Beta blockers in traumatic brain injury: a systematic review and meta-analysis

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ABSTRACT

Background Traumatic brain injury (TBI) is a major cause of death and disability worldwide. Beta blockers have shown promise in improving mortality and functional outcomes after TBI. The aim of this article is to synthesize the available clinical data on the use of beta blockers in acute TBI.

Methods A systematic search was conducted through MEDLINE, Embase, and Cochrane Central Register of Controlled Trials for studies including one or more outcomes of interest associated with use of beta blockers in TBI. Independent reviewers evaluated the quality of the studies and extracted data on all patients receiving beta blockers during their hospital stay compared with placebo or non-intervention. Pooled estimates, CIs, and risk ratios (RRs) or ORs were calculated for all outcomes.

Results 13,244 patients from 17 studies were eligible for analysis. Pooled analysis demonstrated a significant mortality benefit of overall use of beta blocker (RR 0.8, 95% CI 0.68 to 0.94, I2=75%). Subgroup analysis of patients with no preinjury use of beta blocker compared with patients on preinjury beta blockers showed no mortality difference (RR 0.99, 95% CI 0.7 to 1.39, I2=84%). There was no difference in rate of good functional outcome at hospital discharge (OR 0.94, 95% CI 0.56 to 1.58, I2=65%); however, there was a functional benefit at longer-term follow-up (OR 1.75, 95% CI 1.09 to 2.8, I2=0%). Cardiopulmonary and infectious complications were more likely in patients who received beta blockers (RR 1.94, 95% CI 1.69 to 2.24, I2=0%; RR 2.36, 95% CI 1.42 to 3.91, I2=88%). Overall quality of the evidence was very low.

Conclusions Use of beta blockers is associated with decreased mortality at acute care discharge as well as improved functional outcome at long-term follow-up. Lack of high-quality evidence limits definitive recommendations for use of beta blockers in TBI; therefore, high-quality randomized trials are needed to further elucidate the utility of beta blockers in TBI.

PROSPERO registration number CRD42021279700

INTRODUCTION

Traumatic brain injury (TBI) is a major cause of death and disability worldwide, with nearly one-half of all trauma-related deaths involving head injuries.1 Head injuries are associated with significant morbidity, long-term disability, and economic burden.2 The major focus of TBI management is on limiting secondary injury, which is the expansion of the injured territory by physiological responses. After primary injury, there is a disruption in cerebral blood flow leading to anoxia and edema, subsequent neuronal cell death, further deterioration, and eventual neurodegeneration.3 Secondary injury can develop for the days and weeks after the initial insult and is a major contributor to subsequent brain damage and overall outcome. Unfortunately, few strategies exist to mitigate this process. No therapeutic intervention has been approved to prevent progression of secondary neural injury, leaving a great need for optimization of treatment options to improve outcomes in patients with TBI.

Catecholamines are an integral part of the neuroendocrine-immune inflammatory network and are markers of TBI functional outcome and mortality.4 The catecholamine surge is a well-documented process after TBI where the circulating levels of these neurotransmitters increase in correlation with the severity of the injury.5–7 This can persist for more than 10 days,8 leading to inflammation and apoptosis of neural cells, thus contributing to secondary injury.9 Although the exact mechanism is not yet known, beta blockers have shown promise in improving patient outcomes after TBI.6,10–12 The hypothesized mechanism is related to the catecholamine surge, such that beta blockade may reduce the actions of catecholamines after TBI and therefore reduce or slow the progression of secondary injury. In humans, a recent meta-analysis summarizing the
available clinical data established lower mortality with beta blockade and conditionally recommends the use of in-hospital beta blockers after TBI in adult patients, with an emphasis on holding beta blockers to avoid bradycardia and hypotension.\textsuperscript{16} Propranolol, in particular, has shown a lower mortality rate even when compared with other beta blockers.\textsuperscript{17} However, the objective of trauma care is not limited to survival and acute management, but rather includes functional recovery and reintegration into work and community settings. Although a reduction in mortality rate may be beneficial on its own, there exists the possibility that improved patient survival comes at the cost of increased incidence of severe debilitation. Although the use of beta blockers in patients with TBI has been investigated for years, there is a lack of consensus on the effect of beta blockers on functional outcome. Although there are recent meta-analyses on this subject, there is a need for more rigorous analysis and quality assessment of available evidence.

