

Continuous vs Intermittent β -Lactam Antibiotic Infusions in Critically Ill Patients With Sepsis

The BLING III Randomized Clinical Trial

Joel M. Dulhunty, MD, PhD; Stephen J. Brett, MD; Jan J. De Waele, MD, PhD; Dorrilyn Rajbhandari, PGDip(Clinical Nursing); Laurent Billot, MRes; Menino O. Cotta, PhD; Joshua S. Davis, MD, PhD; Simon Finfer, MD; Naomi E. Hammond, RN, PhD; Serena Knowles, RN, PhD; Xiaoqiu Liu, PhD; Shay McGuinness, MD; Jayanthi Mysore, MS; David L. Paterson, MD, PhD; Sandra Peake, MD, PhD; Andrew Rhodes, MD, MD(Res); Jason A. Roberts, BPharm, PhD; Claire Roger, MD, PhD; Charudatt Shirwadkar, MD; Therese Starr, RN; Colman Taylor, PhD; John A. Myburgh, MD, PhD; Jeffrey Lipman, MD, DMed(Res); for the BLING III Study Investigators

IMPORTANCE Whether β -lactam antibiotics administered by continuous compared with intermittent infusion reduces the risk of death in patients with sepsis is uncertain.

OBJECTIVE To evaluate whether continuous vs intermittent infusion of a β -lactam antibiotic (piperacillin-tazobactam or meropenem) results in decreased all-cause mortality at 90 days in critically ill patients with sepsis.

DESIGN, SETTING, AND PARTICIPANTS An international, open-label, randomized clinical trial conducted in 104 intensive care units (ICUs) in Australia, Belgium, France, Malaysia, New Zealand, Sweden, and the United Kingdom. Recruitment occurred from March 26, 2018, to January 11, 2023, with follow-up completed on April 12, 2023. Participants were critically ill adults (≥ 18 years) treated with piperacillin-tazobactam or meropenem for sepsis.

INTERVENTION Eligible patients were randomized to receive an equivalent 24-hour dose of a β -lactam antibiotic by either continuous ($n = 3498$) or intermittent ($n = 3533$) infusion for a clinician-determined duration of treatment or until ICU discharge, whichever occurred first.

MAIN OUTCOMES AND MEASURES The primary outcome was all-cause mortality within 90 days after randomization. Secondary outcomes were clinical cure up to 14 days after randomization; new acquisition, colonization, or infection with a multiresistant organism or *Clostridioides difficile* infection up to 14 days after randomization; ICU mortality; and in-hospital mortality.

RESULTS Among 7202 randomized participants, 7031 (mean [SD] age, 59 [16] years; 2423 women [35%]) met consent requirements for inclusion in the primary analysis (97.6%). Within 90 days, 864 of 3474 patients (24.9%) assigned to receive continuous infusion had died compared with 939 of 3507 (26.8%) assigned intermittent infusion (absolute difference, -1.9% [95% CI, -4.9% to 1.1%]; odds ratio, 0.91 [95% CI, 0.81 to 1.01]; $P = .08$). Clinical cure was higher in the continuous vs intermittent infusion group (1930/3467 [55.7%] and 1744/3491 [50.0%], respectively; absolute difference, 5.7% [95% CI, 2.4% to 9.1%]). Other secondary outcomes were not statistically different.

CONCLUSIONS AND RELEVANCE The observed difference in 90-day mortality between continuous vs intermittent infusions of β -lactam antibiotics did not meet statistical significance in the primary analysis. However, the confidence interval around the effect estimate includes the possibility of both no important effect and a clinically important benefit in the use of continuous infusions in this group of patients.

TRIAL REGISTRATION ClinicalTrials.gov Identifier: [NCT03213990](https://clinicaltrials.gov/ct2/show/study/NCT03213990)

JAMA. 2024;332(8):629-637. doi:[10.1001/jama.2024.9779](https://doi.org/10.1001/jama.2024.9779)
Published online June 12, 2024.

- [+ Visual Abstract](#)
- [← Editorial page 623](#)
- [+ Multimedia](#)
- [← Related article page 638](#)
- [+ Supplemental content](#)
- [+ CME Quiz at \[jamacmelookup.com\]\(https://jamacmelookup.com\)](#)

Author Affiliations: Author affiliations are listed at the end of this article.

Group Information: The BLING III Study Investigators are listed in Supplement 3.

Corresponding Author: Joel M. Dulhunty, MD, PhD, Butterfield Street, Intensive Care Services, Royal Brisbane and Women's Hospital, Herston, QLD 4029, Australia (Joel.Dulhunty@health.qld.gov.au).

Section Editor: Christopher Seymour, MD, Associate Editor, JAMA (christopher.seymour@jamanetwork.org).

Defined as life-threatening organ dysfunction due to a dysregulated response to infection,¹ sepsis is a major cause of mortality worldwide. Early antibiotic therapy directed at the likely infective microorganism is a cornerstone of treatment,²⁻⁴ of which β -lactam antibiotics are an important class of antibiotics.⁴ For patients treated in the intensive care unit (ICU), meropenem and piperacillin-tazobactam are commonly used drugs in this antibiotic class.^{5,6} β -Lactam antibiotics have been primarily administered as multiple, short (eg, 30-minute) intermittent infusions. Due to time-dependent kill characteristics, there is a biological rationale that continuous infusion may be more effective than intermittent administration.⁷⁻⁹

Recent clinical trials have reported that the administration of β -lactam antibiotics by continuous infusion resulted in concentrations above the minimum inhibitory concentration of typical pathogens.^{10,11} However, clinical trials and meta-analyses have not provided conclusive evidence of microbiological cure and improved patient-centered outcomes.¹²⁻¹⁶ To address uncertainty about the optimal method of β -lactam antibiotic administration in the ICU setting,^{17,18} a randomized clinical trial was conducted to determine whether continuous infusion of piperacillin-tazobactam or meropenem resulted in decreased all-cause mortality at 90 days in critically ill patients with sepsis compared with intermittent infusion.

Methods

Trial Design and Oversight

The Beta-Lactam Infusion Group (BLING) III trial was an international, open-label, phase 3, randomized clinical trial comparing continuous vs intermittent infusions of β -lactam antibiotics on all-cause 90-day mortality in critically ill patients with sepsis. The study protocol (Supplement 1) and statistical analysis plan (Supplement 2) have been published previously.^{19,20} The trial was approved by the relevant human research ethics committee or equivalent in each region; institutional approval was obtained as per site requirements. In some jurisdictions, approval was obtained for enrollment prior to consent in certain circumstances (eMethods in Supplement 3); in all countries, written informed consent was obtained from patients or their legal surrogate with documented verbal consent obtained in some regions during the SARS-CoV-2 (COVID-19) pandemic as per ethics committee approval (eMethods in Supplement 3).

The trial management committee was responsible for the design of the study. The George Institute for Global Health generated the allocation sequence and conducted the statistical analysis. An independent data and safety monitoring committee conducted a prespecified midpoint safety analysis (Supplement 2). Study reporting adhered to the CONSORT 2010 Statement for randomized clinical trials.

