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Data Article

Data in Brief of: Clinical benefits of moxifloxacin as initial treatment of community-acquired pneumonia: Data from meta-analyses

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ABSTRACT

Moxifloxacin and levofloxacin are currently recommended as empirical initial treatment options for community-acquired pneumonia (CAP) in China by clinical guidelines and widely used in clinical settings. Several clinical outcomes comparing the efficacy and safety profiles of moxifloxacin versus levofloxacin through a meta-analysis were reported in paper 'Clinical benefits and cost-effectiveness of moxifloxacin as initial treatment for community-acquired pneumonia: a meta-analysis and economic evaluation'. In this dataset, we aimed at investigating more clinical endpoints comparing the efficacy and safety of moxifloxacin and levofloxacin in the treatment of CAP.

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Specification Table

Subject	Pulmonary and Respiratory Medicine
Specific subject area	Community-acquired pneumonia
Type of data	Table Figure
How data were acquired	Data were collected through literature review, and analyzed through Review Manager 5.4 (RevMan; The Cochrane Collaboration, 2014) and R (version 3.5.2)
Data format	Analyzed
Parameters for data collection	Sample: community-acquired pneumonia patients using either moxifloxacin or levofloxacin as initial empirical therapeutic drug Parameters: drug regimen, enrolled population, age, ethnicity, treatment duration, severity of CAP, response rate during 3∼5 days of treatment, response rate at test-of-cure visit, incidence of any drug-related adverse events, fever release time, cough disappear time, pulmonary rales disappear time, shortness of breath release time, duration of $\geq$ 50% improvement in radiologic findings, duration of white blood cell (WBC) count decrease to normal level, hospital length-of-stay
Description of data collection	Data were collected through literature review
Data source location	China, United States, Argentina, Belgium, Chile, Colombia, Germany, Spain, France, United Kingdom, Greece, Israel, Lithuania, Mexico, The Netherlands, Peru, Poland, Sweden, South Africa
Data accessibility	In the ARTICLE
Related research article	Du X, Han Y, Jian Y, Chen L, Xuan J, Clinical benefits and cost-effectiveness of moxifloxacin as initial treatment for community-acquired pneumonia: a meta-analysis and economic evaluation, Clin Ther. In Press.

Value of the Data

- Moxifloxacin and levofloxacin are all recommended for the initial empirical treatment of community-acquired pneumonia by guidelines released by Infectious Diseases Society of America/American Thoracic Society and Chinese Thoracic Society [1,2]. Both of the above antibiotics are widely used in the initial treatment of CAP in clinical settings in China. It is very crucial to select optimal empirical initial anti-infective agents to effectively and safely control the infection, which helps in minimizing mortality and the risk of antibiotic resistance. Our dataset aimed to compare the effectiveness and safety of moxifloxacin and levofloxacin by meta-analysis, aiming to find the preferable antibiotics in the initial treatment of CAP.
- Several clinical trials have compared the efficacy and safety of moxifloxacin and levofloxacin as the initial empirical treatment of CAP, but mostly are single-centered trials and high-quality evidence is still sparse. The pooled data used in the meta-analysis would provide a more precise estimate of the effect size and increases the generalizability of the efficacy and safety outcomes of moxifloxacin and levofloxacin in the treatment of CAP.
- Clinical benefits data of moxifloxacin reported in this Data in Brief paper and its related research article may hopefully give further useful information in choosing anti-infective therapy of CAP.

1. Data Description

This dataset gives details and explanations about the enrolled population, drug regimens and statistical analysis techniques. These data are expressed as figures and tables.

- Table 1 describes the search strategy applied to bibliographic databases in literature search.
- Table 2 describes the characteristics and JADAD score of included RCTs in meta-analysis.
- Table 3 describes the results from meta-analysis.
- Table 4 describes the JADAD score calculation and assessment guideline.

Table 1
Search strategy.