The aim of this systematic review and meta-analysis is to synthesize the available clinical data to better understand the role of beta blockers in TBI. Namely, we aim to update the consensus on mortality benefit and summarize the documented role of beta blockers in TBI. Namely, we aim to update the consensus on mortality benefit and summarize the documented role of beta blockers in TBI. Specifically, we will complete subset analyses for propranolol compared with other beta blockers. Finally, we will analyze outcomes for patients who were on beta blockers prior to their injury compared with those that were initiated in the hospital.

**METHODS**

This systematic review was registered with the International Prospective Register of Systematic Reviews (ID: CRD42021279700).

**Search strategy**

Systematic searches covering the period from database inception through February 22, 2022, were conducted in MEDLINE (Ovid platform), Embase (Ovid platform), and Cochrane Central Register of Controlled trials (CENTRAL). Keywords and Medical Subject Headings terms related to TBI and adrenergic beta antagonists were used. Full search strategy for the Ovid platform and CENTRAL may be found in online supplemental appendix A. Studies were not restricted by language or full text.

**Study selection**

All screening was completed using Covidence systematic review software (Veritas Health Innovation, Melbourne, Australia) and the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) statement was followed at all review stages.\textsuperscript{18} All citations obtained from the search strategies were imported into Covidence. After removal of duplicates by the Covidence software, two reviewers (SH and AC) independently evaluated the systematically searched titles and abstracts for eligibility. Discrepancies regarding study inclusion or exclusion were reviewed and resolved through discussion or, if needed, a third reviewer (ML) was consulted.

We included articles that compared the use of any beta-adrenergic receptor blockers with placebo or non-intervention in patients with TBI. Included studies focused on adult patients (aged 18 years and older) that reported our primary outcomes (mortality and functional outcome). Randomized or non-randomized control trials, prospective, and retrospective study designs were included. Exclusion criteria included exclusively pediatric populations, case reports, review articles, animal studies, and any article that did not report our primary outcomes. Studies that combined beta-adrenergic receptor blockers with other medications (eg, clonidine) were excluded. There were no restrictions on the type or dose of beta blocker used, the timing of beta-blocker initiation, or severity of TBI. Intensive care unit admission was not required.

**Data abstraction**

Two reviewers (SH and AC) independently conducted data abstraction onto a data collection manual designed a priori. Abstracted data included study characteristics, patient demographics, type and dose of beta blocker administered, functional outcome, mortality, number of patients requiring surgical intervention, Glasgow Coma Scale at presentation, number of patients with blunt versus penetrating injury, and cardiopulmonary and infectious complications.

**Data analysis**

All statistical analyses and meta-analyses were performed using DataParty (DataParty, Hamilton, Canada). The statistical significance was set a priori at a p value of <0.05. A pairwise meta-analysis was performed using an inverse variance random effects model for all meta-analyzed outcomes. Weights were calculated using the Mantel-Haenzel method. Pooled effect estimates were obtained by calculating the mean difference in outcomes for continuous variables and risk ratios (RRs) for dichotomous variables with their respective 95% CIs to confirm the effect size estimation. Assessment of heterogeneity was completed using the inconsistency (I² statistic). An I² greater than 50% was considered to represent considerable heterogeneity.

![Figure 1 Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) diagram detailing search results.](http://tsaco.bmj.com/ on March 1, 2024 by guest. Protected by copyright.)
Assessing methodological quality
Quality of evidence was assessed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach19 by two independent reviewers (SH and AC). Evidence was ranked as being of very low quality, low quality, moderate quality, and high quality, based on the risk of bias, inconsistency, indirectness, imprecision, and publication bias. Risk of bias was assessed using ROBINS-I tool for observational studies and the RoB-2 tool for randomized controlled trials (RCTs).20 21 Disagreement was resolved by consensus with a third arbitrator (ML) available for any necessary cases.

