOT</th>
<th>Hypercapnia</th>
<th>NIV target</th>
<th>Comparator</th>
<th>Main outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tsolaki et al,29</td>
<td>49 (31/46, 67%)</td>
<td>12 months</td>
<td>Stable clinical state, as assessed by a pH &gt; 7.35, and free from exacerbations at least 4 weeks preceding recruitment LTOT: proportion unclear</td>
<td>Inclusion criterion: PaCO\textsubscript{2} ≥50 mmHg (6.6 kPa)</td>
<td>Pressure</td>
<td>Usual care</td>
<td>Survival, exacerbations, hospitalizations, QoL, adherence, PaCO\textsubscript{2} and PaO\textsubscript{2}</td>
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<tr>
<td>Greece</td>
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<tr>
<td>Prospective</td>
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<tr>
<td>Controlled studies: posthospitalization for acute exacerbation</td>
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<tr>
<td>Budweiser et al,36</td>
<td>140 (91/140, 65%)</td>
<td>NIV mean (SD) 19.8 (12.9) months and usual care 12.9 (9.9) months</td>
<td>Both stable and posthospital patients (classified as posthospital): patients with immediately preceding exacerbation eligible for inclusion (proportion of patients not stated) LTOT: proportion unclear</td>
<td>Inclusion criterion: PaCO\textsubscript{2} ≥50 mmHg (or 6.6 kPa)</td>
<td>Blood gases</td>
<td>Usual care</td>
<td>Survival and adherence</td>
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<tr>
<td>Germany</td>
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<tr>
<td>Prospective</td>
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<tr>
<td>Heinemann et al,35</td>
<td>82 (59/82, 72%)</td>
<td>12 months</td>
<td>Posthospital: patients with severe COPD who required prolonged weaning from invasive mechanical ventilation due to acute exacerbation, pneumonia, or postoperative respiratory failure LTOT: 55% prior to study and 91% upon discharge</td>
<td>Inclusion criterion: PaCO\textsubscript{2} ≥52.5 mmHg (or 6.9 kPa) for those receiving NIV</td>
<td>Blood gases</td>
<td>Usual care</td>
<td>Survival and adherence</td>
</tr>
<tr>
<td>Germany</td>
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<td>Retrospective</td>
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<tr>
<td>Lu et al,34</td>
<td>44 (31/44, 70%)</td>
<td>6 months</td>
<td>Posthospital: patients who were discharged once they were stable following hospitalization LTOT: 100%</td>
<td>Inclusion criterion: PaCO\textsubscript{2} ≥55 mmHg (or 7.33 kPa)</td>
<td>Blood gases</td>
<td>Usual care</td>
<td>Survival, hospitalizations adherence, FEV\textsubscript{1}, FVC, PaCO\textsubscript{2}, PaO\textsubscript{2} and 6MWD</td>
</tr>
<tr>
<td>People's Republic of China</td>
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<tr>
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<tr>
<td>Milane and Jonquet,37</td>
<td>66 (62/66, 94%)</td>
<td>Up to 10 years</td>
<td>Posthospital: patients hospitalized during 1973–1983 due to an exacerbation LTOT: no details</td>
<td>&quot;Blood gas measurements determined eligibility for NIV&quot;. Mean (SD) PaCO\textsubscript{2} NIV group 56.1 (5.3) mmHg (or 7.45 kPa) and usual care group 48 (6.6) mmHg (or 6.4 kPa)</td>
<td>Blood gases</td>
<td>No details</td>
<td>Usual care</td>
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<td>France</td>
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hypercapnia a prerequisite for treatment with nIV (no cut-off stated)

Notes: not listed in table: patients across all studies were GOLD stage III and/or IV or were described as “severe” (where reported). Eighteen studies provided details on assessing patients for obstructive sleep apnea (to rule out overlap syndrome).

