Effect of intravenous corticosteroids on death within 14 days in 10 008 adults with clinically significant head injury (MRC CRASH trial): randomised placebo-controlled trial

CRASH trial collaborators*

Summary
Background Corticosteroids have been used to treat head injuries for more than 30 years. In 1997, findings of a systematic review suggested that these drugs reduce risk of death by 1–2%. The CRASH trial—a multicentre international collaboration—aimed to confirm or refute such an effect by recruiting 20 000 patients. In May, 2004, the data monitoring committee disclosed the unmasked results to the steering committee, which stopped recruitment.

Methods 10 008 adults with head injury and a Glasgow coma score (GCS) of 14 or less within 8 h of injury were randomly allocated 48 h infusion of corticosteroids (methylprednisolone) or placebo. Primary outcomes were death within 2 weeks of injury and death or disability at 6 months. Prespecified subgroup analyses were based on injury severity (GCS) at randomisation and on time from injury to randomisation. Analysis was by intention to treat. Effects on outcomes within 2 weeks of randomisation are presented in this report. This study is registered as an International Standard Randomised Controlled Trial, number ISRCTN74459797.

Findings Compared with placebo, the risk of death from all causes within 2 weeks was higher in the group allocated corticosteroids (1052 [21·1%] vs 893 [17·9%] deaths; relative risk 1·18 [95% CI 1·09–1·27]; p=0·0001). The relative increase in deaths due to corticosteroids did not differ by injury severity (p=0·22) or time since injury (p=0·05).

Interpretation Our results show there is no reduction in mortality with methylprednisolone in the 2 weeks after head injury. The cause of the rise in risk of death within 2 weeks is unclear.

Introduction Every year, millions of people worldwide are treated for head injury. A substantial proportion die or are permanently disabled. Although much damage is done at the time of injury, post-traumatic inflammatory changes are believed to contribute to neuronal degeneration. Corticosteroids have been used to treat head injury for more than 30 years. A survey of UK neurosurgical intensive-care units in 1996 showed that these drugs were used in 14% of units to treat head injuries; a survey of intensive-care management of patients with a head injury in the USA reported that corticosteroids were used in 64% of trauma centres. Corticosteroids are also used for management of head injury in Asia.

Previous randomised trials of corticosteroids in head injury have included no more than a few hundred patients, and altogether only about 2000 patients have been studied. In 1997, a systematic review of available trials suggested that the absolute risk of death in the corticosteroid-treated group was about 1–2% lower than in controls, but the 95% CI was from 6% fewer to 2% more deaths.

The second US National Acute Spinal Cord Injury Study (NASCIS-2) compared 24 h of methylprednisolone with placebo in 333 patients with acute spinal-cord injury. At 6 months, people receiving methylprednisolone within 8 h of injury seemed to have greater improvement in motor function and sensation to pinprick and touch than did those given placebo. Similar results were reported in a Japanese trial of the same regimen. Results of NASCIS-3 indicated slightly more neurological recovery with 48 h of treatment than with 24 h. Use of corticosteroids to treat acute spinal-cord injury led to renewed interest in their role in the treatment of head injury.

The CRASH trial (corticosteroid randomisation after significant head injury) is a large, international, randomised placebo-controlled trial of the effect of early administration of 48 h infusion of methylprednisolone on risk of death and disability after head injury. The trial aimed to inform clinical decision-making in an area of increasing global health importance. Reliable demonstration of even a small absolute benefit from corticosteroids would have the potential to avoid thousands of deaths and disabilities. Similarly, because corticosteroids are widely used to treat head injury, reliable refutation of any benefit would protect thousands of patients from possible side-effects and avoid unnecessary cost.

Patients and methods
The protocol for the CRASH trial has been published elsewhere (http://www.crash.lshtm.ac.uk). All collaborating investigators were required to secure local ethics or research committee approval before recruitment could begin. Patients with clinically significant head injury are...
unable to give valid informed consent. Local ethics committees set consent procedures for participating hospitals. Some allowed consent waiver and others consent from a legal representative. We always adhered to these requirements.