RESULTS

Study characteristics
From 7922 relevant citations, 17 studies met the inclusion criteria (2 prospective, 2 RCTs, and 13 retrospective).8–12 14 15 17 22–30 A PRISMA flow diagram of the study selection is illustrated in figure 1. A total of 13244 patients were included in this review. From the 17 studies, 4533 received beta blockers and 8711 did not receive beta blockers. Detailed study characteristics of included studies are reported in table 1. Average age was 51.1±8.1 for those receiving beta blockers and 45.7±11.0 for those who did not. Penetrating injuries were reported in 12 studies, with a total of 301 subjects suffering from penetrating injury (145 beta blockers and 156 controls). Neurosurgical intervention occurred in 947 patients in the beta-blocker group (18%) and 873 controls (11%), including external ventricular drain or intracranial pressure monitor insertion, craniotomy, or craniectomy. The majority of studies (11 of 17) broadly included all patients who received at least one dose of any beta blocker while in the hospital. Only three studies included information on specific dosing.21 27 29

Mortality and functional outcome
Results of the meta-analyses for outcomes of interest are displayed in figures 2–4. All included studies reported mortality

Table 1  Characteristics of included studies

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Study type</th>
<th>Intervention arm</th>
<th>n (%)</th>
<th>Age (years)*</th>
<th>Male, N (%)</th>
<th>Penetrating injury, n (%)</th>
<th>Neurosurgical intervention, n (%)</th>
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</thead>
<tbody>
<tr>
<td>Abli et al, 201722</td>
<td>Retrospective</td>
<td>BB+</td>
<td>76 (50)</td>
<td>57.2±14</td>
<td>57 (75.0)</td>
<td>0</td>
<td>ICP monitoring 49 (64.5) Operation 46 (60.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>76 (50)</td>
<td>57.9±15.8</td>
<td>60 (78.9)</td>
<td>0</td>
<td>ICP monitoring 48 (63.2) Operation 37 (48.7)</td>
</tr>
<tr>
<td>Asmar et al, 202123</td>
<td>Retrospective</td>
<td>BB+</td>
<td>772 (50)</td>
<td>64.2±15.3</td>
<td>437 (56.6)</td>
<td>137 (18.8)</td>
<td>EVD 69 (8.0) Craniotomy/craniectomy 84 (10.8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>772 (50)</td>
<td>62.6±15.4</td>
<td>431 (55.8)</td>
<td>144 (19.6)</td>
<td>EVD 67 (8.7) Craniotomy/craniectomy 86 (11.1)</td>
</tr>
<tr>
<td>Bukur et al, 201224</td>
<td>Retrospective</td>
<td>BB+</td>
<td>866 (35.4)</td>
<td>43±22</td>
<td>684 (79.0)</td>
<td>0</td>
<td>Craniotomy/craniectomy 130 (15.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>1580 (64.6)</td>
<td>39±21</td>
<td>1201 (76.0)</td>
<td>0</td>
<td>Craniotomy/craniectomy 63 (4.0)</td>
</tr>
<tr>
<td>Cotton et al, 200724</td>
<td>Retrospective</td>
<td>BB+</td>
<td>174 (41.4)</td>
<td>50.5 (28–70)</td>
<td>105 (60.3)</td>
<td>6 (3.4)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>246 (58.6)</td>
<td>30.5 (21–47)</td>
<td>162 (65.8)</td>
<td>11 (4.5)</td>
<td>–</td>
</tr>
<tr>
<td>Edavettal et al, 201625</td>
<td>Retrospective</td>
<td>BB+</td>
<td>56 (33.3)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>112 (66.7)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Inaba et al, 200826</td>
<td>Retrospective</td>
<td>BB+</td>
<td>203 (17.6)</td>
<td>50.1±21.1</td>
<td>158 (78)</td>
<td>0</td>
<td>Craniectomy 47 (23)</td>
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<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>953 (82.4)</td>
