STUDY PROTOCOL

Protocol for a comparison study of 1-day versus 2-day prophylactic antibiotic administration in Holmium Laser enucleation of the prostate (HoLEP): a randomized controlled trial [version 1; peer review: 1 approved, 1 approved with reservations]

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Abstract

Background: The best method of antimicrobial prophylaxis administration for surgical site infection (SSI) in transurethral holmium laser resection and enucleation of the prostate (HoLEP)/bipolar transurethral enucleation (TUEB) remains controversial. The purpose of this study is to compare one-day and two-day cefazolin in a randomized 2nd phase study to help establish a protocol with a 95% confidence interval (CI) for SSI prevention.

Methods: Patients undergoing HoLEP/TUEB for benign prostate hyperplasia without preoperative pyuria will be enrolled and randomized to receive prophylactic antibiotic administration for HoLEP/TUEB in two groups, 1-day cefazolin and 2-day cefazolin. The primary endpoint is the occurrence rate of postoperative urinary tract infection or urogenital infection within 30 days after HoLEP/TUEB with a statistical 95% CI in comparison between those groups. Secondary outcomes include the kind of infectious disease and evidence of diagnosis, day of diagnosis of infectious disease, performance of urine or blood culture, detection of bacteria, treatments, duration of treatments, AEs other than surgical site infection, and drug-induced AEs.

Discussion: The results of this study will provide evidence for defining the optimal duration of cefazolin prophylactic antibiotic administration for SSI.

Trial registration: This study was registered in the University Hospital Medical Information Network-Clinical Trial Registry (UMIN000027955) based on recommendations from the International Committee of Medical Journal Editors (ICMJE) on July 1st, 2017.
Keywords
HoLEP, Transurethral resection of the prostate, prophylactic antibiotic administration

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Competing interests: No competing interests were disclosed.

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Trial registration
This study is registered in the University Hospital Medical Information Network-Clinical Trial Registry (UMIN000027955) based on recommendations from the International Committee of Medical Journal Editors (ICMJE).

Methods
Study sites
Patients recruitment began on May 1st 2018 and will continue up to April 30th 2021 from the institutions of Kobe University Hospital, Kobe University International Clinical Cancer Research Center, Hara Genitourinary Hospital, Shinko Memorial Hospital, Hyogo prefectural Amagasaki General Medical Center, Kobe City Medical Center West Hospital, Kakogawa Central City Hospital and Hyogo Prefectural Kakogawa Medical Center. Those patients undergoing HoLEP/TUEB for BPH without preoperative pyuria will be enrolled. Preoperative pyuria will be defined as 5 or more white blood cells (WBC)/higher power field (HPF). Since PAA duration is limited to 72 h or less in TURP and 48h or less in HoLEP or TUEB, we will carry out a randomized study of 1-day and 2-day PAA for HoLEP/TUEB using cefazolin (CEZ). This is a feasible randomized 2nd phase study to help design further confirmatory studies evaluating the differences of SSI occurrence rate with a 95% confidential interval.

Eligibility criteria
Selection criteria
In the period from May 1st 2018 to April 30th 2021, patients 20 years old or older undergoing HoLEP/TUEB without preoperative pyuria and bacteriuria will be enrolled. Pyuria will be defined as 5 ≥WBC/HPF or ≥10/ μl (flowcytometer) preoperatively.

Exclusion criteria
i) Patients who have undergone another procedure such as prostate biopsy or bladder urolithiasis at the time of HoLEP/TUEB. ii) Those with an indwelling urethral catheter. iii) Those with an allergy to CEZ. iv) Hemodialysis patients.

Interventions
Eligible patients will be randomized in equal proportions between 1-day and 2-day PAA for HoLEP/TUEB using cefazolin (CEZ).

Outcomes
Primary endpoint
Primary endpoint is to compare SSI occurrence rate in both 2 groups.

Secondary endpoints
In cases where perioperative infection requires antibiotic therapies, the following information will be recorded. 1) The kind of infection and reasons for the diagnosis; 2) Occurrence data of such infection; 3) Blood culture and urine culture; 4) Identified bacteria; 5) Methods of therapies; 6) Duration of therapies; 7) Other postoperative complications than infectious ones; 8) Drug-induced adverse events.

Feasible purpose
This is a feasible randomized study to investigate the occurrence rate of postoperative UTI or urogenital infection within 30 days after HoLEP/TUEB with an estimated 95% CI, and will be followed by confirmatory studies.