The trial was conducted in 104 adult ICUs in Australia, Belgium, France, Malaysia, New Zealand, Sweden, and the United Kingdom. Participants were enrolled between March 26, 2018, and January 11, 2023; 90-day follow-up was completed on April 12, 2023.

Key Points

Question Is there a difference in mortality between continuous and intermittent infusions of β -lactam antibiotics in critically ill patients with sepsis?

Findings In this randomized clinical trial that included 7031 adult patients with sepsis, there was not a statistically significant difference in the proportion of patients who died within 90 days who received continuous (24.9%) compared with intermittent (26.8%) β -lactam antibiotic infusions (odds ratio, 0.91).

Meaning In critically ill patients with sepsis, continuous vs intermittent β -lactam antibiotic infusions did not significantly reduce 90-day mortality in the primary analysis.

Participants

Eligible participants (Table 1)^{21,22} were adult (≥ 18 years) ICU patients with (1) a documented site or strong suspicion of infection, (2) treatment with piperacillin-tazobactam or meropenem commenced within the previous 24 hours, and (3) 1 or more organ dysfunction criteria met in the previous 24 hours as defined in the study inclusion criteria (eMethods in Supplement 3). Eligible participants were expected to remain in the ICU for at least the next calendar day and in whom the administration of either piperacillin-tazobactam or meropenem by intermittent or continuous infusion was considered equally appropriate for the patient by the attending clinicians. Full details of inclusion and exclusion criteria are provided in the eMethods in Supplement 3.

Randomization

Participants were randomized in a 1:1 ratio to receive the prescribed antibiotic by either continuous (intervention group) or intermittent (control group) infusion.¹⁹ Randomization was generated using a minimization algorithm via a password-protected, encrypted, web-based interface with stratification by study site.

Interventions

In both groups, the total 24-hour β -lactam antibiotic dose was determined by the attending clinicians. A defined daily dose of 14 g for piperacillin-tazobactam and 3 g for meropenem was used as a reference measure.²³ All participants received at least 1 β -lactam antibiotic infusion dose prior to open-label randomized treatment. Randomized drug administration by continuous infusion (over 24 hours) or intermittent infusion (over 30 minutes) was continued for the duration of the treatment course or until ICU discharge, whichever occurred first. A switch between piperacillin-tazobactam and meropenem (or vice versa) was permitted in the same treatment group after receipt of a loading dose by intermittent infusion for participants in the continuous infusion group. Additional details on study drug administration appear in the eMethods in Supplement 3.

Outcome Measures

The primary outcome was all-cause mortality at 90 days from the date of randomization. Secondary outcomes were clinical cure, defined as the completion of the β -lactam antibiotic

Table 1. Baseline Characteristics of Participants in the BLING III Trial

Characteristic	Continuous infusion (n = 3498) ^a	Intermittent infusion (n = 3533) ^a
Age, mean (SD), y	59.3 (16.4)	59.6 (16.1)
Median (IQR)	62 (49-72)	63 (50-72)
Sex, No. (%)		
Female	1190 (34.0)	1233 (34.9)
Male	2308 (66.0)	2300 (65.1)
Weight, mean (SD) [No.], kg	82.7 (22.6) [3493]	82.7 (22.9) [3530]
Median (IQR)	80 (68-94)	80 (67-94)
Height, mean (SD) [No.], cm	170.5 (9.9) [3468]	170.3 (10.2) [3509]
Median (IQR)	170 (164-178)	170 (164-178)
Source of ICU admission, No./total (%)		
Accident and emergency department	1203/3495 (34.4)	1178/3532 (33.4)
Hospital floor (ie, wards)	982/3495 (28.1)	1047/3532 (29.6)
Operating theater following emergency surgery	732/3495 (20.9)	720/3532 (20.4)
Operating theater following elective surgery	254/3495 (7.3)	265/3532 (7.5)
Transfer from another hospital (except from another ICU)	179/3495 (5.1)	173/3532 (4.9)
Transfer from another ICU ^b	145/3495 (4.1)	149/3532 (4.2)
Time from ICU admission to randomization, mean (SD) [No.], h	80.2 (135.2) [3496]	78.9 (148.3) [3532]
Median (IQR)	25.2 (12.6-102.9)	24.8 (12.1-104.1)
APACHE II score, mean (SD) [No.] ^c	19.6 (7.6) [3495]	19.5 (7.4) [3529]
Median (IQR)	19 (14-25)	19 (14-24)
Lowest Pao ₂ /Fio ₂ ratio in the 24 h prior to randomization, mean (SD) [No.]	190.5 (102.5) [3322]	192.4 (103.6) [3371]
Median (IQR)	169 (111-252)	172 (113-252)
Highest creatinine, mean (SD) [No.], μ mol/L	122.6 (95.2) [3481]	123.6 (106.5) [3519]
Median (IQR)	92 (64-150)	91 (63-148)
Highest bilirubin, mean (SD) [No.], μ mol/L	25.9 (45.8) [3308]	24.7 (43.9) [3346]
Median (IQR)	14 (8-24)	13 (8-24)
Lowest platelet count, mean (SD) [No.], $\times 10^9$ /L	232.3 (141.0) [3460]	228.6 (137.6) [3492]
Median (IQR)	208 (138-298)	204 (136-295)
Lowest MAP in the 24 h prior to randomization, mean (SD) [No.], mm Hg	63.8 (12.4) [3485]	64.0 (12.1) [3512]
Median (IQR)	63 (57-70)	63 (57-70)
Worst Glasgow Coma Scale score (nonsedated), mean (SD) [No.] ^d	12.2 (4.1) [2776]	12.3 (4.0) [2814]
Median (IQR)	14 (10-15)	14 (11-15)
Received inotropes/vasopressors in the 24 h prior to randomization, No./total (%)	2481/3496 (71.0)	2482/3532 (70.3)
Received antibiotics in the 24 h prior to randomization, No./total (%) ^e	2340/3496 (66.9)	2460/3532 (69.6)

(continued)

Table 1. Baseline Characteristics of Participants in the BLING III Trial (continued)

Characteristic	Continuous infusion (n = 3498) ^a	Intermittent infusion (n = 3533) ^a
Primary site of infection, No./total (%)		
Pulmonary	2062/3494 (59.0)	2119/3532 (60.0)
Intra-abdominal	469/3494 (13.4)	447/3532 (12.7)
Blood	268/3494 (7.7)	294/3532 (8.3)
Urinary	214/3494 (6.1)	166/3532 (4.7)
Skin	184/3494 (5.3)	186/3532 (5.3)
Gut	98/3494 (2.8)	120/3532 (3.4)
Central nervous system	65/3494 (1.9)	74/3532 (2.1)
Intravenous catheter	18/3494 (0.5)	20/3532 (0.6)
Endocarditis	13/3494 (0.4)	4/3532 (0.1)
Other ^f	103/3494 (2.9)	102/3532 (2.9)

Abbreviations: APACHE, Acute Physiology and Chronic Health Evaluation; BLING, Beta-Lactam Infusion Group; Fio₂, fraction of inspired oxygen; ICU, intensive care unit; MAP, mean arterial pressure; Pao₂, arterial partial pressure of oxygen.