<td>38.1±20.4</td>
<td>705 (74)</td>
<td>0</td>
<td>Craniectomy 35 (4)</td>
</tr>
<tr>
<td>Jang et al, 201827</td>
<td>Retrospective</td>
<td>BB+</td>
<td>18 (19)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>77 (81)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Khalili et al, 202028</td>
<td>Randomized control trial</td>
<td>BB+</td>
<td>99</td>
<td>37±17</td>
<td>86 (86.9)</td>
<td>0</td>
<td>Craniotomy/craniectomy 30 (30.3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>120</td>
<td>39±20</td>
<td>103 (85.8)</td>
<td>0</td>
<td>Craniotomy/craniectomy 50 (41.7)</td>
</tr>
<tr>
<td>Ko et al, 201629</td>
<td>Prospective</td>
<td>BB+</td>
<td>109</td>
<td>49.6±20.8</td>
<td>77 (70.6)</td>
<td>–</td>
<td>Craniotomy/craniectomy 12 (11.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>331</td>
<td>60.4±23.1</td>
<td>216 (65.3)</td>
<td>–</td>
<td>Craniotomy/craniectomy 51 (15.4)</td>
</tr>
<tr>
<td>Ley et al, 201830</td>
<td>Prospective</td>
<td>BB+</td>
<td>1120 (49.7)</td>
<td>57±22</td>
<td>784 (0.7)</td>
<td>0</td>
<td>EVD 134 (12) Craniectomy 257 (23)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>1132 (50.3)</td>
<td>49±21</td>
<td>770 (68.8)</td>
<td>0</td>
<td>EVD 79 (7) Craniectomy/craniectomy 148 (13)</td>
</tr>
<tr>
<td>Mohseni et al, 201531</td>
<td>Retrospective</td>
<td>BB+</td>
<td>287 (32.8)</td>
<td>62±16</td>
<td>210 (70.3)</td>
<td>–</td>
<td>Craniotomy/craniectomy 32 (10.1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>587 (67.2)</td>
<td>49±21</td>
<td>429 (73.7)</td>
<td>–</td>
<td>Craniotomy/craniectomy 141 (24.0)</td>
</tr>
<tr>
<td>Riordan et al, 200732</td>
<td>Retrospective</td>
<td>BB+</td>
<td>138 (30.9)</td>
<td>35.8 (23.6–49.7)</td>
<td>113 (81.9)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>308 (69.1)</td>
<td>28.7 (20.6–41.0)</td>
<td>232 (75.3)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Salim et al, 200833</td>
<td>Retrospective</td>
<td>BB+</td>
<td>91 (21.7)</td>
<td>53.9±21.6</td>
<td>70 (76.9)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>329 (78.3)</td>
<td>41.1±20.3</td>
<td>243 (73.9)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Schroeppe1 et al, 201034</td>
<td>Retrospective</td>
<td>BB+</td>
<td>506 (19.5)</td>
<td>51±20</td>
<td>–</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>2095 (80.5)</td>
<td>38±17</td>
<td>–</td>
<td>0</td>
<td>–</td>
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<tr>
<td>Schroeppe1 et al, 201435</td>
<td>Retrospective</td>
<td>BB+</td>
<td>427 (24.3)</td>
<td>49±20</td>
<td>333 (0.78)</td>
<td>–</td>
<td>–</td>
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<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>1328 (75.7)</td>
<td>40±18</td>
<td>963 (0.74)</td>
<td>–</td>
<td>–</td>
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<td>Schroeppe1 et al, 201936</td>
<td>Randomized control trial</td>
<td>BB+</td>
<td>13 (52.0)</td>
<td>49.7±19.0</td>
<td>9 (69.2)</td>
<td>2 (1.05)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>12 (48.0)</td>
<td>53.0±21.9</td>
<td>7 (58.3)</td>
<td>1 (0.08)</td>
<td>–</td>
</tr>
<tr>
<td>Zangbar et al, 201637</td>
<td>Retrospective</td>
<td>BB+</td>
<td>178 (50.0)</td>
<td>57.6±19.9</td>
<td>130 (73)</td>
<td>0</td>
<td>Craniotomy/craniectomy 32 (18)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB−</td>
<td>130 (50.0)</td>
<td>59.7±20.9</td>
<td>125 (70)</td>
<td>0</td>
<td>Craniotomy/craniectomy 23 (13)</td>
</tr>
</tbody>
</table>