Participant timeline (See Table 1)
Sample size
For a feasible randomized comparing study, the target sample size is n=180 (1 day: n=90 and 2 days: n=90). The sample calculation was performed as follows: this study is a feasibility study. We referred to the following study which examined their 164 TURP and HoLEP cases, and found the postoperative infectious complications in 7/72 cases (9.7%) and 2/72 cases (2.8%), respectively. Accordingly, if we estimate 3 or 4 cases of UTI or urogenital

Abbreviation
SSI: surgical site infection; HoLEP: Holmium laser resection and enucleation of the prostate; TUEB: bipolar transurethral enucleation; CI: confidence interval; TURP: Transurethral resection of the BPH: prostate; benign prostate hyperplasia; UTI: urinary tract infection; PAA: prophylactic antibiotic administration; CEZ: cefazolin

1. Patients 20 years old or older undergoing HoLEP/TUEB without preoperative pyuria and bacteriuria will be enrolled. Pyuria will be defined as 5 ≥WBC/HPF or ≥10/ μl (flowcytometer) preoperatively.

2. Exclusion criteria
   i. Patients who have undergone another procedure such as prostate biopsy or bladder urolithiasis at the time of HoLEP/TUEB.
   ii. Those with an indwelling urethral catheter.
   iii. Those with an allergy to CEZ.
   iv. Hemodialysis patients.

3. Interventions
   Eligible patients will be randomized in equal proportions between 1-day and 2-day PAA for HoLEP/TUEB using cefazolin (CEZ).

4. Outcomes
   Primary endpoint
   Primary endpoint is to compare SSI occurrence rate in both 2 groups.

5. Secondary endpoints
   In cases where perioperative infection requires antibiotic therapies, the following information will be recorded. 1) The kind of infection and reasons for the diagnosis; 2) Occurrence data of such infection; 3) Blood culture and urine culture; 4) Identified bacteria; 5) Methods of therapies; 6) Duration of therapies; 7) Other postoperative complications than infectious ones; 8) Drug-induced adverse events.

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<table>
<thead>
<tr>
<th>Items</th>
<th>Preoperative observation period</th>
<th>Day of dosing (surgery day)</th>
<th>Postoperative observation period</th>
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<tbody>
<tr>
<td>Term</td>
<td>Hospitalized day</td>
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<td>1st day after administration</td>
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<td>Confirmation of patients' background</td>
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<td>Antibiotic administration (one-day group)</td>
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<td>Antibiotic administration (2-days group)</td>
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<td>Subjective symptom/ objective findings</td>
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<td>Observation of adverse events including infectious complications$^a$</td>
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<td>Biochemical examination</td>
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<td>Urinalysis$^c$</td>
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<td>Urine culture</td>
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○: Items to be done before antibiotic administration; ●: Items to be done after antibiotic administration

a: Adverse events are not necessarily associated with antibiotics.
b: Hematological examination consists of hematological laboratory tests, biochemical laboratory tests and urinalysis to check the safety of the tested antibiotics and includes white blood cell (WBC) and differential white blood count as inflammatory markers. The volume for hematological laboratory tests is 8ml.
c: Biochemical laboratory tests use CRP as inflammatory markers, which is performed within the range of daily clinical examination.
d: Urinalysis includes white blood cell (WBC) and bacteriuria as inflammatory markers. These tests are done as a confirmation safety check for this study.
infectious complication within 30 days after HoLEP, the occurrence frequencies for a 95% confidence interval (CI) are 0.007-0.094 and 0.012-0.111, respectively. The upper limit of a 95% CI is 10% or so, and it may be useful for planning the next study to set them as in Jhanwar et al.\(^7\).

**Statistical analysis**
Analysis of study participants’ background:
The difference between groups will be analyzed by the following methods:
Pearson’s chi-square: nominal variables; Fisher’s direct probability calculation method is performed where the expected frequency of less than 5 is 20% or higher; T-tests will be done for continuous variables. The Significance standard is set as 5% in two-sided tests.

**Recruitment strategy**
Recruitment will be performed from the patients with indication of HoLEP in those institutions participated in this study. Randomization will be performed by a table of random numbers as a simple randomized study under the control of the responsible party (Dr. Yuzo Nakano, Department of Urology, Kobe University Hospital).

**Allocation**
Participants will be randomly assigned to either 1-day or 2-days antibiotic group with a 1:1 allocation as per a computer-generated randomization schedule.