Database	Search Strategy
PubMed	((moxifloxacin [Title/Abstract]) AND (levofloxacin[T*itle*/*Abstract*]) AND (community-acquired pneumonia[T*itle*/*Abstract*]))
Embase	(moxifloxacin:ab,ti) AND (levofloxacin:ab,ti) AND ('community-acquired pneumonia':ab,ti)
Cochrane	(moxifloxacin:ab,ti) AND (levofloxacin:ab,ti) AND ('community-acquired pneumonia':ab,ti)
CNKI	((AB=(moxifloxacin+levofloxacin+'community-acquired pneumonia') or (TI=(moxifloxacin+levofloxacin+'community-acquired pneumonia'))
VIP	((*R*=(moxifloxacin or levofloxacin or 'community-acquired pneumonia') or (*T*=(moxifloxacin or levofloxacin or 'community-acquired pneumonia'))
Wanfang	((Abstract=(moxifloxacin or levofloxacin or 'community-acquired pneumonia') or (Title=(moxifloxacin or levofloxacin or 'community-acquired pneumonia'))

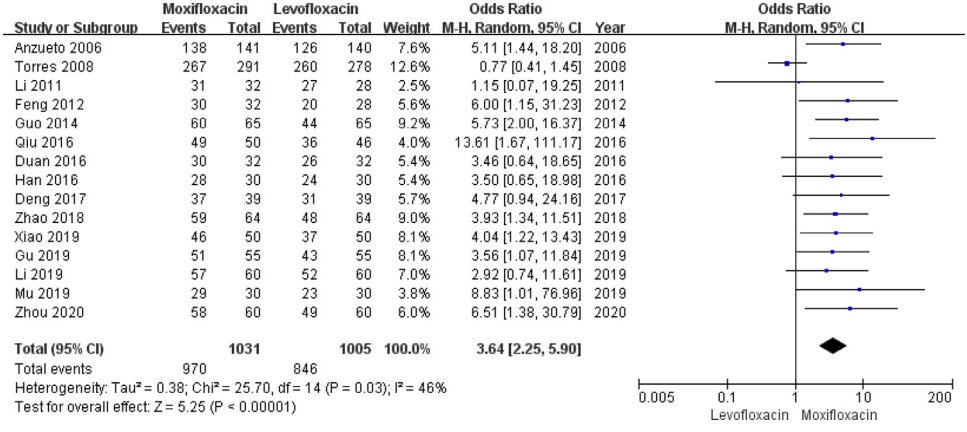


Fig. 1. Forest plot reporting the clinical response rate of moxifloxacin and levofloxacin in sequential therapy.

- Fig. 1 is the forest plot comparing the clinical response rate of moxifloxacin and levofloxacin in sequential therapy.
- Fig. 2 is the forest plot comparing the clinical response rate of moxifloxacin and levofloxacin at test-of-cure (TOC) visit in the elderly population.
- Fig. 3 is the forest plot comparing the clinical response rate of moxifloxacin and levofloxacin during 3∼5 days of treatment in the elderly population.
- Fig. 4 is the forest plot comparing the clinical response rate of moxifloxacin and levofloxacin in the Chinese population.
- Fig. 5 is the forest plot comparing the incidence of drug-related adverse events (gastrointestinal disorders) of moxifloxacin and levofloxacin.
- Fig. 6 is the forest plot comparing the incidence of drug-related adverse events (rash) of moxifloxacin and levofloxacin.
- Fig. 7 is the forest plot comparing the incidence of drug-related adverse events (cardiac events) of moxifloxacin and levofloxacin.
- Fig. 8 is the forest plot comparing the incidence of drug-related adverse events (impaired liver function) of moxifloxacin and levofloxacin.
- Fig. 9 is the forest plot comparing the fever release time of moxifloxacin and levofloxacin.
- Fig. 10 is the forest plot comparing the cough disappear time of moxifloxacin and levofloxacin.
- Fig. 11 is the forest plot comparing the pulmonary rales disappear time of moxifloxacin and levofloxacin.