*Means SD or median (IQR). BB, beta blocker; EVD, external ventricular drain; ICP, intracranial pressure.
Figure 2. Results of meta-analyses comparing mortality with use of beta blockers to placebo or non-intervention. Outcomes evaluated are (A) overall pooled in-hospital mortality; (B) in hospital mortality, subgroup analysis for patients maintained on home beta blocker prior to TBI and those who were started on beta blocker post injury only; (C) in-hospital mortality for use of propranolol only; and (D) in-hospital mortality for blunt injury only. RR, risk ratio; TBI, traumatic brain injury.

(figure 2). Pooled analysis of the 15 cohort studies and 2 RCTs revealed a significant difference between patients receiving beta blockers and those who did not, with decreased in-hospital mortality for the beta blocker group (RR 0.8, 95% CI 0.68 to 0.94, $I^2=75\%$). Most studies (13 of 17) included all patients who had received beta blockers during their hospital stay in their analysis, regardless of whether participants had been prescribed these prior to their injury or not. A select few studies (6 of 17) included data on patients who were prescribed beta blockers for the first time after their injury, excluding those maintained on home beta blocker prior to the injury. Unlike the pooled data, this subgroup analysis did not show a significant mortality benefit for those starting beta blockers post injury (RR 0.99, 95% CI 0.7 to 1.39, $I^2=84\%$). Only two studies included specific data for patients who were on preinjury beta blocker and continued post injury, which also did not exhibit a mortality benefit (RR 0.6, 95% CI 0.25 to 1.43, $I^2=68\%$). Three studies included data for propranolol only, which did not show a significant mortality benefit over control (RR 0.67, 95% CI 0.33 to 1.36, $I^2=72\%$). Although some studies did include patients with penetrating injury, mortality data specifically for this cohort were not reported. As penetrating injuries are fundamentally different
from blunt injuries, subset analysis was undertaken for studies that specified blunt injury only. Beta blockers inferred a mortality benefit over the control in this group (RR 0.82, 95% CI 0.74 to 0.9, I²=12%).

Three studies reported on functional outcome, all of which used the Glasgow Outcome Score-Extended (GOS-E) (figure 3). All three studies measured GOS-E at time of acute care discharge, one study reported GOS-E at 6 months post-injury, and another reported GOS-E at 12 months post-injury. Reported data for all studies was number of subjects above a certain GOS-E score predetermined by the authors to represent a good functional outcome. There was no significant difference in rates of good functional outcome at the time of hospital discharge between groups (OR 0.94, 95% CI 0.56 to 1.58, I²=65%); however, those who received beta blockers were more likely to have good functional outcome at long-term (≥6 month) follow-up (OR 1.75, 95% CI 1.09 to 2.8, I²=0%). All of these studies were on blunt injury only. Only one study included functional outcome for propranolol only; therefore, analysis was not completed for this subgroup. In this study, propranolol did not show any difference in the rate of good functional outcome compared with other beta blockers (OR 1.29, 95% CI 0.86 to 1.95, p=0.21).

Complications
Complications were not commonly reported among studies. Cardiopulmonary complications were reported in three studies and included respiratory failure, life-threatening tachyarrhythmias, bradycardia, acute myocardial infarction, cardiogenic shock, cardiac arrest, or requirement of vasopressors. Use of beta blocker was associated with an increased rate of these complications (RR 1.94, 95% CI 1.69 to 2.24, I²=0%). Only two studies reported infectious complications, which showed overall increased infectious complications with beta blocker use (RR 2.36, 95% CI 1.42 to 3.91, I²=88%) (figure 4).

Quality assessment
For RCTs, the risk of bias was serious for one study and low for the other (figure 5). Risk of bias was serious for all observational studies, mainly due to the inherently non-blinded nature of the studies (figure 6). The overall quality of the included studies was very low according to the GRADE approach (figure 7).