Main findings

NIV compared with usual care only: stable population

Data from seven RCTs19,21,23–27 (pooled relative risk [RR] 0.88 [0.55, 1.43], \(I^2 = 60.4\%\)) and four controlled studies22,28–30 (pooled RR 1.19 [0.65, 2.18], \(I^2 = 0\%\)) suggested no significant difference between domiciliary NIV and usual care alone in terms of survival up to 24 months (Figure 2). Excluding the RCT by Casanova et al.,19 which included only few patients with hypercapnia, had little effect, changing the pooled RR to 0.85 (0.46, 1.58). Data from five RCTs21,23–25,27 and three controlled studies22,28,29 (Figure 3) suggested a trend toward fewer hospital admissions/days in hospital with NIV, albeit “severe” (where reported). Eighteen studies provided details on assessing patients for obstructive sleep apnea, to rule out overlap syndrome. Twenty studies were on stable populations and nine on posthospital populations, and there were no details for two. For posthospital populations, there was clear evidence in all study reports that NIV treatment commenced after hospitalization due to an exacerbation. For both populations, there was usually no information on the length of time before NIV was initiated, or previous exacerbation history. Varying proportions of patients were on long-term oxygen therapy. Most studies included hypercapnic patients, though the cut-off for classification varied. Two RCTs17,18 included normocapnic patients, while one RCT19 stated that the number of hypercapnic patients included was small.

NIV settings, therapeutic/tolerability targets (pressure, volume, or blood gases), and reporting of these varied across studies. There was some variability in usual care, with three studies considered to have more intensive approaches to usual care: a 12-week multidisciplinary rehabilitation program, followed by a long-term home-based rehabilitation program,20,21 a pulmonary rehabilitation program for part of the RCT,18 and a “home supervision program”.22

There was a lack of reporting of some details relevant to study quality, particularly regarding loss to follow-up, handling of missing data, and blinding of outcome assessors. Only three RCTs included a “sham NIV” arm, lack of which may have led to performance bias and/or bias in patient-reported QoL. By definition, the nonrandomized studies were more prone to bias; some retrospective studies had clear evidence of baseline imbalances between NIV and comparator groups, with the consequence of this on study findings unknown.

Length of follow-up varied between 3 and 24 months (RCTs) and between 12 months and 10 years (controlled studies). The longest follow-up periods (4–10 years) were in the retrospective controlled studies.
not statistically significant. Evidence on exacerbations not leading to hospitalization based on four RCTs\(^1\)\(^7\),\(^1\)\(^9\),\(^2\)\(^1\)\(^,\)\(^2\)\(^4\) and one controlled study\(^2\)\(^9\) showed no significant effect of NIV (Supplementary material). For QoL, there appeared to be a trend favoring NIV, but a consistent benefit could not be demonstrated; heterogeneity in outcomes measured and time points hampered analyses of this measure (Supplementary material). There was some evidence to suggest that NIV improved blood gases (based on mainly unadjusted results; Figures 4 and 5).

### NIV compared with usual care only: posthospital population

No survival benefit was evident from three RCTs\(^3\)\(^1\)–\(^3\)\(^3\) (pooled RR 0.89 [0.53, 1.49], \(I^2=25.1\%\)), though four nonrandomized controlled studies\(^3\)\(^4\)–\(^3\)\(^7\) which are potentially more prone to bias, favored NIV (pooled RR 0.45 [0.32, 0.65], \(I^2=0\%\); Figure 2). Findings for hospital admissions were inconsistent, with one RCT\(^3\)\(^3\) finding a statistically significant benefit of NIV, one\(^3\)\(^1\) marginally favoring NIV, and one\(^3\)\(^2\) marginally favoring usual care (without NIV) (Figure 3). QoL data were reported in only one posthospital RCT,\(^3\)\(^2\) and there were no differences between NIV and usual care. Limited data from three trials\(^3\)\(^1\)–\(^3\)\(^3\) suggested a potential benefit from NIV in terms of reduction in PaCO\(_2\) (Figure 5).