SI conversion factors: To convert bilirubin to mg/dL, divide by 17.104; creatinine to mg/dL, divide by 88.4.

^a Descriptive statistics are reported for all participants with available data by group. The group denominator for each characteristic is reported.

^b From the same or a different hospital.

^c The APACHE II score is a severity of illness scoring system that ranges from 0 to 71; higher scores correspond to more severe disease and a higher risk of death.²¹ A median APACHE II score of 19 equates to a 90-day mortality of approximately 22% in critically ill patients.²²

^d The Glasgow Coma Scale score ranges from 3 to 15, with lower scores indicating a greater degree of neurologic dysfunction. A score of 14 most commonly indicates a patient who opens their eyes spontaneously and follows verbal commands but is confused.

^e Other than piperacillin-tazobactam or meropenem.

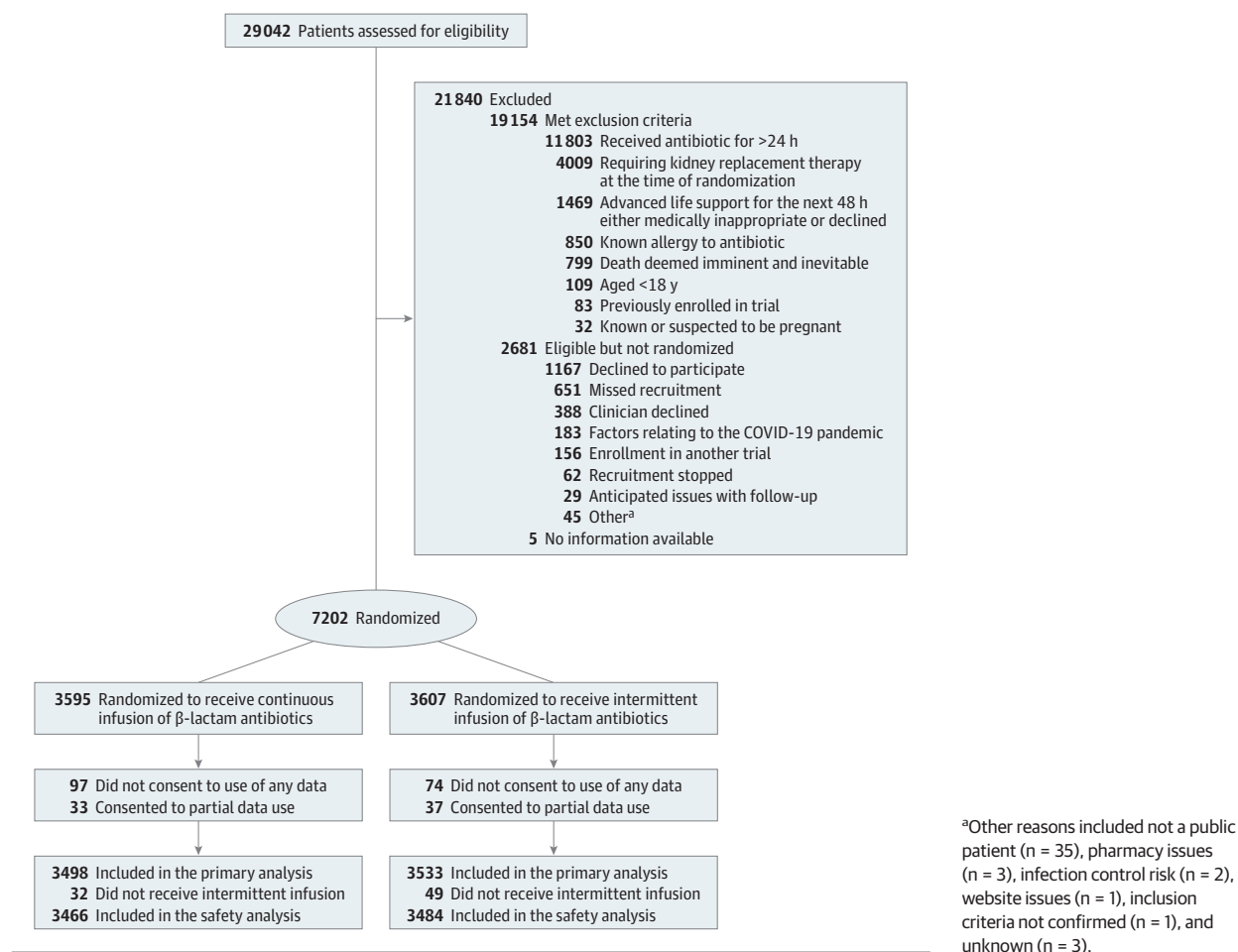
^f Other includes, for continuous vs intermittent infusion, respectively, musculoskeletal, 18 (0.5%) vs 20 (0.6%); oronasopharyngeal, 20 (0.6%) vs 15 (0.4%); intrathoracic, 15 (0.4%) vs 13 (0.4%); soft tissue, 13 (0.4%) vs 13 (0.4%); gynecological, 3 (0.1%) vs 2 (0.1%); ear/eye infection, 2 (0.1%) vs 2 (0.1%); infected graft/hardware, 2 (0.1%) vs 2 (0.1%); and unknown, 30 (0.9%) vs 35 (1.0%).

treatment course by day 14 without recommencement of antibiotic therapy within 48 hours of cessation for the same infectious episode (eMethods in Supplement 3); new acquisition, colonization, or infection with a multiresistant organism or *Clostridioides difficile* infection up to 14 days after randomization (eMethods in Supplement 3); all-cause ICU mortality; and all-cause hospital mortality. Tertiary outcomes were the number of days free of ICU, hospital, mechanical ventilation, and kidney replacement therapy up to 90 days after randomization.¹⁹ Study days are defined in the eMethods in Supplement 3. Drug reactions thought to have a causal relationship (ie, possible, probable, or definitely related) to the study-assigned administration method were reported as adverse events. Protocol deviations related to administration of the β -lactam antibiotic included predefined events (eMethods in Supplement 3).

Trial Population

A sample size of 7000 patients provided 90% power to detect an absolute difference of 3.5% in all-cause mortality at

Figure 1. Screening, Randomization, and Analysis of Study Participants in the BLING III Trial



90 days from an estimated baseline mortality of 27.5%, at an α of .05.²⁰ This calculation allowed for a rate of withdrawal and loss to follow-up of up to 5% of participants. Recruitment proceeded for 6 months at 13 sites after 7000 participants to facilitate recruitment in a prespecified pharmacokinetic-pharmacodynamic substudy.

Statistical Analysis

The effectiveness of the intervention was evaluated by a modified intention-to-treat analysis of all participants randomized to the trial where consent or approval to use their data was obtained, regardless of protocol adherence. This primary analysis consisted of logistic regression with treatment allocation as a fixed effect and trial site as a random effect. Results are presented as odds ratios (ORs) and 95% CIs and converted to absolute differences (ADs) in proportions.