**Blinding**
Assessments regarding clinical recovery will be conducted by Dr. Yuzo Nakano blind to treatment allocation. Due to the nature of the intervention neither participants nor staff can be blinded to allocation, but are strongly inculcated not to disclose the allocation status of the participant at the follow up assessments. An employee outside the research team will feed data into the computer in separate datasheets so that the researchers can analyse data without having access to information about the allocation

**Assignment of intervention**
**Tested antibiotics**
1st generation cephalosporine : Cefazolin Sodium Hydrate (J01DB04)

**Method of administration**
Patients will be randomly divided into a 1-day group (CEZ 1g, once per i.v. just before HoLEP/TUEB) and a 2-day group (CEZ 1g, i.v. just before HoLEP/TUEB with a repeat dose the next morning). Comparison of SSI occurrence in these 2 groups is a feasible randomization study.

**Outline of study**

i) One-day dosing: i.v. initiation of CEZ (1g) 30 min prior to surgery, completed in 30–60 min (with no any other antibiotic administration)

ii) Two-day dosing: i.v. initiation of CEZ (1g) 30 min prior to surgery, completed in 30–60 min, repeated every 12 hours for 2 days including the surgery day. Additional dosing is necessary in cases with 3 hours or longer of surgery time. Test items and schedule of this study is shown in Table 1.

**Study therapy**
To investigate the inhibiting effect of cefazolin (CEZ) 1-day and 2-day administration on perioperative infectious complications in HoLEP with a calculated 95% CI.

**Combination medicine**
Exclusion criteria include use of other antibiotics or cases requiring an additional antibiotic.

**Termination of antibiotic administration**
Cases exhibiting or suspicious for drug-induced allergy.

**Assignment of interventions (for controlled trials)**
**Management and delivery of study drug**
Applicants will be contacted by fax or e-mail and then given either 1-day or 2-day CEZ under randomization as described above.

**Post-test treatments**
In cases where the attending physician diagnoses a perioperative infectious complication, the doctor can treat at discretion, including i.v. for severe cases and oral antibiotics for mild cases.

**Evaluating items**
We will gather the following data from the medical records.

i) Patients’ background factors
Age, Body Mass Index (BMI), Preoperative IPSS/QOL・Qmax・residual urine volume (ml), Estimated prostate volume(ml), Preoperative PSA, ASA-PS, Diabetes mellitus (HbA1c, blood sugar control), Chemotherapy and immune-suppressants

ii) Surgery-related categories
Surgical time (min, including morcellation), Resected prostate weight (g), Catheterized period (days), Post-operative residual urine volume (ml): until 30 days after surgery, Duration of antibiotic administration (1 day or 2 days)

iii) Postoperative infectious complications
Investigation for 30 days after surgery (need to record), UTI or urogenital infection (prostatitis, epididymitis or pyelonephritis), Postoperative complication other than infectious ones, Occurrence date, Cases with infectious complications requiring additional antibiotic therapy, Detail of infection and the diagnosing evidence, Infection occurrence date, Urine culture and blood culture, Detected bacteria, Therapy, Therapeutic duration, and Days needed to reduce pyuria

**Screening tests**
Screening tests will be done to check the following criteria i) and ii).

i) Enrollment criteria
Those patients who are older than 20 years old undergoing HoLEP for benign prostate hyperplasia (BPH) without pyuria* or
bacteriuria preoperatively and with informed consent. *Definition of pyuria: WBC ≥ 5/hpf in urine (under microscopy) or WBC ≥ 10/ul in urine (flowcytometry)

ii) Exclusion criteria: see above

Information on participants
The following information will be recorded at the time of informed consent acquisition and screening tests.

i) Date of informed consent acquisition; ii) Class card number of study participants; iii) Backgrounds of study participants, birth date, age, height, body weight, past history, complication (underlying disease), iv) Present illness: date of definitive diagnosis, risk scoring, family history

Items for observation/ tests/ evaluation
Subjective symptom/ objective findings
Observation of adverse events including infectious complications, blood pressure, heart rate, body weight, hematology examination, blood biochemical examination, urinalysis, chest X-ray, ECG, urine culture

Patients' background
Age, body mass index (BMI), preoperative PSS/QOL, Qmax, residual urine volume (ml), estimated prostate weight (ml), preoperative PSA, ASA-PS, diabetes mellitus (HbA<sub>1c</sub>, blood sugar control), chemotherapy or immune-suppressants,

Surgery-related items
Surgical time (min; including morcellation time), resected prostate weight (g), duration (days) to removal of urethral catheter postoperatively, Postoperative residual urine volume (ml) till 30-days after surgery, duration of prophylactic antibiotic administration (CEZ) : 1-day or 2-days group

Items for postoperative perioperative infection and complications: Examination till 30-days after surgery
UTI and urogenital infection (prostatitis, epididymitis and pyelonephritis), postoperative adverse events including infectious ones, except postoperative infection, occurrence date.