### Study quality

None of the RCTs assessed as having a high risk of bias contributed data to meta-analyses; yet some of the nonrandomized controlled studies in the meta-analyses

<table>
<thead>
<tr>
<th>Trial ID</th>
<th>Follow-up</th>
<th>RR (95% CI)</th>
</tr>
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<tbody>
<tr>
<td>Stable: RCT</td>
<td></td>
<td></td>
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<tr>
<td>Casanova et al(^1)(^9)(^,*)</td>
<td>12 months</td>
<td>1.20 (0.34, 4.20)</td>
</tr>
<tr>
<td>Köhnelin et al(^2)(^3)(^,)(^,*)</td>
<td>12 months</td>
<td>0.35 (0.19, 0.65)</td>
</tr>
<tr>
<td>Zhou et al(^2)(^4)(^,*)</td>
<td>12 months</td>
<td>0.47 (0.05, 4.06)</td>
</tr>
<tr>
<td>Kamiński et al(^2)(^5)(^,*)</td>
<td>Mean 16 and 23 months</td>
<td>2.24 (0.98, 5.13)</td>
</tr>
<tr>
<td>McEvoy et al(^2)(^6)(^,*)</td>
<td>Median 20.5 and 28.5 months</td>
<td>0.87 (0.66, 1.14)</td>
</tr>
<tr>
<td>Clini et al(^2)(^7)(^,*)</td>
<td>24 months</td>
<td>1.09 (0.45, 2.66)</td>
</tr>
<tr>
<td>Duivenen et al(^2)(^1)</td>
<td>24 months</td>
<td>0.95 (0.30, 2.99)</td>
</tr>
<tr>
<td>Subtotal ((I^2=60.4%), (P=0.019))</td>
<td></td>
<td>0.88 (0.55, 1.43)</td>
</tr>
</tbody>
</table>

| Stable: controlled            |                      |                   |
| Clini et al\(^2\)\(^8\)\(^,*\) | 12 months           | 1.00 (0.25, 4.00) |
| Tsolaki et al\(^2\)\(^9\)     | 12 months           | 0.92 (0.14, 5.96) |
| Paone et al\(^2\)\(^1\)\(^1\)\(^,*\) | 18 months         | 1.33 (0.35, 5.08) |
| Subtotal (\(I^2=0\%\), \(P=0.978\)) |                    | 1.19 (0.65, 2.18) |

| Unclear: controlled           |                      |                   |
| Laijer-Groeneveld and Criee\(^2\)\(^1\)\(^,*\) | 12 months         | 1.06 (0.30, 3.73) |
|                               |                      | 1.06 (0.30, 3.73) |

| Posthospital: RCT             |                      |                   |
| Cheung et al\(^3\)\(^1\)     | 12 months           | 1.15 (0.41, 3.22) |
| Struijk et al\(^3\)\(^2\)\(^,*\) | 12 months         | 1.02 (0.67, 1.57) |
| Xiang et al\(^3\)\(^3\)\(^,*\) | 24 months           | 0.38 (0.12, 1.21) |
| Subtotal (\(I^2=25.1\%\), \(P=0.263\)) |                    | 0.89 (0.53, 1.49) |

| Posthospital: controlled      |                      |                   |
| Lu et al\(^3\)\(^4\)\(^,*\)   | 6 months            | 0.37 (0.02, 8.48) |
| Heinemann et al\(^3\)\(^5\)\(^,*\) | 12 months         | 0.33 (0.15, 0.74) |
| Budweiser et al\(^3\)\(^6\)\(^,*\) | 24 months           | 0.55 (0.34, 0.90) |
| Milane and Jonquet et al\(^3\)\(^7\)\(^,*\) | 24 months | 0.39 (0.19, 0.80) |
| Subtotal (\(I^2=0\%\), \(P=0.698\)) |                    | 0.45 (0.32, 0.65) |

Figure 2 Mortality (relative risk).
Notes: \(^*\)Calculated by authors of this report. \(^\ddagger\)Controlled study with matching.
Abbreviations: RR, relative risk; CI, confidence interval; RCT, randomized controlled trial; NIV, noninvasive ventilation.
Systematic review of domiciliary noninvasive ventilation in COPD

For both populations (for both populations) did. The small number of studies precluded assessment of the potential for publication bias (eg, using funnel plots) and sensitivity analyses around study quality.