The primary outcome was also examined in a prespecified adjusted analysis with the following covariates added to the main logistic regression model: sex, Acute Physiology and Chronic Health Evaluation Score (APACHE) II score (a severity of illness score ranging from 0 to 71, with higher scores indicating an increased risk of death) at randomization,²¹

source of admission (admitted following emergency or elective surgery vs other), and type of β -lactam antibiotic used before randomization (piperacillin-tazobactam or meropenem). Five prespecified subgroup analyses were also carried out according to the following prerandomization variables: presence vs absence of presumed pulmonary infection at baseline, type of β -lactam antibiotic first administered (piperacillin-tazobactam or meropenem), age (<65 years vs \geq 65 years), sex (male vs female), and low vs high severity of illness (defined by an APACHE II score at randomization <25 or \geq 25).^{15,19,24}

Secondary binary outcomes were analyzed using a similar logistic regression to the primary analysis. Tertiary duration outcomes were analyzed using linear regression. Time to discharge or cessation were summarized using a cumulative incidence function treating death as a competing risk, censored at 90 days. Intervention effects were estimated as hazard ratios and 95% CIs obtained from a cause-specific Cox model with a fixed effect of treatment and a random site effect. Proportions of patients with adverse events were compared using a Fisher exact test among patients who received 1 or more doses of the β -lactam antibiotic in the assigned treatment group.

Table 2. Reporting of Primary, Secondary, and Tertiary Outcomes

Outcome	Continuous infusion (n = 3498) ^a	Intermittent infusion (n = 3533) ^a	Absolute difference, % (95% CI)	Odds ratio or mean difference (95% CI)	P value ^b
Primary outcome					
All-cause mortality at day 90, No./total (%)	864/3474 (24.9)	939/3507 (26.8)	-1.9 (-4.9 to 1.1)	0.91 (0.81 to 1.01)	.08
Adjusted analysis			-2.2 (-5.5 to 1.1)	0.89 (0.79 to 0.99)	.04
Secondary outcomes					
Clinical cure at day 14, No./total (%)	1930/3467 (55.7)	1744/3491 (50.0)	5.7 (2.4 to 9.1)	1.26 (1.15 to 1.38)	<.001
New acquisition, colonization, or infection with an MRO or <i>C difficile</i> , No./total (%) ^c	253/3498 (7.2)	266/3533 (7.5)	-0.3 (-1.9 to 1.4)	0.96 (0.80 to 1.15)	.65
All-cause ICU mortality, No./total (%)	595/3474 (17.1)	645/3507 (18.4)	-1.3 (-4.0 to 1.4)	0.92 (0.81 to 1.04)	.35
All-cause hospital mortality, No./total (%)	808/3474 (23.3)	878/3507 (25.0)	-1.8 (-4.8 to 1.2)	0.91 (0.81 to 1.02)	.27
Tertiary outcomes					
Days alive and free of ICU up to day 90, mean (SD) [No.]	59.4 (33.9) [3481]	57.8 (34.2) [3516]	NA	1.5 (-0.1 to 3.0)	.18
Median (IQR)	78 (31 to 84)	76 (22 to 84)			
Days alive and free of hospital up to day 90, mean (SD) [No.]	42.4 (32.2) [3476]	40.6 (32.5) [3515]	NA	1.8 (0.3 to 3.3)	.08
Median (IQR)	52 (0 to 73)	48 (0 to 72)			
Days alive and free of mechanical ventilation up to day 90, mean (SD) [No.]	64.2 (34.5) [3486]	62.9 (34.8) [3520]	NA	1.2 (-0.4 to 2.8)	.28
Median (IQR)	84 (41 to 89)	83 (32 to 89)			
Days alive and free of KRT up to day 90, mean (SD) [No.]	71.2 (32.8) [3489]	70.2 (33.1) [3521]	NA	0.9 (-0.6 to 2.4)	.25
Median (IQR)	90 (70 to 90)	90 (54 to 90)			

Abbreviations: ICU, intensive care unit; KRT, kidney replacement therapy; MRO, multiresistant organism; NA, not applicable.

^a Descriptive statistics and odds ratio or mean difference are reported for all participants with available data by group. The group denominator for each outcome is reported.

^b P values for secondary and tertiary outcomes corrected with a Holm-Bonferroni adjustment.

^c The number and percentage of new acquisition, colonization, or infection with an MRO, excluding *Clostridioides difficile*, was 6.1% (213/3498) in the continuous infusion group and 6.6% (232/3533) in the intermittent infusion group.

There was no imputation of missing data across all analyses. All tests were 2-sided with a nominal significance level at 5%. Analyses of the primary outcome are unadjusted for multiplicity; however, the family-wise error rate was controlled across secondary outcomes (1 family) and tertiary outcomes (1 family) using a Holm-Bonferroni correction.²⁵ Analyses were performed using SAS Enterprise Guide 8.3, SAS version 9.4 (SAS Institute Inc).

Results

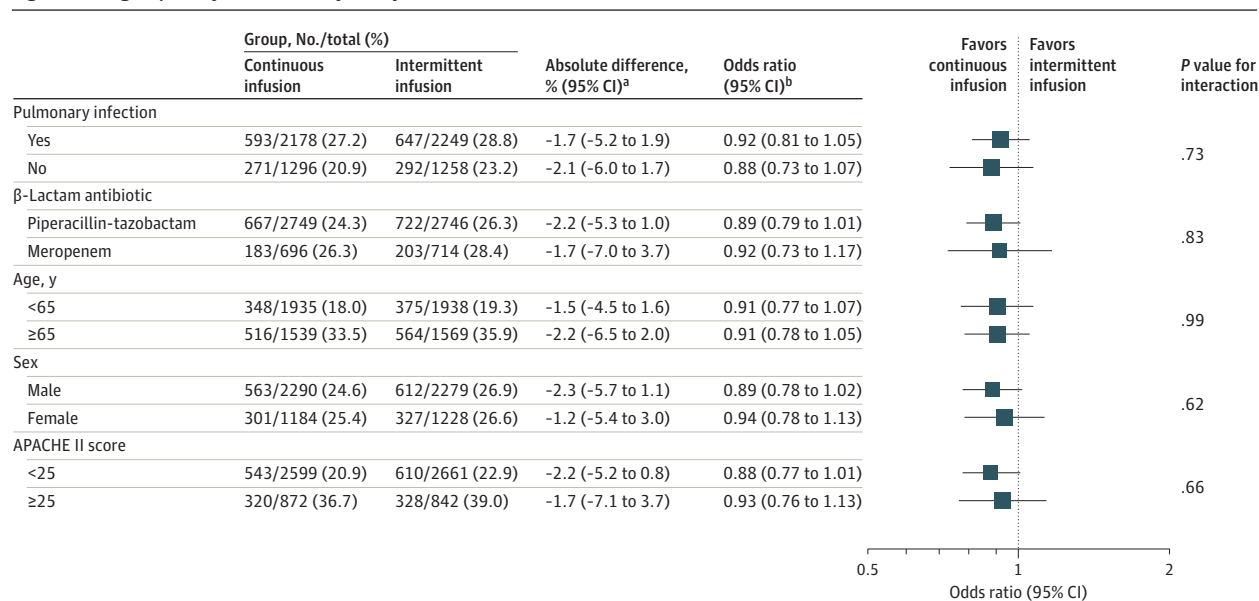
Trial Population

A total of 7202 participants were randomized, of whom 7031 with consent or approval to use data were included in the primary analysis (Figure 1). Of these, 6950 received at least 1 dose of the β -lactam antibiotic by allocation group and were included in the safety analysis. Enrollment by country and site is shown in eTable 1 in Supplement 3. The intervention and control groups had similar baseline characteristics (Table 1 and eTable 2 in Supplement 3).