In cases with perioperative infection who need antibiotic therapies, the details include bacterial information (see above).

Cancellation criteria
i) Those cases who are not willing to continue this study and/or wish to withdraw informed consent. ii) Those cases who are found not to be satisfied about their applicability to this study or who cannot continue the study owing to the occurrence of complications and/or exacerbation. iii) Those cases who cannot continue the study owing to study-related adverse events. iv) The study itself is canceled. v) Cases with uncontrollable infectious complications postoperatively. vi) PIs or the members of this research judge that cancelation is needed owing to other reasons.

Study period
May 1<sup>st</sup> 2018 to April 30<sup>th</sup> 2021; the follow-up period is 1 year afterwards.

Analysis of efficacy
Main analysis
We will estimate the difference in postoperative infection occurrence rate at the 95% CI and do the 5% two-sided test for Significant for such differences.

Interim analysis
This study needs interim analysis because it is planned as a feasible randomized study.

That is, once 45 cases are completed, the occurrence rate of postoperative infection can be compared in the 2 groups and to determine if there is less than a 5% of difference and then to continue if the difference is 5% or less.

Ethics and dissemination
Ethical consideration and consent
This protocol was approved by the Institutional review board of the Kobe University Graduate School of Medicine (C180043). All procedures were in compliance with the relevant laws and guidelines in accordance with the ethical standards of the Declaration of Helsinki.

This study was registered in the University Hospital Medical Information Network-Clinical Trial Registry (UMIN000027955) based on recommendations from the International Committee of Medical Journal Editors (ICMJE) on July 1<sup>st</sup> 2017.

Protocol amendments
Any modifications to the protocol which may impact on the conduct of the study, potential benefit of the patient or may affect patient safety, including changes of study objectives, study design, patient population, sample sizes, study procedures, or significant administrative aspects will require a formal amendment to the protocol. Such amendment will be approved by the Ethics Committee/IRB (institutional review board) prior to implementation and notified to the health authorities in accordance with local regulations. Administrative changes of the protocol are minor corrections and/or clarifications that have no effect on the way the study is to be conducted. These administrative changes will be agreed upon by Ethics Committee/IRB, and will be documented in a memorandum. The Ethics Committee/IRB may be notified of administrative changes at the discretion of Helsinki Declaration.

Consent of assent
A trained research doctor will introduce the trial to patients who will be shown an informed consent form regarding the main aspects of the trial. Research doctors will discuss the trial with patients in light of the information provided in information sheets. Patients will then be able to have an informed discussion with the participating consultant. Research doctors will obtain written consent from patients willing to participate in the trial. Information sheets and consent forms are provided for all
patients (Extended data’). All information sheets and consent forms transcripts have been translated into Japanese.

Confidentiality
All study-related information will be stored securely at the study site. All participant information will be stored in locked file cabinets in areas with limited access. All laboratory specimens, reports, data collection, process, and administrative forms will be identified by a coded ID number only to maintain participant confidentiality. All records that contain names or other personal identifiers, such as locator forms and informed consent forms, will be stored separately from study records identified by code number. All local databases will be secured with password-protected access systems. Forms, lists, logbooks, appointment books, and any other listings that link participant ID numbers to other identifying information will be stored in a separate, locked file in an area with limited access.

Access to data
The Data Management Coordinating Center will oversee the intra-study data sharing process, with input from the Data Management Subcommittee. All Principal Investigators will be given access to the cleaned data sets. Project data sets will be housed on the Project Accept Web site and/or the file transfer protocol site created for the study, and all data sets will be password protected. Project Principal Investigators will have direct access to their own site’s data sets, and will have access to other sites data by request. To ensure confidentiality, data dispersed to project team members will be blinded of any identifying participant information.

Ancillary and post-trial care
Patients that are enrolled into the study are covered by national health insurance in all the tests and treatments including the ones performed additionally owing to the adverse events of this study.

Dissemination policy
We plan to disseminate the information of this study through the UMIN and our department homepage.

Study status
The study is now undergoing pre-recruitment for participants (recruitment started May 1st, 2018).