Table 2
Study characteristics and JADAD score of included RCTs in meta-analysis.

Study	Drug regimens	Enrolled Population	Age (mean±SD)	Treatment duration	Severity of CAP	JADAD score
Zhang 2017 [13]	PO moxifloxacin 0.4 g qd	50	43.51 ± 11.32	10d	–	4
	PO levofloxacin 0.1 g bid	50	43.51 ± 11.32	10d	–	
Anzueto 2006 [5]	Sequential IV/PO moxifloxacin 0.4 g/d	141	77.9	7–14d	PSI I-V	4
	Sequential IV/PO levofloxacin 0.25–0.5 g/d	140	77.4	7–14d	PSI I-V	
Tang 2010 [28]	PO moxifloxacin 0.4 g/d	56	41.0 ± 1.7	7–14d	–	2
	IV levofloxacin 0.1 g bid	54	40.0 ± 1.5	7–14d	–	
Zhou 2020 [6]	Sequential IV/PO moxifloxacin 0.4 g/d	60	63.28 ± 4.36	7∼14d	–	2
	Sequential IV/PO levofloxacin 0.5 g/d	60	62.28 ± 4.37	15d	–	
Lin 2020 [7]	IV moxifloxacin 0.4 g/d	60	52.51 ± 8.94	7d	–	2
	IV levofloxacin 0.5 g/d	60	53.26 ± 9.11	7d	–	
Torres 2008 [4]	Sequential IV/PO moxifloxacin 0.4 g/d	291	66.0 ± 16.2	7–14d	PSI III-V	2
	Sequential IV/PO levofloxacin 0.5 g bid (in combination with sequential IV/PO ceftriaxone 2 g qd)	278	64.8 ± 16.7	7–14d	PSI III-V	
Xiao 2019 [8]	Sequential IV/PO moxifloxacin 0.4 g/d IV	50	72.10 ± 4.82	14d	–	2
	IV Sequential IV/PO levofloxacin 0.5 g/d	50	71.98 ± 5.03	14d	–	
Mu 2019 [9]	Sequential IV/PO moxifloxacin 0.4 g/d	60	75.31 ± 6.12	3∼5d	PSI IV-V patients>50%	2
	Sequential IV/PO levofloxacin 0.5 g/d	60	74.31 ± 5.72	3∼5d	PSI IV-V patients>50%	
Yang 2014 [22]	IV moxifloxacin 0.4 g qd	92	61.52 ± 4.17	7d	–	2
	IV levofloxacin 0.5 g qd	92	61.42 ± 4.25	7d	–	
Li 2019 [11]	Sequential IV/PO moxifloxacin 0.4 g/d	55	70.39 ± 6.98	14d	–	2
	Sequential IV/PO levofloxacin 0.5 g/d	55	69.37 ± 6.52	14d	–	
Gu 2019 [10]	Sequential IV/PO moxifloxacin0.4 g/d	30	62.5 ± 7.4	10d	–	2
	IV levofloxacin 0.4 g/d	30	60.7 ± 8.7	10d	–	
Zhao 2018 [12]	Sequential IV/PO moxifloxacin 0.4 g/d	64	72.19 ± 5.20	14d	–	2
	Sequential IV/PO levofloxacin 0.5 g/d	64	72.61 ± 5.48	14d	–	
Deng 2017 [14]	Sequential IV/PO moxifloxacin 0.4 g/d	39	70.64 ± 4.57	7–14d	–	2
	Sequential IV/PO levofloxacin 0.2 g/d bid	39	70.42 ± 4.70	7–14d	–	

(*continued on next page*)

Table 2 (*continued*)