DISCUSSION
This systematic review and meta-analysis analyzed current available evidence for the utility of beta blockers in TBI to reduce mortality and improve functional outcome. Our meta-analyses showed that patients who received beta blockers during their hospital admission exhibited lower mortality rates and better functional outcome, though at the cost of an increased risk of cardiopulmonary and infectious complications. Nevertheless, our study demonstrates the need for a larger scale, RCT to further clarify the benefit and safety of in-hospital initiation of beta blockers in TBI.

The proposed explanation for the benefit of beta blockers in TBI is based on the assumed reduction in secondary injury by limiting the catecholamine surge. The catecholamine surge is well documented to occur up to 10 days after the injury and increases cerebral edema, hypoxia, and neural apoptosis. Preventing the resultant secondary injury leads to decreased mortality and improved functional outcome, which are the main goals of TBI management. Propranolol administration in rodent TBI models increases cerebral perfusion, decreases hypoxia, and improves cerebral glucose metabolism in a dose-dependent manner.
manner.\textsuperscript{31} \textsuperscript{32} Additionally, knockout mice lacking beta-adrenergic receptors demonstrate less motor deficiency after head trauma.\textsuperscript{31} \textsuperscript{32} Although not officially included in the Brain Trauma Foundation guidelines, and despite the lack of high-quality data, several societies conditionally recommend beta blocker use in patients with severe TBI with no existing contraindications, provided that beta-blocker-related complications (e.g., hypotension or bradycardia) do not occur.\textsuperscript{16} \textsuperscript{33} According to our summation of the current human data, use of beta blocker in hospitals is associated with decreased all-cause in-hospital mortality in patients with TBI. This was a pooled analysis of anyone who received a beta blocker at all during their hospital stay. However, when we separated the available data for patients who had started a beta blocker for the first time post injury and those who had been maintained on a beta blocker before their injury, the mortality benefit was no longer seen in either group. Although it is an interesting question whether the total length of beta-blocker therapy has an impact on mortality and what effect preinjury beta blocker has on outcomes, our findings do not suggest any definitive conclusion regarding this. It is possible that the proposed blunting of the catecholamine surge occurs more effectively with longer-term beta-blocker therapy prior to the injury and that acute initiation has less of an impact. However, our data presented here are not without significant bias. Relative to the total amount of patients in the overall analysis, very few data points were available for the subgroups. Few studies included analysis specifically on beta blockers initiated post injury. Instead, the majority of studies broadly included any and all patients who received one or more doses of beta blocker at any point during their admission, which leads to considerable variability and limits what effect we can reasonably attribute to the beta blockers themselves, no matter when they were started. Additionally, all of the studies in this subgroup analysis had a high risk of bias and were overall low quality as per the GRADE assessment.

Although most studies give prominence to mortality outcomes, it is certainly not the only focus in the management and rehabilitation after TBI. Despite the primary clinical goal in TBI management being full recovery and return to baseline level of function, there is limited evidence available for the effect of beta blockers on this. In fact, only three studies were identified in our review that included functional outcome in their analysis. Pooled analysis was undertaken for functional outcome at hospital discharge and at long-term follow-up despite the small number of studies, and though there was no difference in outcomes at
acute care discharge, pooled long-term follow-up showed a functional benefit of using beta blockers. Functional recovery is often slow after brain injury; therefore, GOS-E as measured at discharge from acute care may not be the most appropriate time to compare this outcome. Longer-term measurements at 6 or 12 months are likely more realistic to true functional outcome. However, there are several issues to be addressed with these results. First, each study had a different definition of the GOS-E score, which showed a ‘good’ functional outcome. Each reported the number of patients above this predetermined level and not average scores for each group. The measurements ranged from including any patient with a score above 3, to those only including a score above or equal to 5. A score of 3 or 4 still signifies a severe upper or lower limb deficit and dependency on others for major daily tasks of living. This vast difference from a score of 5, which is only a moderate disability. This inconsistency in measurements limits practical conclusions that can be made from our analysis, as these represent vast discrepancies in true function. In addition, the data on long-term follow-up is based on two smaller studies, each of which had a different time point for follow-up. Six months compared with 12 months is relatively significant in the rehabilitation from a brain injury; therefore, this inconsistency lends to the uncertainty of these results. This lack of consistent and comprehensive data regarding functional outcome outlines the need for rigorous controlled trials addressing this gap in the literature.