Subgroup analysis
No further subgroup analysis (beyond study design and population) was possible, given the small number of trials and inconsistent reporting of relevant characteristics. However, many clinicians believe that the extent of hypercapnia or a change in hypercapnia status is related to the effect of NIV. In this context, it is worth noting that the study by Köhnlein et al. had the highest hypercapnia threshold as an eligibility criterion (PaCO$_2$ ≥ 7 kPa), and also showed a statistically significant survival benefit (and a nonsignificant trend toward fewer hospital admissions). Further, the study by Zhou et al. which along with the Köhnlein et al. study had the highest mean PaCO$_2$, found a statistically significant benefit from NIV in hospital admissions. In order to explore the hypercapnia level further as a potential predictor of benefit from NIV, data on mean PaCO$_2$ levels prior to initiation of NIV and change in mean PaCO$_2$ levels due to NIV from each study (where reported) were plotted against mortality and hospitalization data in order to determine if baseline PaCO$_2$ levels could predict response to NIV, and whether the effect of NIV on PaCO$_2$ levels correlates with the effect on clinical outcomes (Figure 6A–D). These exploratory analyses suggested a trend toward a correlation between changes in hypercapnia status and hospital admissions (based on eight RCTs$^{21,23–25,27,31–33}$). Such a potential correlation was not observed for mortality (based on ten RCTs$^{19,21,23–27,31–33}$). Baseline hypercapnia status did not appear to predict response to NIV for mortality (based on ten RCTs$^{19,21,23–27,31–33}$); the data were suggestive of a possible trend toward a correlation between baseline hypercapnia and hospital admissions (based on eight RCTs$^{21,23–25,27,31–33}$). Formal subgroup analysis based on the level of hypercapnia was however not deemed to be appropriate as this would have meant dichotomizing trials

![Figure 3](https://example.com/image.png)

**Figure 3** Hospital admissions per patient per year (weighted mean difference).

**Notes:** $^a$Calculated by authors of this report. $^b$Individual mean differences (95% CI) presented for this outcome.

**Abbreviations:** CI, confidence interval; WMD, weighted mean difference; RCTs, randomized controlled trials; ICU, intensive care unit; NIV, noninvasive ventilation.

<table>
<thead>
<tr>
<th>Trial ID</th>
<th>Follow-up</th>
<th>WMD (95% CI)</th>
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<tbody>
<tr>
<td><strong>Stable: hospital admissions RCTs</strong></td>
<td></td>
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<tr>
<td>Clini et al$^{27}$</td>
<td>24 months</td>
<td>$-0.50 (-1.25, 0.25)$</td>
</tr>
<tr>
<td>Duiverman et al$^{21}$</td>
<td>12 months</td>
<td>$-0.16 (-0.67, 0.35)$</td>
</tr>
<tr>
<td>Kamiński et al$^{25}$</td>
<td>Mean 16 and 23 months</td>
<td>$0.30 (-0.66, 1.26)$</td>
</tr>
<tr>
<td>Köhnlein et al$^{23}$</td>
<td>12 months</td>
<td>$-0.90 (-3.16, 1.36)$</td>
</tr>
<tr>
<td>Zhou et al$^{24}$</td>
<td>12 months</td>
<td>$-1.20 (-1.80, -0.60)$</td>
</tr>
<tr>
<td><strong>Subtotal (I$^2$:59.2%, P=0.044)</strong></td>
<td></td>
<td>$-0.46 (-1.02, 0.09)$</td>
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| **Stable: hospital admissions controlled studies** |           |                |
| Clini et al$^{22,4}$  | 18 months | $0.20 (-0.25, 0.65)$ |
| Tsolaki et al$^{29}$  | 12 months | $-0.70 (-1.69, 0.29)$ |
| **Subtotal (I$^2$:61.9%, P=0.105)** |           | $-0.14 (-0.99, 0.72)$ |

| **Stable: ICU admissions RCTs** |           |                |
| Clini et al$^{27}$     | 24 months | $-0.20 (-0.46, 0.06)$ |
| Clini et al$^{22,4}$   | 18 months | $-0.20 (-0.46, 0.06)$ |

| **Stable: ICU admissions controlled studies** |           |                |
| Clini et al$^{28}$     | Mean 35 months | $-0.70 (-0.87, -0.53)$ |
| Clini et al$^{22,4}$   | 18 months | $0.00 (-0.30, 0.30)$ |
| **Subtotal (I$^2$:93.5%, P=0.000)** |           | $-0.36 (-1.05, 0.32)$ |

| **Posthospital: hospital admissions RCTs$^a$** |           |                |
| Cheung et al$^{21,7}$  | 12 months | $-0.28 (-0.55, -0.01)$ |
| Struijk et al$^{22}$   | 12 months | $0.39 (-0.05, 0.83)$ |
| Xiang et al$^{23}$     | 24 months | $-2.50 (-2.72, -2.28)$ |
based on an arbitrary CO\textsubscript{2} threshold. Adherence to NIV and effect of NIV settings could also not be analyzed.