Study	Drug regimens	Enrolled Population	Age (mean±SD)	Treatment duration	Severity of CAP	JADAD score
Chen 2017 [15]	IV moxifloxacin 0.4 g/d	30	58.85 ± 5.45	7d	–	2
	IV levofloxacin 100 ml bid	30	58.69 ± 5.88	7d	–	
Zhao 2016 [16]	IV moxifloxacin 0.4 g/d	64	74.22 ± 2.38	7d	–	2
	IV levofloxacin 0.5 g/d	56	73.39 ± 2.19	7d	–	
Qiu 2016 [17]	Sequential IV/PO moxifloxacin 0.4 g/d	50	65.20 ± 4.20	7∼14d	–	2
	Sequential IV/PO levofloxacin 0.5 g/d 0.2 g bid	46	64.60 ± 3.70	7∼14d	–	
Han 2016 [18]	Sequential IV/PO moxifloxacin 0.4 g/d	30	73.00 ± 5.00	10d	–	2
	PO levofloxacin 0.4 g/d	30		10d	–	
Duan 2016 [19]	Sequential IV/PO moxifloxacin 0.4 g/d	32	74.44 ± 4.92	14d	–	2
	Sequential IV/PO levofloxacin 0.2 g/d	32	74.35 ± 4.86	14d	–	
Chen 2016 [20]	IV moxifloxacin 0.4 g/d	96	78.6 ± 22.7	7d	–	2
	IV levofloxacin 0.5 g/d	45	79.2 ± 26.8	7d	–	
Zhang 2014 [21]	IV moxifloxacin 0.4 g/d	100	71.13 ± 9.33	10d	–	2
	IV levofloxacin 0.4 g/d	100	71.13 ± 9.33	10d	–	
Yuan 2014 [24]	IV moxifloxacin 0.4 g/d	32	64.7 ± 6.4	14d	–	2
	IV levofloxacin 0.5 g/d	32	64.7 ± 6.4	14d	–	
Guo 2014 [23]	Sequential IV/PO moxifloxacin 0.4 g/d	65	66.3 ± 7.6	10d	–	2
	IV levofloxacin 0.4 g/d	65	67.4 ± 8.1	10d	–	
Liu 2012 [25]	IV moxifloxacin 0.4 g/d	33	51.3 ± 15.6	7∼14d	mild∼moderate	2
	IV levofloxacin 0.4 g/d	32	50.8 ± 15.7	7∼14d	mild∼moderate	
Feng 2012 [26]	Sequential IV/PO moxifloxacin 0.4 g/d,	32	63.4 ± 5.5	7∼14d	–	2
	IV levofloxacin 0.5 g/d	28	62.8 ± 4.9	7d	–	
Shen 2010 [29]	IV moxifloxacin0.4 g/d	75	49.50	7∼14d	–	2
	IV levofloxacin 0.2 g/d bid	75	46.20	7∼14d	–	
Lin 2007 [30]	IV moxifloxacin 0.4 g/d	33	–	7d	–	2
	IV levofloxacin 0.4 g/d	32	–	7d	–	
Li 2011 [27]	Sequential IV/PO moxifloxacin 0.4 g/d	32	63.4 ± 5.5	7∼14d	–	2
	IV levofloxacin 0.5 g/d	28	62.8 ± 4.9	7d	–	

The punctuation "-" in this table indicated that "Severity of CAP" or "Age" didn't reported in orginal article.
IV: intravenous; qd: daily; PO: per os; bid: twice daily; tid: three times daily; PSI: pneumonia severity index; d:day.

Table 3
Results from meta-analysis.