Of 7026 participants, the most common primary sites of infection were pulmonary in 4181 participants (59.5%), intra-

abdominal in 916 (13.0%), blood in 562 (8.0%), and urinary in 380 (5.4%) (Table 1). Infective organisms for the primary site of infection are listed in eTable 3 in Supplement 3. Secondary and tertiary sites of infection and associated infective organisms are shown in eTables 4 through 6 in Supplement 3. The median duration of randomized treatment was 5.8 days (IQR, 3.1-10.2) and 5.7 days (IQR, 3.1-10.3) in the continuous and intermittent infusion groups, respectively (eTable 7 in Supplement 3). The median defined daily dose was 1.0 in both groups on the first whole day (day 2) post randomization with an IQR of 0.8 to 1.2 defined daily doses (eTable 7 in Supplement 3). The daily dose of study drugs was similar in both groups over the postrandomization treatment period up to day 16 (eFigures 1 and 2 in Supplement 3). The reasons for cessation of a β -lactam antibiotic are listed in eTable 8 in Supplement 3. Prior to randomization, 2658 of 3415 patients (77.8%) in the continuous infusion group and 2809 of 3445 (81.5%) in the intermittent group were prescribed the study drug by intermittent infusion (eTable 7 in Supplement 3). Other antibiotics administered in the 24 hours before randomization up to day 16 are listed in eTable 9 in Supplement 3; 16.2% (568/3498) and 14.0% (496/3533) in the continuous and intermittent infusion groups, respectively, did not receive any other antibiotics during this period.

Figure 2. Subgroup Analysis of Mortality at Day 90



APACHE indicates Acute Physiology and Chronic Health Evaluation Score.

^aAbsolute differences (95% CIs) were derived from the logistic regression by applying an inverse link transformation.

^bOdds ratios (95% CIs) were obtained from logistic regression with treatment group and the subgroup variable and its interaction with the treatment group as a fixed effect and site as a random effect.

Primary Outcome

At 90 days after randomization, 864 of 3474 patients (24.9%) randomized to the continuous infusion group and 939 of 3507 (26.8%) randomized to the intermittent infusion group had died (AD, -1.9% [95% CI, -4.9% to 1.1%]; OR, 0.91 [95% CI, 0.81 to 1.01]; $P = .08$); day 90 status was missing for 0.7% of participants (50/7031) (Table 2). After adjusting for prespecified covariates, the AD was -2.2% (95% CI, -5.5% to 1.1%; OR, 0.89 [95% CI, 0.79 to 0.99]; $P = .04$). The cumulative incidence function of time to death is shown in eFigure 3 in Supplement 3. There was no significant heterogeneity in the effect of the intervention assignment on mortality at 90 days in any of the 5 predefined subgroup pairs (Figure 2). The place and cause of death are listed in eTable 10 in Supplement 3.

Secondary Outcomes

There was a statistically significant difference in the rates of clinical cure at 14 days post randomization in favor of the continuous infusion group (AD, 5.7% [95% CI, 2.4% to 9.1%]; OR, 1.26 [95% CI, 1.15 to 1.38]). There were no statistically significant differences between groups in the rates of new acquisition, colonization, or infection with a multiresistant organism or *C difficile* infection (AD, -0.3% [95% CI, -1.9% to 1.4%]; OR, 0.96 [95% CI, 0.80 to 1.15]); ICU mortality (AD, -1.3% [95% CI, -4.0% to 1.4%]); and hospital mortality (AD, -1.8% [95% CI, -4.8% to 1.2%]).

Tertiary Outcomes

There were no statistical differences in days alive and free of ICU stay, hospital stay, mechanical ventilation, and kidney replacement therapy (Table 2). Daily participant disposition is shown in Figure 3 and cumulative incidence functions of time

to alive discharge from the index ICU and hospital admission are shown in eFigures 4 and 5 in Supplement 3.

Adverse Events

There were 10 adverse events in the continuous infusion group (0.3%) and 6 adverse events in the intermittent infusion group (0.2%), including 1 serious adverse event in the continuous infusion group (eTable 11 in Supplement 3). The serious adverse event was severe encephalopathy resulting in aspiration pneumonia, cardiac arrest, and death in the setting of septic shock. The event was assessed by site clinicians as possibly related to meropenem treatment. Administration by continuous infusion was hypothesized as potentially contributing to a higher minimum meropenem blood concentration leading to a higher cerebrospinal fluid concentration.

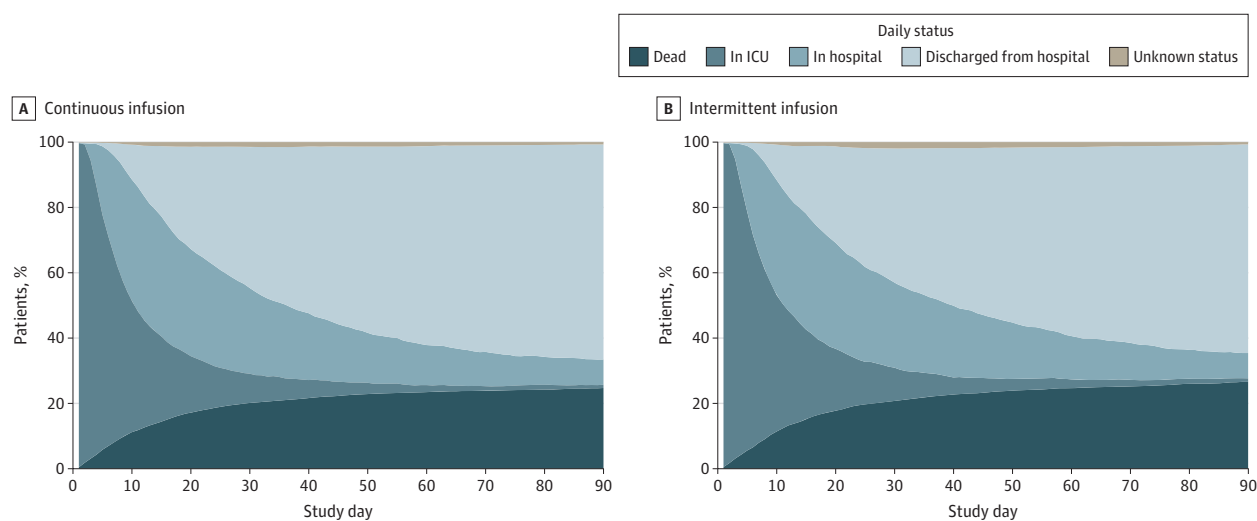
Protocol Deviations

There were no statistical differences in the proportions of protocol deviations in both groups (eTable 12 in Supplement 3).