**Different types of NIV**

With regard to the effectiveness of different NIV settings, three small crossover trials in stable populations were identified: two\textsuperscript{38,39} comparing higher vs lower pressure NIV and one\textsuperscript{40} comparing different back-up rates. All were short term (6–8 weeks) and did not assess mortality or hospitalizations/exacerbations. Treatment compliance was similar between arms in two studies,\textsuperscript{39,40} and higher in the high-pressure arm for the third,\textsuperscript{38} but drop-out rates were high in the pressure trials.\textsuperscript{38,39} The limited QoL data precluded drawing firm conclusions. The only statistically significant result\textsuperscript{38} was greater PaCO\textsubscript{2} reduction with high-pressure NIV (Supplementary material).

**Discussion**

This is the first systematic review of domiciliary NIV to attempt to account for differing baseline risks of exacerbation by categorizing populations into stable and posthospital based on proximity to an in-patient stay for an exacerbation; it is also the most comprehensive review to date, including evidence from RCTs, nonrandomized controlled studies, and RCTs comparing different NIV settings, and without restriction to English language-only publications. Overall, the evidence from RCTs in a stable population could not demonstrate benefit for mortality from domiciliary NIV compared to usual care alone (seven RCTs\textsuperscript{19,21,23–27} and four controlled studies\textsuperscript{22,28–30}), although there was a trend toward fewer hospital admissions (five RCTs\textsuperscript{21,23–25,27} and three controlled studies\textsuperscript{22,28,29}), and to a lesser extent, improved QoL (seven RCTs\textsuperscript{17,18,21,23,26,27,41} and one controlled study\textsuperscript{29}), for the stable population. A survival benefit for the posthospital population could not be shown based on three RCTs,\textsuperscript{31–33} though there was some evidence of benefit based on four (potentially biased) nonrandomized controlled studies.\textsuperscript{34–37} Findings for hospital admissions (three RCTs\textsuperscript{31–33}) were inconsistent. There was too little evidence to draw any conclusions on the potential benefits of high-pressure NIV settings.
Exacerbation risk and domiciliary NIV

It was hoped that subgroup analyses based on the frequency of exacerbations prior to NIV treatment would be possible, as frequent exacerbators (patients with two or more exacerbations/year) are a clinically relevant subgroup, with a generally stable exacerbation frequency on other existing therapies. However, this was hampered by lack of reporting of this parameter.

There is evidence, however, to support the use of recent hospitalization as a proxy for a higher risk of recurring exacerbation. Prior hospital admission is recognized to be the biggest driver for a further exacerbation requiring admission, and NIV use in hospital has also been recognized as a predictor of overall exacerbation rate. Furthermore, recurrent type 2 respiratory failure, that is, respiratory failure with carbon dioxide retention, occurs in over 30%, and readmission at 1 year in 60%, of those who require NIV acutely in hospital. Consequently, stratification based on NIV started at recent hospitalization was thought to be a justifiable surrogate marker of exacerbation risk. In reality, there is likely to be much more of a continuum of risk, and it is further unknown what proportion of the posthospital populations considered in the individual studies are COPD patients at the more severe end of the disease spectrum.

Which patients may benefit from domiciliary NIV?

The results of the review show that division of data based on potential exacerbation risk did not indicate a difference between populations in terms of mortality or hospitalizations; in fact, there was no clear evidence for benefit for either population, though there was a nonsignificant trend toward...
a benefit with NIV in the stable population, for hospital admissions. The apparent similarity in hospitalization effect in our chosen subgroups is perhaps surprising, given that those previously admitted are at higher risk of subsequent readmission. It is possible that the division used failed to capture other important differences within and between populations; for example, the pretreatment exacerbation rates were unknown. There was evidence of some heterogeneity between both stable and posthospital studies, with some studies showing a significant benefit from NIV; one RCT in a stable population showed a statistically significant benefit from NIV for mortality (Figure 2), and one RCT for stable and two for posthospital populations showed significant benefit for hospital admissions (Figure 3). Two of these RCTs used a higher hypercapnia threshold for patient inclusion (PaCO₂ > 7 kPa); one RCT had a lower inclusion criterion (PaCO₂ > 6 kPa), though means were suggestive of higher levels. There was no detail on the inclusion threshold for the third RCT.