Clinical response rate	Included trials	Patients	Model	Results	P-value
Sequential therapy [4–6,8–12,14,17–19,23,26–27]	15	2036	REM	OR=3.64 [2.25, 5.90], I^2=46%	<0.01*
In the elderly population during 3∼5 days of treatment [4-5,18-21]	6	1315	REM	OR=2.77 [1.24, 6.17], I^2=68%	0.01*
In the elderly population at TOC visit[b] [4,5,8,9,11,14,16–21,23,24]	14	2083	REM	OR=3.79 [2.34, 6.15], I^2=50%	<0.01*
In the Chinese population at TOC visit [6–30]	25	2551	REM	OR=3.79 [2.88, 5.00], I^2=0%	<0.01*
Adverse events					
Gastrointestinal disorders [4,5,7,9,12,17,19,20,22–25,29,30]	14	2454	REM	OR=0.96 [0.73, 1.25], I^2=0%	0.74
Rash [7,9,12,17,22-23,25,30]	9	971	REM	OR=0.56 [0.24, 1.32], I^2=0%	0.18
Cardiac event [4-5]	2	1127	FEM	OR=0.83 [0.49, 1.41], I^2=53%	0.49
Impaired liver function [20,25,29,30]	4	420	REM	OR=1.16 [0.28, 4.79], I^2=0%	0.84
Clinical manifestations					
Fever release time [6,10,15,19,22]	5	488	REM	MD=−1.42 [−2.45, −0.40], I^2=97%	<0.01*
Cough disappear time [6,13,15,16,19,22]	6	548	REM	MD=−1.73 [−2.54, −0.93], I^2=93%	<0.01*
Pulmonary rales disappear time [6,10,16,19]	4	360	REM	MD=−1.33 [−2.40, −0.25], I^2=94%	0.02*
Shortness of breath release time [10,16]	2	180	FEM	MD=−4.63 [−4.91, −4.36], I^2=99%	<0.01*
Laboratory tests					
Duration of ≥50% improvement in radiologic findings [15,22]	2	244	FEM	MD=−1.88 [−2.55, −1.22], I^2=0%	<0.01*
Duration of white blood cell (WBC) count decrease to normal level [15,22]	2	244	FEM	MD=−2.12 [−2.66, −1.59], I^2=0%	<0.01*
Hospital LOS [5,16,27]	3	461	REM	MD=−1.98 [−4.06, 0.11], I^2=92%	0.06

* $P<0.05$ level of confidence was interpreted as the differences between moxifloxacin and levofloxacin group are statistically significant result.
[a] Sequential therapy is patients start with intravenous moxifloxacin/levofloxacin and then treated with per os moxifloxacin/levofloxacin tablets.
[b] Elderly population is patients older than 65-year-old.

Table 4
JADAD score calculation and assessment guideline.

Item	Score
Was the study described as randomized (this includes words such as randomly, random, and randomization)?	0/1
Was the method used to generate the sequence of randomization described and appropriate (table of random numbers, computer-generated, etc.)?	0/1
Was the study described as double blind?	0/1
Was the method of double blinding described and appropriate (identical placebo, active placebo, dummy, etc.)?	0/1
Was there a description of withdrawals and dropouts?	0/1
Assessment Guideline	
Randomization	A method to generate the sequence of randomization will be regarded as appropriate if it allowed each study participant to have the same chance of receiving each intervention and the investigators could not predict which treatment was next. Methods of allocation using date of birth, date of admission, hospital numbers, or alternation should not be regarded as appropriate
Blinding	A study must be regarded as double blind if the word "double blind" is used. The method will be regarded as appropriate if it is stated that neither the person doing the assessments nor the study participant could identify the intervention being assessed, or if in the absence of such a statement the use of active placebos, identical placebos, or dummies is mentioned
Withdrawals and dropouts	Participants who were included in the study but did not complete the observation period or who were not included in the analysis must be described. The number and the reasons for withdrawal in each group must be stated. If there were no withdrawals, it should be stated in the article. If there is no statement on withdrawals, this item must be given no points