Discussion

In this randomized clinical trial, the use of continuous compared with intermittent infusions of β -lactam antibiotics in critically ill patients with sepsis did not meet statistical significance in reducing mortality at 90 days. However, the confidence interval around the effect estimate includes a clinically important benefit. The observed absolute reduction in mortality of around 2 percentage points with the use of continuous infusion represents a number needed to treat of 50 patients to prevent 1 death. The clinical significance of this

Figure 3. Daily Participant Disposition



ICU indicates intensive care unit.

finding is further supported by increased rates of clinical cure in the continuous infusion group and consistent directional changes in point estimates across other secondary and tertiary outcomes.

This pragmatic trial has several strengths. An extensive body of work informed the design of the trial that included feasibility and phase 2 trials previously conducted by the BLING investigators.^{10,18} This work facilitated the establishment of an international collaboration to conduct the trial in multiple ICUs in 7 countries under routine clinical conditions over a relatively short trial inception period. The effect of continuous infusion of β -lactam antibiotics was assessed using a robust, patient-centered primary outcome that was not susceptible to adjudication bias. The definition of clinical cure used in this trial was also not susceptible to adjudication bias. The size of this trial greatly exceeded all previous trials. The recent Continuous Infusion vs Intermittent Administration of Meropenem in Critically Ill Patients (MERCY) trial (N = 607) comparing continuous and intermittent infusions of meropenem with double-dummy administration reported a difference of 2.5 percentage points in mortality at 28 days in favor of continuous infusions that is consistent with the current trial despite differences in mortality, rates of drug resistance, and trial end points.²⁶

Effective delivery of β -lactam antibiotics by continuous infusion present some practical considerations for patients treated in the ICU.^{27,28} Pharmacokinetic and pharmacodynamic considerations mandate that the same daily doses are used for both continuous and intermittent infusions.²⁷ While overall drug costs may remain consistent, the time taken to prepare and administer drugs with continuous infusions may be shorter than intermittent infusions,^{8,16,29} although this may be negated by a higher incidence of interruptions of continuous infusions for clinical reasons. Continuous infusions of carbapenems that require multiple infusions in a 24-hour period for drug stability reasons and use of dedicated infusion pumps

and intravenous portals pose additional pragmatic considerations, particularly in resource-limited environments.^{8,28-30} Consistent with previous trials, there were no observed differences in adverse events between continuous and intermittent infusions of β -lactam antibiotics.^{16,18,26,27}

Limitations

This study had some limitations. First, blinding was not feasible in a pragmatic trial of this size. This was mitigated by using a robust primary outcome and blinded outcome adjudication. Second, some participants may have been randomized despite having a noninfectious cause of organ dysfunction. Third, while this international study has high indices of external validity and generalizability, extrapolation of these results to regions with high levels of antibiotic resistance requires caution. Fourth, there was no adjustment for susceptibility to the β -lactam antibiotic or the impact of additional antibiotics and dosing strategies, although the groups were observed to have a high degree of baseline balance. Fifth, the difference in outcomes may have been reduced by the use of intermittent dosing prior to randomization in the continuous group and after ICU discharge. Sixth, these results relate to the use of continuous infusions primarily in a high-income ICU setting and extrapolation to low- and middle-income settings in and outside the ICU cannot be inferred.

Conclusions

The observed difference in 90-day mortality between continuous vs intermittent infusions of β -lactam antibiotics did not meet statistical significance in the primary analysis. However, the confidence interval around the effect estimate includes the possibility of both no important effect and a clinically important benefit in the use of continuous infusions in this group of patients.

ARTICLE INFORMATION

Accepted for Publication: May 7, 2024.

Published Online: June 12, 2024.

doi:10.1001/jama.2024.9779

Author Affiliations: Royal Brisbane and Women's Hospital, Brisbane, Queensland, Australia (Dulhunty, Cotta, Paterson, Roberts, Starr, Lipman); Redcliffe Hospital, Brisbane, Queensland, Australia (Dulhunty); The University of Queensland, Brisbane, Queensland, Australia (Dulhunty, Cotta, Paterson, Roberts, Lipman); Imperial College Healthcare NHS Trust, London, United Kingdom (Brett); Department of Surgery and Cancer, Imperial College London, London, United Kingdom (Brett); Department of Critical Care Medicine, Ghent University Hospital, Ghent, Belgium (De Waele); The George Institute for Global Health, The University of New South Wales, Sydney, New South Wales, Australia (Rajbhandari, Billot, Finfer, Hammond, Knowles, Liu, Mysore, Taylor, Myburgh); Infection Research Program, Hunter Medical Research Institute, University of Newcastle, Newcastle, New South Wales, Australia (Davis); Department of Infectious Diseases, John Hunter Hospital, Newcastle, New South Wales, Australia (Davis); School of Public Health, Imperial College London, United Kingdom (Finfer); Malcolm Fisher Department of Intensive Care, Royal North Shore Hospital, Sydney, New South Wales, Australia (Hammond); Auckland City Hospital, Auckland, New Zealand (McGuinness); Medical Research Institute of New Zealand, Wellington, New Zealand (McGuinness); Saw Swee Hock School of Public Health and Yong Loo Lin School of Medicine, National University of Singapore, Singapore (Paterson); The Queen Elizabeth Hospital, Adelaide, South Australia, Australia (Peake); School of Medicine, The University of Adelaide, Adelaide, South Australia, Australia (Peake); School of Epidemiology and Preventive Medicine, Monash University, Melbourne, Victoria, Australia (Peake); St George's University Hospitals NHS Foundation Trust, London, United Kingdom (Rhodes); St George's University of London, London, United Kingdom (Rhodes); Herston Infectious Diseases Institute, Metro North Health, Brisbane, Queensland, Australia (Roberts); Department of Anesthesiology, Critical Care, Pain, and Emergency Medicine, University Hospital of Nîmes, Nîmes, France (Roberts, Roger, Lipman); University of Montpellier, Montpellier, France (Roger); Blacktown Hospital, Sydney, New South Wales, Australia (Shirwadkar); Metro North Health, Brisbane, Queensland, Australia (Starr); St George Hospital, Sydney, New South Wales, Australia (Myburgh).

Author Contributions: Dr Dulhunty and Mr Billot had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Dulhunty, Brett, De Waele, Rajbhandari, Cotta, Davis, Finfer, Knowles, McGuinness, Paterson, Peake, Rhodes, Roberts, Shirwadkar, Starr, Taylor, Myburgh, Lipman.

Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Dulhunty, Rajbhandari, Myburgh.

Critical review of the manuscript for important intellectual content: All authors.

Statistical analysis: Billot, Liu, Mysore.