Elements such as blood gases, prior admissions, and social support have been identified as drivers to clinical decision making regarding domiciliary NIV in COPD, all of which may impact NIV efficacy. The nonrandomized posthospital studies assessing mortality (Figure 2) suggest a beneficial effect from NIV (significant pooled RR), however, it is possible that patient selection for NIV biased findings toward a positive response to NIV.

Most populations included in studies were hypercapnic (Table 2), although the threshold used to define this varied. Post hoc analyses undertaken across both stable and posthospital populations suggested a trend toward a positive correlation between changes in hypercapnia and hospital admissions (but not for mortality or correlation using pretreatment PaCO₂ level). As these are exploratory analyses, the results should be interpreted cautiously; the analysis used aggregate – study-level – data for baseline hypercapnia, change in hypercapnia, and clinical outcomes, and a patient-level association cannot be inferred even if there is clear biological plausibility. Further caveats relate to the fact that not all trials contributed data to these analyses and that PaCO₂ change scores were mostly not adjusted for baseline differences. Nevertheless, it does suggest that there should be further investigation of the association between hypercapnia and clinical outcomes, particularly with regard to mortality.

Figure 6 Hypercapnia and clinical outcomes.

Notes: (A) Mortality (RR) and baseline PaCO₂; (B) Mortality (RR) and change in PaCO₂; (C) Hospital admissions (MD) and baseline PaCO₂; (D) Hospital admissions (MD) and change in PaCO₂.

Abbreviations: RR, relative risk; PaCO₂, partial pressure of carbon dioxide; MD, mean difference.
to the ability of the NIV to reduce PaCO₂ levels. Patients hypercapnic at discharge may normalize their PaCO₂ levels over time, although those who remain hypercapnic have higher mortality.⁴⁷ Thus, if hypercapnia (or change in hypercapnia) were a driver of NIV response and were used to select patients for treatment after an exacerbation, subsequent reassessment may be needed to determine likelihood of ongoing benefit.

The current recommendation in the UK suggests that domiciliary NIV is considered on health economic grounds if a patient has had three hospital admissions with acute hypercapnic respiratory failure.⁴⁸ There may be other, as yet unconfirmed, patient characteristics which influence its effectiveness. Uncertainty also remains regarding the length of time NIV may provide benefit for; there are at least two RCTs looking at the effect of discontinuing NIV, but this question was beyond the scope of this systematic review.

Strengths and limitations
A number of RCTs of reasonably good methodological quality were available, particularly for the stable population, and a comprehensive search strategy meant that this systematic review identified more relevant studies than previous ones, even after taking into account different search periods. No language restrictions meant that 19% of the included studies were non-English, a substantial proportion of the overall evidence base omitted by prior reviews.⁸⁻¹¹ This is also the first systematic review to examine patient-related outcomes and incorporate data from nonrandomized studies. Furthermore, by calculating summary measures from raw data or converting data, the number of results that could be presented in forest plots was maximized. In contrast to some previous systematic reviews, secondary outcome data (lung function, blood gases, and 6-minute walk distance) were not pooled due to a lack of results adjusted for baseline differences. This means that our analyses are likely to be more robust.

There were several limitations in the available data, largely due to inconsistency of reporting (particularly for hospital admissions) or measurement tools (especially for QoL). This meant that not all available evidence could contribute to the pooled estimates. Furthermore, admissions data may be skewed; thus, the mean (SD) may not be an appropriate metric to use, though it was frequently reported. For primary outcomes, there was a lack of data explicitly linking the number of exacerbations to subsequent hospitalizations and survival for individual patients. This latter point has potential implications for double-counting data as these outcomes are not independent of each other. Ventilator settings may influence effectiveness, and settings have changed over time, such that earlier settings may be considered ineffective today. The small crossover trials in this analysis did not allow any conclusions to be drawn, and subgroup analysis based on the larger/parallel trials was not possible due to inconsistent reporting: studies variously reported mean, median, or target settings, based on pressure, blood gas, or volume targets, with some stating only that levels were adjusted to patient comfort/tolerance. Reporting times also varied (eg, at start of study or at discharge).