**Patients**

Adults (age 16 years or older) with head injury were screened for inclusion in the study if they were within 8 h of injury and were noted in hospital to have a Glasgow coma score (GCS) of 14 or less (maximum score 15). Such patients were eligible if, after assessment, the treating doctor was substantially uncertain whether or not to treat with corticosteroids—ie, the uncertainty principle. Thus, if we noted a clear indication for corticosteroids, the patient was not randomly assigned to receive randomised treatment with methylprednisolone or placebo. One 20 mL ampoule of sterile water, one 100 mL bag of 0·9% NaCl (for use with the loading dose), CRASH trial stickers to attach to the infusion bags and patient’s notes, a patient’s information leaflet in the appropriate language, and two copies of the form for collection of early outcome data. We translated the stickers and early outcome forms into local languages if needed. The loading dose was 2 g methylprednisolone (or placebo) over 1 h in a 100 mL infusion. The maintenance dose was 0·4 g methylprednisolone (or placebo) per h for 48 h in a 20 mL per h infusion. The methylprednisolone and placebo vials were identical and the solutions looked the same. This treatment regimen was based on that used in the NASCIS trials, but fixed doses were used to simplify procedures. Emergency unmasking of treatment allocation was possible by telephoning the randomisation service in Oxford or via a call to the 24 h emergency pager.

Primary outcome measures were death from any cause within 2 weeks of injury and death or disability at 6 months. We obtained mortality data within 2 weeks of injury from the early outcome form that was completed at death, discharge, or at 2 weeks, whichever happened first. These data were obtained electronically (with electronic data forms and the CRASH-Net website [http://crashnet.lshtm.ac.uk]) and by fax and post. The early outcome form included patient’s contact details, cause of injury, short-term outcome, management and complications, results from the first computerised tomography (CT) scan, and adherence to trial treatment. Data on management and complications included number of days in intensive care and occurrence of seizure, haematemesis or melaena requiring transfusion, wound infection with pus, pneumonia treated with antibiotics, use of antibiotics for other reasons, whether the patient had a neurosurgical operation, and whether they had sustained major extracranial injury. Events were recorded if they arose while the patient was still in hospital and within 14 days of randomisation. Non-fatal events happening after discharge but within 14 days of randomisation were not recorded.

We assessed disability at 6 months with a questionnaire that was mailed to patients or their carers, administered by telephone interview, or undertaken during a home visit or hospital appointment. Before the start of the trial, a simple questionnaire version of the Glasgow outcome scale was developed and shown to be both reliable and valid. The questionnaire was translated into relevant languages for use in every country, with back-translation into English to ensure accuracy. Completed questionnaires were sent to the coordinating centre in London to be entered into the trial database.

With respect to prespecified subgroup analyses, we planned to report the effects of treatment subdivided by two main baseline characteristics of patients: time from injury to randomisation (≤1 h, >1 to ≤3 h, >3 to ≤8 h)
and severity of head injury based on the GCS at randomisation (severe 3–8, moderate 9–12, mild 13–14).

Statistical analysis
We initially estimated that risk of death in patients allocated to placebo might be around 15%. Because even a 2% survival difference would be clinically important, the trial had to be large enough to detect a difference of this size. A trial of 20 000 patients would have a good chance of showing a 2% survival difference at convincing levels of significance—ie, more than 90% power to achieve p<0.01. All analyses were undertaken on an intention-to-treat basis, that is, patients were analysed on the basis of the group to which they were randomised, irrespective of whether they actually received their allocated treatment. Effect measures were relative risk and absolute risk reduction. Precision was quantified with 95% CIs for overall risk and 99% CIs for subgroup results. We assessed homogeneity in treatment effects within subgroups by the χ² test at a 5% significance level.

During the study, interim analyses of in-hospital mortality, complications, and 6-month outcome were supplied at least once a year to the independent data monitoring and ethics committee. This committee had responsibility for deciding whether, while randomisation was in progress, the unmasked results should be revealed to the trial steering committee. The data monitoring and ethics committee terms of reference stated that they would unmask results only if the randomised comparisons in the trial provided both (1) proof beyond reasonable doubt of a difference in outcome between the study and control groups and (2) evidence that would be expected to alter substantially the choice of treatment for patients whose doctors were, in view of data from other randomised controlled trials, substantially uncertain whether to give corticosteroids to patients with head injury.

This study is registered as an International Standard Randomised Controlled Trial, number ISRCTN74459797. The protocol for this study was peer-reviewed and accepted by The Lancet; a summary of the protocol was published on the journal’s website, and the journal then made a commitment to peer-review the primary clinical manuscript.