Obtained funding: Dulhunty, Brett, De Waele, Finfer, McGuinness, Paterson, Peake, Rhodes, Roberts, Roger, Myburgh, Lipman.

Administrative, technical, or material support: Dulhunty, Brett, Rajbhandari, Cotta, Hammond, Knowles, Rhodes, Roberts, Roger, Taylor, Myburgh, Lipman.

Supervision: Brett, De Waele, Billot, Myburgh, Lipman.

Conflict of Interest Disclosures: Dr Brett reported receiving consultancy fees from GSK to the university account for a project on real-world effectiveness of sotrovimab outside the submitted work. Dr De Waele reported receiving grants from Flanders Research Foundation Senior Clinical Investigator Fellowship during the conduct of the study and speaker activities and honoraria paid to the institution from Pfizer, MSD, Menarini, and Viatrix outside the submitted work. Dr Davis reported receiving a National Health and Medical Research Council Career Development Award (salary funding) during the conduct of the study. Dr Finfer reported receiving consulting fees from RevImmune Inc paid to his institution during the conduct of the study, stock options from Sepsis Scout outside the submitted work, and support from the National Health and Medical Research Council of Australia with a Leadership Fellowship. Dr Hammond reported receiving consulting fees from RevImmune Inc paid to her institution outside the submitted work and support from the National Health and Medical Research Council of Australia with an Emerging Leader grant. Dr Paterson reported receiving grants from Shionogi, Pfizer, Merck, BioVersys, bioMerieux, and Gilead and personal fees from Shionogi, Merck, GSK, bioMerieux, Cepheid, Aurobac, Arrepath, CARB-X, and AMR Action Fund outside the submitted work. Dr Rhodes reported receiving nonfinancial support from St George's University NHS Foundation Trust during the conduct of the study and serving as past chair of the sepsis guidelines committee and executive member of the Surviving Sepsis Campaign. Dr Roberts reported receiving personal fees from Qpex, Gilead, Advanz Pharma, Pfizer, Sandoz, MSD, Cipla, and bioMerieux and grants from Qpex, Pfizer, bioMerieux (provided e-Tests for bacterial susceptibility testing within the BLING III pharmacokinetic-pharmacodynamic substudy), and the British Society for Antimicrobial Chemotherapy outside the submitted work; Dr Roberts was supported by a Leadership Fellowship from the National Health and Medical Research Council of Australia and an Advancing Queensland Clinical Fellowship. He is also in receipt of a Centre of Research Excellence from the National Health and Medical Research Council of Australia. Dr Roger reported receiving personal fees from Shionogi, bioMerieux, AOP Orphan, MSD, Viatrix, Pfizer, Fresenius, and Advanz Pharma outside the submitted work. Dr Taylor reported being part owner of Health Technology Analysts Pty Ltd, which provides consulting services to pharmaceutical companies, medical device companies, and the Australian government. Dr Myburgh reported receiving support from a Leadership Fellowship from the National Health and Medical Research Council of Australia outside the submitted work. No other disclosures were reported.

Funding/Support: The George Institute for Global Health sponsored the study, generated the allocation sequence, and conducted the statistical analysis. The trial was funded by the National Health and Medical Research Council (Australia; APP1121481), the Belgian Health Care Knowledge Centre (KCE), the Health Research Council of New Zealand, the National Institute for Health and Care Research (United Kingdom), the University of Queensland (Malaysian sites), University Hospital of Nîmes (French sites), Skåne University Hospital (Swedish sites), and the US Food and Drug Administration (pharmacokinetic-pharmacodynamic substudy). The trial was endorsed by the Australian and New Zealand Intensive Care Society Clinical Trials Group, the Australasian Society for Infectious Diseases Clinical Research Network, and the European Society of Clinical Microbiology and Infectious Diseases and reviewed and supported by the Infection Section of the European Society of Intensive Care Medicine. In the United Kingdom, infrastructure support for this trial was provided to Dr Brett by the National Institute for Health and Care Research Imperial Biomedical Research Centre.

Role of the Funder/Sponsor: The funders had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Group Information: The collaborating investigators for the BLING III trial are listed in [Supplement 4](#).

Meeting Presentation: The study was presented at the Critical Care Reviews Meeting 2024; June 12, 2024; Belfast, United Kingdom.

Data Sharing Statement: See [Supplement 5](#).

Additional Contributions: We thank the trial participants and their families, the trial teams, and the independent data and safety monitoring committee: J. Duncan Young (chair), MD, University of Oxford, Oxford, United Kingdom, John Marshall, MD, St Michael's Hospital and University of Toronto, Toronto, Canada, and Tom van der Poll, MD, Amsterdam University Medical Centers, University of Amsterdam, Amsterdam, the Netherlands; the project support, data monitoring, data management, and legal teams at the George Institute for Global Health ([Supplement 3](#)); the University of Queensland project support team ([Supplement 3](#)); Farah Al-Beidh, BSc, PhD, and Janis Best-Lane, BSc, MRes (United Kingdom), Daisy Vermeiren, RN (Belgium and Europe), Sally Hurford, RN (New Zealand), Loubna Elotmani, MSc (France), Mohd Hafiz Abdul-Aziz, BPharm(Hons), PhD (Malaysia), and Frederik Sjövall, MD, PhD (Sweden), for regional coordination; and Greg Barton, BSc, MPhil (United Kingdom), for technical (drug stability) and project management support. Dr Al-Beidh, Ms Best-Lane, Ms Vermeiren, Ms Hurford, Ms Elotmani, and Dr Abdul-Aziz received salary support for their role in the trial; other named individuals did not receive compensation.