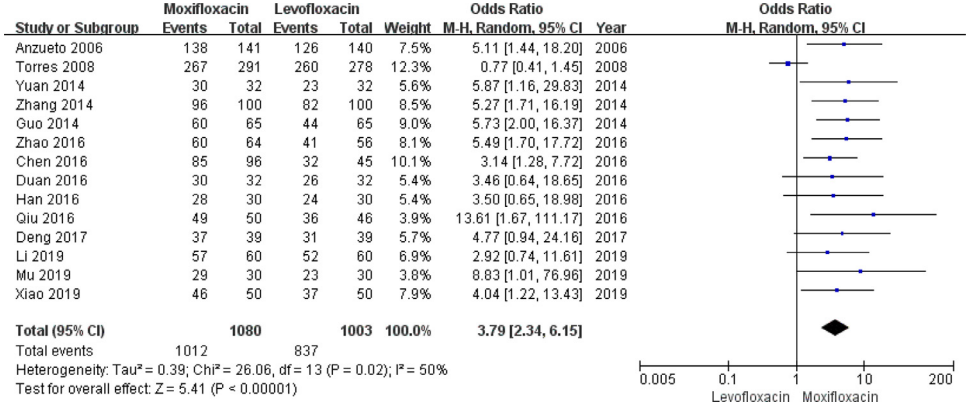


Fig. 2. Forest plot reporting the clinical response rate of moxifloxacin and levofloxacin at test-of-cure (TOC) visit in the elderly population.

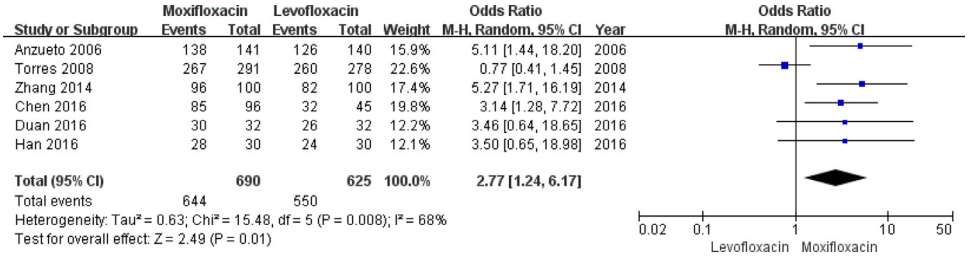


Fig. 3. Forest plot reporting the clinical response rate of moxifloxacin and levofloxacin during 3∼5 days of treatment in the elderly population.

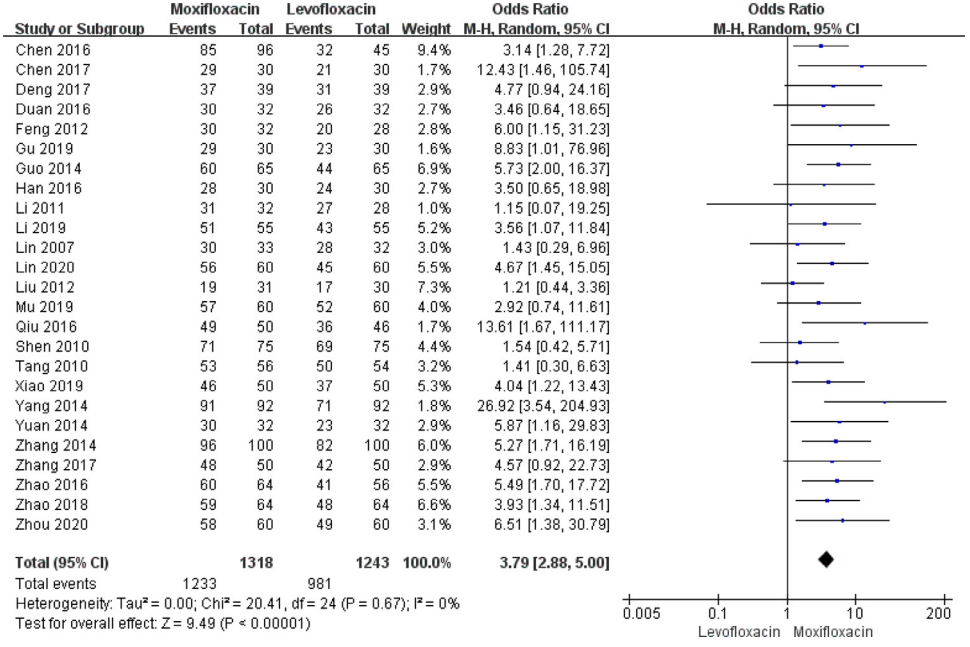


Fig. 4. Forest plot reporting the clinical response rate of moxifloxacin and levofloxacin in the Chinese population.