Role of the funding source
The sponsors of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Results
Patients were enrolled in 239 hospitals from 49 countries: 2141 (21%) were enrolled by central telephone randomisation and 7867 (79%) were non-centrally randomised. The first patient was enrolled in 10 008 randomised

<table>
<thead>
<tr>
<th>Corticosteroid (n=5007)</th>
<th>Placebo (n=5001)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at randomisation (years)</td>
<td></td>
</tr>
<tr>
<td>&lt;25</td>
<td>1481 (30%) 1450 (29%)</td>
</tr>
<tr>
<td>25–34</td>
<td>1513 (30%) 1271 (25%)</td>
</tr>
<tr>
<td>35–44</td>
<td>1554 (31%) 1485 (30%)</td>
</tr>
<tr>
<td>&gt;44</td>
<td>821 (16%) 849 (17%)</td>
</tr>
<tr>
<td>Men</td>
<td>4075 (81%) 4093 (81%)</td>
</tr>
<tr>
<td>GCS</td>
<td></td>
</tr>
<tr>
<td>Severe (3–8)</td>
<td>1985 (40%) 1981 (39%)</td>
</tr>
<tr>
<td>Moderate (9–12)</td>
<td>1577 (31%) 1483 (30%)</td>
</tr>
<tr>
<td>Mild (13–14)</td>
<td>1462 (29%) 1537 (31%)</td>
</tr>
<tr>
<td>Time since injury (h)</td>
<td></td>
</tr>
<tr>
<td>&lt;1</td>
<td>1350 (27%) 1347 (27%)</td>
</tr>
<tr>
<td>1 to &lt;3</td>
<td>1532 (31%) 1567 (31%)</td>
</tr>
<tr>
<td>&gt;3 to &gt;8</td>
<td>2125 (42%) 2087 (42%)</td>
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<tr>
<td>Both pupils reactive to light</td>
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<tr>
<td>No</td>
<td>722 (14%) 728 (15%)</td>
</tr>
<tr>
<td>Yes</td>
<td>4285 (86%) 4273 (85%)</td>
</tr>
<tr>
<td>Major extracranial injury</td>
<td>1134 (23%) 1082 (22%)</td>
</tr>
<tr>
<td>Cause of head injury</td>
<td></td>
</tr>
<tr>
<td>Road traffic crash</td>
<td>3249 (65%) 3169 (65%)</td>
</tr>
<tr>
<td>Fall &gt;2 m</td>
<td>608 (12%) 699 (14%)</td>
</tr>
<tr>
<td>Other</td>
<td>1085 (22%) 1053 (21%)</td>
</tr>
<tr>
<td>Not known</td>
<td>65 (1%) 80 (2%)</td>
</tr>
<tr>
<td>Head CT scan done</td>
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</tr>
<tr>
<td>Yes</td>
<td>3916 (78%) 3966 (78%)</td>
</tr>
<tr>
<td>No/not known</td>
<td>1091 (22%) 1105 (22%)</td>
</tr>
<tr>
<td>CT scan results!</td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>897 (23%) 878 (23%)</td>
</tr>
<tr>
<td>One or more petechial haemorrhages within the brain</td>
<td>1139 (29%) 1098 (28%)</td>
</tr>
<tr>
<td>Obliteration of the third ventricle or basal cisterns</td>
<td>906 (23%) 920 (24%)</td>
</tr>
<tr>
<td>Subarachnoid bleed</td>
<td>1226 (31%) 1231 (31%)</td>
</tr>
<tr>
<td>Medline shift &gt;5 mm</td>
<td>556 (14%) 579 (15%)</td>
</tr>
<tr>
<td>Non-evacuated haematoma</td>
<td>1061 (27%) 1050 (27%)</td>
</tr>
<tr>
<td>Evacuated haematoma</td>
<td>486 (12%) 500 (13%)</td>
</tr>
<tr>
<td>Cortical contusion &gt;1 cm in diameter</td>
<td>869 (22%) 886 (23%)</td>
</tr>
</tbody>
</table>

*Includes 21 patients randomised more than 8 h after injury. Percentages shown are of patients who had a CT scan; patients may have more than one result. ْCortical contusion as a CT-reporting category was introduced after randomisation started.