Discussion
This study is designed to address the following issues:

1) AMR: antimicrobial resistance action plan
WHO suggested the AMR action plan in 2015 based on recent trends of emergence of antibiotic resistant bacteria in infectious diseases. Many researchers suggest that inappropriate antibiotic use may cause this problem. Inappropriate antibiotic prescriptions are often seen, for instance in upper respiratory infections which is caused by not only bacteria but also virus5. Accordingly, the Japanese government suggested an AMR action plan aiming at a 50% decrease in the use of oral antibiotic such as cephalosporines or macrolides6. The chief justification for the preventive use of antibiotics is for the purpose of inhibiting postoperative infectious complications. Not only surgery, but interventional examinations such as transrectal prostate biopsy require antibiotics. There are many reports on the efficacy of PAA to inhibit SSI when compared with no use of antibiotics11,12.

2) Duration of PAA
Considering the two contradictory concepts mentioned above, what we should do next is to determine how to safely decrease antibiotic use without affecting or increasing the SSI occurrence rate. Another thing we need to consider is that long term antibiotic use can cause untreatable infections by antibiotic-resistant strains11. Therefore, this kind of prospective study is a valuable way to learn how to decrease antibiotic use safely.

3) Semi-contaminated
Many guidelines say that surgeries need to be classified according to the extent of pre-surgical pollution, infection, or bacterial colonization. Especially in urological cases, the concept of clean-contaminated operation exists when opening the urinary tract with the possibility of urine dissemination. Preoperative pyuria or bacteriuria should be checked in advance pre-operatively and treated before surgery, including confirmation of absence of such infection in order to decrease the risk of SSI.

4) HoLEP in Japan
Most of the prospective studies on how to decrease antibiotic use, for instance comparisons between 1-day and 3-day prophylactic antibiotic administration (PAA) for urological surgeries such as TUR-P in prospective 2-group or double-blind studies are from western countries13. We should not forget the differences in medical systems and standards between countries13. Arguably, individual studies need to be designed or undertaken in each country or region with the same or similar medical systems. For instance, one major difference between most western countries versus Korea and Japan is that high volume surgical centers are more common in the west, and thus the number of surgical cases per surgeons is higher in the west than Japan. High volume centers expect shorter surgical times, which can affect SSI occurrence16. These issues support the necessity of our study.

5) Prior studies as evidence for drawing up guidelines
There are several studies regarding the optimal PAA duration period17,18. However, we need to decrease the variation in patients’ backgrounds in such studies; How many patients with preoperative UTI cases that need to be controlled before surgery. There is no definitive study for comparison between controlled and uncontrolled preoperative UTI caused by retention19 and SSI occurrence after HoLEP. Also, case numbers are limited; so, variations in patient criteria and the surgeons’ experience cannot be ignored.

6) Sample size
This kind of prospective feasibility study needs a setting with the necessary case numbers for analysis. A similar study referred to above had 164 cases for comparison in 2 groups with TUR-P
and HoLEP for SSI occurrence, with SSI occurrence after HoLEP being 2/72 cases (2.8%). We therefore anticipate 180 cases (90 cases per arm) for a feasibility study with 95% CI for the future design of a prospective double blind non-inferiority study. To our knowledge, no definitive study with one-day PAA for HoLEP has been performed so, we have designed this study as a comparison with 2-days dosing.

7) Study setting
In most retrospective studies, the study period for patients’ enrollment may be different. For instance, comparing TUR-P and HoLEP, HoLEP is a comparatively newer technique leading to the possibility of selection bias for HoLEP surgeons with TUR-P experience and this may influence the results of SSI occurrence. To reduce selection bias, prospective studies where not only patients but also surgeons have similar backgrounds, should be undertaken for definitive conclusions with high evidence level.

8) Significance and problems with prospective studies
Many guidelines refer to prospective studies as providing a high evidence level. However, prospective randomized studies with intervention may be more difficult to perform. In Japan, apart from research by medical doctors, publication of scientific papers in the medical field is decreasing. IRB referees need to be strict about study approval and this can make things more complicated for prospective clinical interventional studies. Protocol papers will help researchers plan, design and perform clinical studies. This study describes a comparison study of PAA for HoLEP with 1-day and 2-day dosing and help to establish a protocol for PAA taking into account decreasing unnecessary antimicrobial use to prevent the development of AMR.