REFERENCES

1. Singer M, Deutschman CS, Seymour CW, et al. The Third International Consensus Definitions for

- Sepsis and Septic Shock (Sepsis-3). *JAMA*. 2016;315(8):801-810. doi:10.1001/jama.2016.0287
2. Rudd KE, Johnson SC, Agesa KM, et al. Global, regional, and national sepsis incidence and mortality, 1990-2017: analysis for the Global Burden of Disease Study. *Lancet*. 2020;395(10219):200-211. doi:10.1016/S0140-6736(19)32989-7
 3. Fleischmann-Struzek C, Mellhammar L, Rose N, et al. Incidence and mortality of hospital- and ICU-treated sepsis: results from an updated and expanded systematic review and meta-analysis. *Intensive Care Med*. 2020;46(8):1552-1562. doi:10.1007/s00134-020-06151-x
 4. Evans L, Rhodes A, Alhazzani W, et al. Surviving Sepsis Campaign: international guidelines for management of sepsis and septic shock 2021. *Intensive Care Med*. 2021;47(11):1181-1247. doi:10.1007/s00134-021-06506-y
 5. Dulhunty JM, Paterson D, Webb SAR, Lipman J. Antimicrobial utilisation in 37 Australian and New Zealand intensive care units. *Anaesth Intensive Care*. 2011;39(2):231-237. doi:10.1177/0310057X1103900212
 6. Roberts JA, Paul SK, Akova M, et al; DALI Study. DALI: defining antibiotic levels in intensive care unit patients: are current β -lactam antibiotic doses sufficient for critically ill patients? *Clin Infect Dis*. 2014;58(8):1072-1083. doi:10.1093/cid/ciu027
 7. Craig WA. Pharmacokinetic/pharmacodynamic parameters: rationale for antibacterial dosing of mice and men. *Clin Infect Dis*. 1998;26(1):1-10. doi:10.1086/516284
 8. Mouton JW, Vinks AA. Continuous infusion of beta-lactams. *Curr Opin Crit Care*. 2007;13(5):598-606. doi:10.1097/MCC.0b013e3282e2a98f
 9. Roberts JA, Webb S, Paterson D, Ho KM, Lipman J. A systematic review on clinical benefits of continuous administration of beta-lactam antibiotics. *Crit Care Med*. 2009;37(6):2071-2078. doi:10.1097/CCM.0b013e3281a0054d
 10. Dulhunty JM, Roberts JA, Davis JS, et al. Continuous infusion of beta-lactam antibiotics in severe sepsis: a multicenter double-blind, randomized controlled trial. *Clin Infect Dis*. 2013;56(2):236-244. doi:10.1093/cid/cis856
 11. Roberts JA, Kirkpatrick CM, Roberts MS, Robertson TA, Dalley AJ, Lipman J. Meropenem dosing in critically ill patients with sepsis and without renal dysfunction: intermittent bolus versus continuous administration? Monte Carlo dosing simulations and subcutaneous tissue distribution. *J Antimicrob Chemother*. 2009;64(1):142-150. doi:10.1093/jac/dkp139
 12. Chytra I, Stepan M, Benes J, et al. Clinical and microbiological efficacy of continuous versus intermittent application of meropenem in critically ill patients: a randomized open-label controlled trial. *Crit Care*. 2012;16(3):R113. doi:10.1186/cc11405
 13. Rhodes NJ, Liu J, O'Donnell JN, et al. Prolonged infusion piperacillin-tazobactam decreases mortality and improves outcomes in severely ill patients: results of a systematic review and meta-analysis. *Crit Care Med*. 2018;46(2):236-243. doi:10.1097/CCM.0000000000002836
 14. Vardakas KZ, Voulgaris GL, Maliaros A, Samonis G, Falagas ME. Prolonged versus short-term intravenous infusion of antipseudomonal β -lactams for patients with sepsis: a systematic review and meta-analysis of randomised trials. *Lancet Infect Dis*. 2018;18(1):108-120. doi:10.1016/S1473-3099(17)30615-1
 15. Roberts JA, Abdul-Aziz MH, Davis JS, et al. Continuous versus intermittent β -lactam infusion in severe sepsis: a meta-analysis of individual patient data from randomized trials. *Am J Respir Crit Care Med*. 2016;194(6):681-691. doi:10.1164/rccm.201601-00240C
 16. Thabet P, Joshi A, MacDonald E, et al. Clinical and pharmacokinetic/dynamic outcomes of prolonged infusions of beta-lactam antimicrobials: an overview of systematic reviews. *PLoS One*. 2021;16(1):e0244966. doi:10.1371/journal.pone.0244966
 17. Cotta MO, Dulhunty JM, Roberts JA, Myburgh J, Lipman J. Should β -lactam antibiotics be administered by continuous infusion in critically ill patients? a survey of Australia and New Zealand intensive care unit doctors and pharmacists. *Int J Antimicrob Agents*. 2016;47(6):436-438. doi:10.1016/j.ijantimicag.2016.02.017
 18. Dulhunty JM, Roberts JA, Davis JS, et al; BLING II Investigators for the ANZICS Clinical Trials Group. A multicenter randomized trial of continuous versus intermittent β -lactam infusion in severe sepsis. *Am J Respir Crit Care Med*. 2015;192(11):1298-1305. doi:10.1164/rccm.201505-0857OC
 19. Lipman J, Brett SJ, De Waele JJ, et al. A protocol for a phase 3 multicentre randomised controlled trial of continuous versus intermittent β -lactam antibiotic infusion in critically ill patients with sepsis: BLING III. *Crit Care Resusc*. 2019;21(1):63-68. doi:10.1016/S1441-2772(23)00582-3
 20. Billot L, Lipman J, Brett SJ, et al; BLING III Investigators. Statistical analysis plan for the BLING III study: a phase 3 multicentre randomised controlled trial of continuous versus intermittent β -lactam antibiotic infusion in critically ill patients with sepsis. *Crit Care Resusc*. 2023;23(3):273-284.
 21. Knaus WA, Draper EA, Wagner DP, Zimmerman JE. APACHE II: a severity of disease classification system. *Crit Care Med*. 1985;13(10):818-829. doi:10.1097/00003246-198510000-00009
 22. Finfer S, Micallef S, Hammond N, et al; PLUS Study Investigators and the Australian New Zealand Intensive Care Society Clinical Trials Group. Balanced multielectrolyte solution versus saline in critically ill adults. *N Engl J Med*. 2022;386(9):815-826. doi:10.1056/NEJMoa2114464
 23. WHO Collaborating Centre for Drug Statistics Methodology. ATC/DDD Index 2024. January 26, 2024. Accessed April 14, 2024. https://atcddd.fhi.no/atc_ddd_index/
 24. Taccone FS, Laupland KB, Montravers P. Continuous infusion of β -lactam antibiotics for all critically ill patients? *Intensive Care Med*. 2016;42(10):1604-1606. doi:10.1007/s00134-016-4241-7
 25. Holm S. A simple sequentially rejective multiple test procedure. *Scand J Stat Theory Appl*. 1979;6(2):65-70.
 26. Monti G, Bradic N, Marzaroli M, et al; MERCY Investigators. Continuous vs intermittent meropenem administration in critically ill patients with sepsis: the MERCY randomized clinical trial. *JAMA*. 2023;330(2):141-151. doi:10.1001/jama.2023.10598
 27. Roberts JA, Paratz J, Paratz E, Krueger WA, Lipman J. Continuous infusion of beta-lactam antibiotics in severe infections: a review of its role. *Int J Antimicrob Agents*. 2007;30(1):11-18. doi:10.1016/j.ijantimicag.2007.02.002
 28. De Waele JJ, Lipman J, Carlier M, Roberts JA. Subtleties in practical application of prolonged infusion of β -lactam antibiotics. *Int J Antimicrob Agents*. 2015;45(5):461-463. doi:10.1016/j.ijantimicag.2015.01.007
 29. Fawaz S, Barton S, Whitney L, Nabhani-Gebara S. Differential antibiotic dosing in critical care: survey on nurses' knowledge, perceptions and experience. *JAC Antimicrob Resist*. 2020;2(4):dlaa083. doi:10.1093/jacamr/dlaa083
 30. Berthoin K, Le Duff CS, Marchand-Brynaert J, Carryn S, Tulkens PM. Stability of meropenem and doripenem solutions for administration by continuous infusion. *J Antimicrob Chemother*. 2010;65(5):1073-1075. doi:10.1093/jac/dkq044