Table: Baseline characteristics
April, 1999. In May, 2004, the data monitoring and ethics committee disclosed the unmasked results to the trial steering committee, which then stopped recruitment. 10008 patients were randomised to corticosteroid or placebo infusions (figure 1); 62 were subsequently found to be younger than 16 years of age, 21 were enrolled more than 8 h after injury, and the trial infusion was stopped in three at the request of a relative. 21 were enrolled more than 8 h after injury, and the trial was subsequently found to be younger than 16 years of age, 21 were enrolled more than 8 h after injury, and the trial infusion was stopped in three at the request of a relative. All these patients are included in the analysis.

The table shows baseline data for all patients randomised. Mean age of participants was 37 years (SD 17) and median time from injury to randomisation was 3 h (IQR 1–5). Treatment groups were balanced with respect to patients’ characteristics and presence of major extracranial injuries, cause of injury, and head CT scan results.

Adherence to treatment was known for 9848 (98%) patients, of whom 9748 (99%) received the full loading dose. Although some patients died or were discharged from hospital before completion of the full 48 h maintenance dose, 8286 (83%) patients received at least 24 h of treatment.

Mortality data during the first 2 weeks were obtained for 9964 patients. Of 4985 patients allocated corticosteroids whose outcomes were known, 1052 (21%) died within 2 weeks of randomisation, compared with 893 (18%) of 4979 allocated placebo. Thus, the relative risk of death from all causes within 2 weeks in patients allocated corticosteroids compared with placebo was 1·18 (95% CI 1·09–1·27; p=0·0001; figure 2). The relative risk of death at 2 weeks did not differ by injury severity (p=0·22) or time since injury (p=0·05; figure 2).

7812 (78%) patients had a head CT scan. The relative risk of death at 2 weeks was not different in any of the eight CT scan diagnosis subgroups examined (figure 3).

Furthermore, the relative risk of death within 2 weeks did not differ in patients with (321/1134 [28%] corticosteroid vs 244/1082 [23%] placebo) and without (731/3851 [19%] vs 649/3897 [17%]; p=0·27) major extracranial injury. We did not record an increase in complications with corticosteroid allocation (figure 4).

Treatment allocation was unmasked for 24 (0·2%) patients (15 corticosteroid, nine placebo). The usual reason for emergency unmasking was that patients were subsequently found to have a disorder that the doctor wished to treat with corticosteroids.

### Discussion

The results of the MRC CRASH trial of methylprednisolone treatment reliably refute any reduction in mortality in the 2 weeks after head injury; this treatment was associated with a significant rise in risk of death within 2 weeks. The apparent increase in mortality did not differ in the prespecified subgroups, although the hazard might be enhanced in patients presenting at a later time. Although the apparent hazard could be a statistical artifact, due in part to the data-dependent stopping of the trial,11 we believe that our results provide evidence that could substantially alter the choice of treatment for patients with head injury. For this reason, we opted for early publication of the 2-week outcome data. The effect of corticosteroids on disability at 6 months will be reported later.

Our study has many strengths. Our randomisation methods ensured that participating clinicians could not have foreknowledge of treatment allocation and that baseline prognostic factors were well balanced between treatment groups. Data on the primary outcome of death

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**Figure 2:** Effects of corticosteroid allocation on deaths from all causes within 2 weeks, by injury severity (based on GCS at randomisation) and time since injury.

**Figure 3:** Effects of corticosteroid allocation on deaths from all causes within 2 weeks, by head CT scan results. Subgroups are not mutually exclusive because some patients are included in more than one category.
from any cause within 2 weeks were available for more than 99% of randomised patients, and all analyses were undertaken on an intention-to-treat basis. The CRASH trial had sufficient power to reliably detect modest but nevertheless clinically important treatment benefits or harms. It was undertaken in more than 200 hospitals in 49 countries. The patients included would have undergone several concurrent interventions that would have varied between hospitals. We did not obtain data on all concurrent interventions, but similar numbers of patients in every hospital were allocated corticosteroids or placebo. Furthermore, because doctors were unaware of treatment allocation, use of concomitant therapies would not have been influenced.

The CRASH trial had one limitation. To establish the main cause of death is difficult when multiple factors relating to trauma are present, so we did not ask participating clinicians what they judged to be the cause of death. We saw no evidence of a large rise in risk of infectious complications or gastrointestinal bleeding from corticosteroid treatment. We are still unsure of the mechanism of the increased mortality with corticosteroids.