Cardiac, respiratory, and infectious complications are common after TBI, and in many cases are directly related to the catecholamine surge and resultant autonomic imbalances. The use of beta blockers in hyperadrenergic states has previously been shown to be beneficial in decreasing adverse cardiopulmonary and infectious events. Contrary to this evidence, the use of beta blockers was associated with higher risk of these complications in our analyses. For pooled cardiopulmonary complications, two studies showed no difference between groups in the rates of these complications; however, they only measured bradycardia and cardiac uncoupling, respectively. The third study included had much more thorough criteria for assessing cardiopulmonary complications and was weighed heavily in our analysis. However, many of their complications were diagnosed prior to beta-blocker initiation; the beta-blocker group had a higher burden of chest injury, and a broad definition of respiratory failure was used. Despite these confounding factors, it is still essential to avoid bradycardia and hypotension after initiation of beta blockers in TBI. For infectious complications, the same study that diagnosed many cardiac complications prior to beta-blocker initiation also stated that many infections were diagnosed prior to beta-blocker initiation. There are growing data emerging regarding the use of beta blockers in sepsis, which, to date, suggests that use of beta blockers is associated with not only a decrease in mortality but also improved management of cardiorespiratory abnormalities.
CONCLUSION
This systematic review and meta-analysis reviewed the effect of use of beta blockers in patients with TBI on mortality and functional outcome. Our findings suggest that the use of beta blockers is associated with an overall decrease in in-hospital mortality and higher rate of good functional outcome at discharge from acute care. However, lack of available high-quality studies limits definitive conclusions and recommendations for use of beta blockers in TBI. Further RCTs are needed to analyze mortality as well as both short-term and long-term functional outcomes with use of beta blockers.

Limitations of this study are largely due to the number of available studies on this topic, as well as the quality of the literature. Limited number of studies were available for high-yield analysis of functional outcome, further complicated by the variability in reporting of good functional outcome. Studies were predominantly retrospective cohort analyses, limiting our ability to make definitive conclusions due to inherent lack of prospective data collection and blinding. Observational studies are by definition low quality, and in our case, this was further lowered by the serious risk of bias, inconsistency, an imprecision of the included studies. There were only two RCTs available, of which neither were blinded and both had small sample sizes, and therefore were weighted very low in our analysis. Additionally, most studies did not include subset analyses for suspected confounding factors such as premorbid patient conditions, time of beta-blocker initiation within hospital, beta-blocker therapy prior to their injury, or the need for surgical intervention. A small proportion of studies did identify an inherent difference between patients who received beta blockers compared with those who did not. For example, patients receiving beta blockers tended to be older and have more severe injuries.\(^\text{11, 17, 28}\) However, subgroup outcomes stratified by these confounders were not provided to allow for an adjusted analysis in our case; therefore, our analysis is based on unadjusted mortality. Some studies did not assess isolated TBI but rather included all multisystem trauma patients. Although beta blockers could be beneficial for all general trauma patients, this is a significant confounder when trying to assess the effect on TBI alone. For example, Khalili et al.\(^\text{26}\) did not find a benefit of beta blockers in all multisystem trauma patients, but their subgroup analysis did reveal a survival benefit of propranolol in patients with isolated severe TBI. Few studies included specific information about the dosing, time of initiation, duration, and type of beta blocker used. For those that did, there was substantial variability between studies in all of these factors. For example, some studies included patients in their beta-blocker cohort who received only one dose of beta blocker during their entire hospital stay, and timing of initiation varied from 24 hours post injury to up to 30 days after admission. Overall, there was wide variability in the methods of patient selection and beta-blocker administration, resulting in significant heterogeneity between studies. Additionally, although we attempt here to consider complications and assess long-term outcomes between groups, this is challenging to accomplish. If beta blockers do in fact decrease mortality, then patients who survive most likely will require a longer hospital stay and thus are at increased risk of inherent complications of hospital admission. Therefore, the benefit of beta blockers may lead to additional complications due to patients surviving who would have otherwise died.

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