Data availability
Underlying data
All data underlying the results are available as part of the article and no additional source data are required

Extended data
The consent form and information sheet that will be used in this study is available from Harvard Dataverse

Harvard Dataverse: Extended data. Replication data for Protocol for a comparison study of 1-day versus 2-day prophylactic antibiotic administration in Holmium Laser enucleation of the prostate (HoLEP): a randomized controlled trial https://doi.org/10.7910/DVN/SGTWJN8

License: CCO 1.0 Universal

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The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

References


PubMed Abstract | Publisher Full Text

PubMed Abstract | Publisher Full Text

PubMed Abstract

19. Chen JS, Chang CH, Yang WH, et al.: Acute urinary retention increases the risk
Open Peer Review

Current Peer Review Status: 

Version 1

Reviewer Report 02 May 2019

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Florian Wagenlehner
Clinic & Policlinic for Urology, Pediatric Urology & Andrology, Justus-Liebig University, Giessen, Germany

The authors submitted a protocol studying two different prophylactic regimens in patients undergoing Holmium Laser enucleation of the prostate. The study is randomized.

The topic of the study is worth while studying, as there are relatively little data especially in laser enucleation of the prostate.

The study design is well described and set up, including the important in- and exclusion criteria. There is one exclusion criterium leucocyturia, which should be reconsidered, as especially patients with large prostates, might have elevated leucocytes in their urine, and those patients would not be included in the study, although holmium laser enucleation is especially done in patients with large prostates.

Is the rationale for, and objectives of, the study clearly described?
Yes

Is the study design appropriate for the research question?
Yes

Are sufficient details of the methods provided to allow replication by others?
Yes

Are the datasets clearly presented in a useable and accessible format?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: infections of the urogenital tract

I have read this submission. I believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.
Katsumi Shigemura, Kobe University Graduate School of Health Science, Kobe, Japan

Thanks, we added the patients with leucocyturia and reflected on the text (See in Eligibility criteria). We revised as same way in another part (See in Screening test).

Competing Interests: No competing interests were disclosed.

Seung-Ju Lee
Department of Urology, St Vincent's Hospital, The Catholic University of Korea, Paldal-gu, Suwon, South Korea

This study protocol aims to establish optimal duration of cefazolin antibiotic prophylaxis prior to HoLEP procedure. The rationale and objective of the study protocol is clearly defined and the overall study design looks appropriate. Regarding details of the method, I have a couple of queries.

- First, one-day dosing and single-dose dosing should be distinguished. If you look at your protocol, it's single-dose (CEZ 1g, once per i.v. just before HoLEP/TUEB). However, the study title is 1-day vs. 2-day. Cefazolin is a cephalosporin antibiotic and is time-dependent. Therefore, 1-day (two or three doses per a day) and single-dose are different dosages.

- Second, most studies select a 3-day regimen as a comparator. Why did you choose 2-day? The reason for comparing the 2-day regimen in this study should be more clear.

Is the rationale for, and objectives of, the study clearly described?
Yes

Is the study design appropriate for the research question?
Yes

Are sufficient details of the methods provided to allow replication by others?
No

Are the datasets clearly presented in a useable and accessible format?
Yes

Competing Interests: No competing interests were disclosed.
**Reviewer Expertise:** Antimicrobial prophylaxis for urological surgeries

I have read this submission. I believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

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**Author Response 30 Apr 2019**

Katsumi Shigemura, Kobe University Graduate School of Health Science, Kobe, Japan

First, one-day dosing and single-dose dosing should be distinguished. If you look at your protocol, it's single-dose (CEZ 1g, once per i.v. just before HoLEP/TUEB). However, the study title is 1-day vs. 2-day. Cefazolin is a cephalosporin antibiotic and is time-dependent. Therefore, 1-day (two or three doses per a day) and single-dose are different dosages.

(Amendment)
Thanks, our 1-day protocol means single-dose protocol.

Second, most studies select a 3-day regimen as a comparator. Why did you choose 2-day? The reason for comparing the 2-day regimen in this study should be more clear.

(Amendment)

**Competing Interests:** No competing interests were disclosed.

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**Author Response 02 May 2019**

Katsumi Shigemura, Kobe University Graduate School of Health Science, Kobe, Japan

And my previous comment (single dose) were reflected in the text (See in many places including title)

Next comment (most studies select a 3-day regimen as a comparator. Why did you choose 2-day? The reason for comparing the 2-day regimen in this study should be more clear.): We reflected on the text (See in 4) HoLEP in Japan in Discussion.

**Competing Interests:** No competing interests were disclosed.

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**Author Response 03 May 2019**

Katsumi Shigemura, Kobe University Graduate School of Health Science, Kobe, Japan

I have posted new version of manuscript.
I have posted new version of manuscript.

**Competing Interests:** No competing interests were disclosed.

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