Before starting the CRASH trial, a systematic review and meta-analysis of the existing trials of corticosteroids in head injury was done. When all previous trials were combined, risk of death in the corticosteroid-treated group seemed lower than in the control group (relative risk 0.96 [95% CI 0.85–1.08]; figure 5). When this meta-analysis is updated to include the findings of the CRASH trial, risk of death in the corticosteroid-treated group seems to be higher than in the control group (1.12 [1.05–1.20]). The CRASH trial result, judged either separately or in combination with previous trials, clearly refutes any material reduction in mortality with corticosteroids, although the size of the CRASH trial has a major influence on the result of the meta-analysis. We noted some statistical heterogeneity in the updated meta-analysis that might be accounted for by the data-dependent stopping of the trial.19

Our early results show that corticosteroids should not be used routinely to treat head injury, whatever the severity. By clearly refuting a mortality benefit from corticosteroids in head injury, the CRASH trial results should protect many thousands of patients from any increased risk of death associated with these drugs. However, our results could also have implications for use of corticosteroids in spinal-cord injury. After publication of NASCIS-2,16 in which some evidence of neurological benefit was seen in the subgroup of patients with spinal-cord injury treated within 8 h, corticosteroids have been widely used to treat this type of injury, although this approach is controversial.11-17 Because trials of corticosteroids in spinal-cord injury have been small (even when combined they include about 500 patients),16 and because of the emphasis on subgroup effects, use of corticosteroids in spinal-cord injury should remain an area for debate.
The effect of corticosteroid treatment on disability 6 months after head injury will be reported as soon as these data are available. Many other treatments of uncertain effectiveness for head injury are in widespread use, and further large-scale randomised trials are needed. The CRASH trial has shown that we can enrol many trauma patients into clinical trials in the emergency setting. Every year, about 3 million people worldwide die from trauma, many after reaching hospital. Of those who do survive to reach hospital, blood loss accounts for nearly half of in-hospital trauma deaths. Hypotension from such loss is one of the strongest predictors of poor outcome after head injury that is amenable to therapeutic modification. A large place-controlled trial of the effects of an antifibrinolytic drug on death and transfusion requirements in patients with clinically significant haemorrhage after trauma is in progress (http://www.crash2.lshtm.ac.uk).

Conflict of interest statement
We declare that we have no conflict of interest.

CRASH trial collaborators by country (number of patients randomised)