Recommendations for future research pertaining to domiciliary NIV in COPD
Variable quality of data reporting, lack of exacerbation data, potential bias, and heterogeneity of reported outcomes were striking features of the included studies. These features are not uncommonly encountered when conducting systematic reviews. While trials of medications are often required to report certain outcomes as part of the licensing process, medical device studies, such as those included in our review, have not always had to meet such standards despite also being subject to regulatory processes. More detailed reporting of exacerbations in particular would be valuable in this high-risk population. It has been suggested that new RCTs could include a sham NIV arm in order to minimize potential bias, as well as high- and low-pressure NIV arm to enable further exploration of the relationship between pressure and effectiveness; many of the earlier studies included used pressures which experts would now consider equivalent to a sham treatment.¹⁹ However, sham NIV could lead to an overestimate of the potential benefit of NIV, due to its potential disbenefits on QoL; therefore, two control arms (with and without sham NIV) are more likely to be appropriate. Qualitative work in NIV users and prescribers not surprisingly suggests that a focus on patient-centered measures (eg, QoL, daily activity) is needed, alongside research to delineate those in whom the treatment is most effective.⁴⁶ Which instruments best capture QoL in this patient group and whether instruments are convertible is debatable.

There is at least one ongoing trial (the UK HOT-HMV trial, NCT00990132), which includes a population with an underlying risk of recurrent events similar to the posthospital population described in this study. Findings from this trial will be important, but additional evidence from individual patient data analyses of pooled studies may be required to determine whether specific patient characteristics or equipment settings predict benefit from NIV, and to establish optimum time points for starting (and potentially
discontinuing) NIV. A previous review attempted such analyses, but based on a smaller group of studies, and without considering hospitalizations or survival.

**Conclusion**
The effectiveness of domiciliary NIV remains uncertain; however, some patients appear to benefit. Further research is required to identify these patients and to explore the relevance of hypercapnic status or changes in hypercapnia due to NIV in influencing clinical outcomes for patients on long-term NIV; optimum time points for starting NIV and equipment settings also need to be established.

**Acknowledgments**
The authors thank the following: Simon Stevens for his invaluable administrative support and excellent organizational skills; all members of the patient group for supporting and contributing to this project: Maireade Bird, Michael Darby, Don Etheridge, Chris Huckle, Jan Turner, and Anne Yeomans; Chris Cates, Peymane Adab, Brendan Cooper, and Rob Stockley for contributions to wider team meetings; and all the people who kindly gave their time to help translate articles. This article summarizes independent research funded by the National Institute for Health Research (NIHR) under its HTA Programme (Ref 11/27/01). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health.

**Author contributions**
JD was the lead systematic reviewer, wrote and edited sections of the paper, and undertook study selection, data extraction and analysis, and quality assessment. DM was co-principle investigator and methodological lead, led all aspects of the project, contributed to all aspects of the project, undertook study selection, and wrote and edited sections of the paper. CD and RM advised on clinical aspects of the project, and undertook study selection. MP advised on statistical aspects, analyzed data, and edited statistical methodological sections of the paper. SB devised the search strategies and ran the searches in electronic databases. XW translated Chinese papers, and undertook data extraction and data checking. RJ undertook study selection and contributed to methodological aspects of the project. AT was co-principle investigator and clinical lead, oversaw all clinical aspects of the project, undertook study selection, and wrote and commented on sections of the paper. All authors contributed toward data analysis, drafting and critically revising the paper and agree to be accountable for all aspects of the work.

**Disclosure**
AT’s clinic has been loaned sleep monitors by ResMed Inc. which also produces NIV equipment. RM has received nonfinancial support from ResMed Inc. and Breas Medical in the form of training sessions for the NIV equipment supplied to his NIV multidisciplinary team. DM and JD acted as peer reviewers for the Cochrane systematic review by Struik et al which is included in this report. RJ was awarded a grant in respect of an NIHR postdoctoral fellowship during the conduct of the study. The fellowship relates to a different COPD project. The authors report no other conflicts of interest in this work.

**References**