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Chile (3) — Hospital Regional Copiapó (3): Pedro Bedoya Barrios.
Medical Education and Research (28): Varinder Khosla, Sunil Gupta; Baby Memorial Hospital (25): Haroon Pllllll, Nisha Thomas; V H S Hospital (22): Krishnamurthy Sridhar; Bobby Bose; Jubilant Life Sciences, Limited; National Institute of Mental Health and Neurosciences (17): Shanti Prasad; Shibli Hossain; Care Hospital (16): Ramana; Sri Sai Hospital (16): Sanjay Gupta; Smita Gupta; Hizabi Cowasjee; Jeangir Medical Research Institute (15): Dilip Kiyawat; Maheshwari Orthopaedic Hospital (13): Kishor Maheshwari; Amrita Institute of Medical Sciences (11): Dilip Panikar; Harjeet Kaur; Nursing and Home Health (7): Jayant Chawla; Kasturba Medical College and Hospital (7): Satyanarayana Shenoy; Annapurna Raja; Chaitram Hospital & Research Centre (6): Yeshovami Rupayana; Gowri Gopal Superspeciality Hospital (6): Suryanarayanan Reddy; Apex Hospital Visakhapatnam (3): Nelanathula Mohan; Central India Institute of Medical Sciences (3): Shailesh Kelkar; Marble City Hospital and Research Centre (3): Yadram Yadav; Government Medical College Amritsar (1); Jayant Chawla; Jhori Hospital (1): Mukesh Jhori; National Hospital Jabalpur (2): Yadram Yadav. Indonesia (238)—Sanglah General Hospital (222): Nyoman Golden NC; Sri Malawang; Sidoarjo General Hospital (14): Achmad Fauzi; Umar Farouk. Iran (233)—Naghib University Hospital (110): Esmail Fakharian; Amir Aramesh; Fatemeh Zahra Hospital (85): Maasoumeh Eghtedari; Farhad Ahmadzadeh; Alireza Gholami; National Institute of Social Security Hospital (38): Maasoumeh Eghtedari; Farhad Ahmadzadeh. Ireland (113)—St James’s Hospital’s (113): Patrick Finnck; Catherine Redican; Geraldine McMahon. Italy (9)—Università Cattolica del Sacro Cuore (8): Maria Giuseppina Annetta; Università di Firenze (3): Homère Sibony; Università di Perugia (2): Gino Testa; Università di Roma (1): Beatrice Harding. Kenya (2)—Aga Khan Hospital (2): Mahmood Qureshi. Malaysia (176)—Hospital University Science Malaysia (162): Abdul Rahman Izzaini Ghani; Ips Specialist Hospital (14): Fazluddin Cheah. Mexico (17)— Alfalfa Cabrera NC; Hospital General Regional no 1 (12): Jose Luis Mejia Gonzalez; Hospital General de Cuernavaca (4): Jose Luis Mejia Gonzalez; Hospital General Regional no 25 (1): Jorge Loría-Castellanos. New Zealand (43)—Dunedin Hospital (43): Suzanne Jackson, Robyn Hutchins. Nigeria (180)—Obafemi Awolowo University Teaching Hospital (57): Narendra Nathoo, Sipho Khumalo; Curamed Kloof Hospital (57): Narendra Nathoo, Sipho Khumalo; Tygerberg Academic Hospital (20): Juan Manuel Navia; Hospital Universitario Virgen de la Victoria (5): Victorio de la Torre-Prados; Hospital General Vague (4): Romero Pellejo. Sri Lanka (132)—Batticaloa General Hospital (132): Véronique Laloe NC; Bernhard Mund, Suhen Neth; National Hospital of Sri Lanka (39): Sunil Perera, Point-Pedro Base Hospital (9): Véronique Laloe, Kanapathipillai Mahendran. Switzerland (160)—University Hospital of Zurich (113): Reto Stocker NC, Silke Ludwig NC; University Hospital Bern (15): Hervé Zimmermann; Kantonsspital Schaffhausen (12): Urs Dzenzer. Thailand (579)—Koh Koen Regional Hospital (153): Watanaiethwaree NC; Warawut Kittiwatthawat; Parnumas Piyavechvirat; Pojana Tapsai; Aijzara Narrungarn-jaad; Chinsruong Prachanamo (12); Upapat Chanathipimla; Rayong Hospital (11); Chonburi Watanaehai; Pusit Subsosom; Krabi Hospital (10): Wipurat Pussananawat, Pensri Khunjan; Surathani Hospital (8): Sakchai Tangkhivitthaya, Somsak Nilapong; Ro-Er Hospital (2): Tanagorn Klangsang, Wibul Taechakosol; Lampang Hospital (1): Atirat Sinati. Tunisia (63)—Hospital Habib Thameur (63): Zoubir Jitri, Nabi Borsali-Falfoul; Monia Rezgui. Turkey (2)—Istanbul Medical Faculty (2): Naht Cakar, Uganda (43)—Makerere Medical School (43): Hussein Ssenyonjo; Olive Kubuniswe. UK (1391)—Hope Hospital (209): Gabrielle Lomas, David Yates, Fiona Lecky; Birmingham Heartlands Hospital (123): Anthony Bleetman, Alan Baldwin, Emma Jenkinson, Shaide Paanjan; North Manchester General Hospital (85): James Stewart, Nasreen Contractor, Trudy Roberts, Jim Butler; Royal Albert Edward Infirmary (83): Alan Pinto, Diane Lee; Colchester General Hospital (79): Nigel Brayley, Karly Robbshaw, Clare Dux; Whiston Hospital (69): Sarah Graham, Sue Pyc; Selby Oak Hospital (61): Marcus Green, Annie Kellins; Royal Bolton Hospital (51): Chris Mouton, Barbara Fogg; Eastbourne District General Hospital (50): Rowland Cottingham, Sam Funnell, Udham Shanker; Trafford General Hospital (41): Claire Summers, Louise Malek; Royal Sussex County Hospital (38): Rowland Cottingham NC, Christopher Ashcroft, Jacy Powell; Countess of Chester Hospital (36): Steve Moore, Stephanie Buckley; Worthing Hospital (34): Mandy Grocott, Steve Chambens; Medway Maritime Hospital (29): Amanda Morriss, Helen Marshall, Chelsea and Westminster Hospital (28): Julia Harris, Wendy Matthews, Jane Tippett; Furness General Hospital (27): Simon Mardell, Fiona MacMillan, Anita Shaw; Royal Oldham Hospital (26); Pramed Luthra; Gill Dixon; Stepping Hill Hospital (16): Mohamed Ahmad, John Butler, Mike Young; Northern General Hospital (25): Sue Mason, Ian Loveday; Blackburn Royal Infirmary (23): Christine Clark, Sam Taylor; Cheltenham General Hospital (23): Paul Wilson; Fairfield General Hospital (23): Kassim Ali; Stuart Greenwood; Queen Elizabeth the Queen Mother Hospital (21): White Martin, Rosa Perez; Nineells Hospital and Medical School (19): Sam Eljamel; Queen Elizabeth Hospital Birmingham (18): Snoikia (179)—Reimann Hospital (71); Stefan Trenkler NC, Matuhi Humensky, Tatiana Stefanová; Nép Poprad (19); Ivan Schwendt, Anton Laincz; Nenkosnia Bojnúri (25); Zelman Julius, Stanis Mazov; Pšné Kosice (12); Jozef Firment; Nép Trehusín (11); Maria Cifranicova; Faculty Hospital in Martin (10); Beata Sániová; Nép Ruzinov (4); Karol Kalig; Nép Nové Zámy (3); Sofia Medekova; Nép Liptovský Mikulas (2); Radoslav Wus; Nép F D Roosevelt (1); Nép Zilina (1); Ivan Mažuta; South Africa (366)—Tygerberg Academic Hospital (307): Bennie Hartenberg NC, Grant du Plessis, Zelda Houle; Wentworth Hospital (57): Narendra Nathoo, Sipho Khumalzo; Curamed Kloof Hospital (1): Ralph Tracey. Spain (259)—Hospital Universitario Virgen del Rocío (131): Angeles Muñoz-Sánchez NC, Francisco Murillo-Cabezas NC, Juan Flores-Cordero; Dolores Rincón-Ferrari; Hospital Torrecárdenas (17); Martin Rubí; Lopez Caler; Hospital Universitario Germans Trias i Pujol (12); Maite Míes del Campo, Luisa Bordejé Lagana; Hospital Mutua de Terrassa (20); Juan Manuel Nava; Hospital Universitario de Girona Dr Josep Trueta (12); Miguel Arruego Mingüela; Hospital Carlos War (10); Alfonso Muñoz Lopez; Hospital General de La Palma (6); Luis Ramos-Gómez; Hospital Universitario Virgen de la Victoria (5): Victoria de la Torre-Prados; Hospital General Vague (4): Romero Pellejo.
Jonathan Wasserberg, Helen Shale; Russell’s Hall Hospital (18); Colin Read, John McCarren; Princess Alexandra Hospital (16); Aaron Pennell; Princess Royal Hospital (14); Gautam Ray; Darent Valley Hospital (13); John Thurston, Emma Brown; Royal Liverpool University Hospital (12); Lawrence Jaffey, Michael Graves; Chesterfield and North Derbyshire Royal Hospital (10); Richard Bailey, Nancy Loveridge; Withybush General Hospital (10); Geraint Evans, Shireleen Hughes, Major Kafred Ahmed; Aberdeen Royal Infirmary (8); Jeremy Richardson, Claire Gallagher; Ormskirk and District General Hospital (8); Titus Odedun, Karen Lees; Queen Mary’s Hospital (8); David Foley, Nick Payne; Arrow Park Hospital (6); Alan Pennycook, Carl Griffiths; City Hospital Birmingham (5); David Moore, Denise Byrne; St Helen Hospital (4); Sunil Dasan; Whittington Hospital (4); Ashis Banerjee, Steve McGuinness; Doncaster Royal Infirmary (2); Claude Chikhani; Leeds General Infirmary (2); Nigel Zolthie, Ian Barlow; Bromley Hospital (1); Ian Stell; Harrogate District Hospital (1); William Hulse, Jacqueline Croyse; Institute of Neurology (1); Laurence Watkins; Queen Elizabeth Hospital Gateshead (1); Bulu Dorani; Vietnam (2)—Cho Ray Hospital (2); Trung Van Viet.

NC—national coordinator. RC—regional coordinator.

CRASH trial coordination

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References