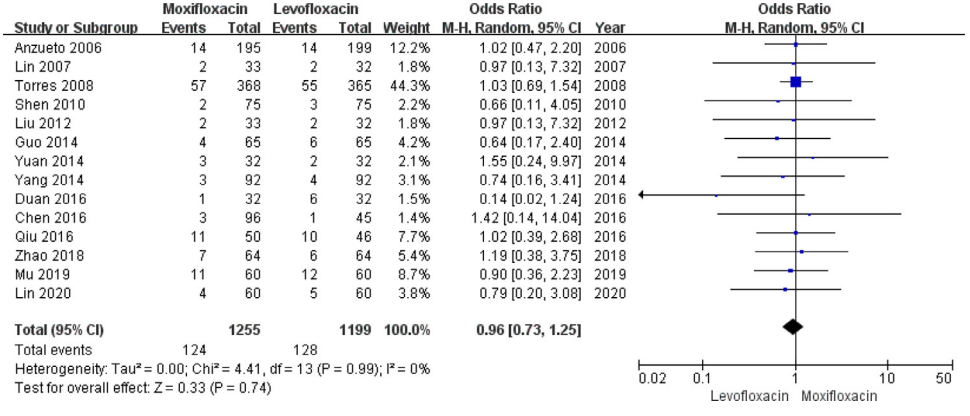


Fig. 5. Forest plot reporting the incidence of drug-related adverse events (gastrointestinal disorders) of moxifloxacin and levofloxacin.

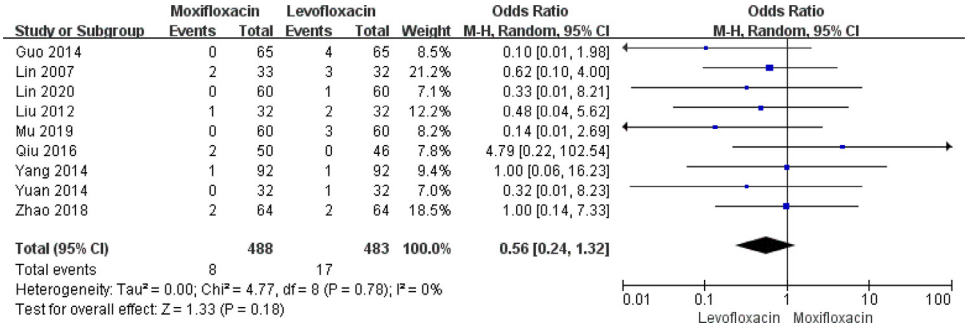


Fig. 6. Forest plot reporting the incidence of drug-related adverse events (rash) of moxifloxacin and levofloxacin.

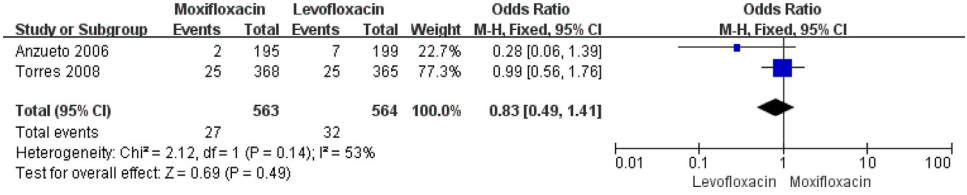


Fig. 7. Forest plot reporting the incidence of drug-related adverse events (cardiac events) of moxifloxacin and levofloxacin.

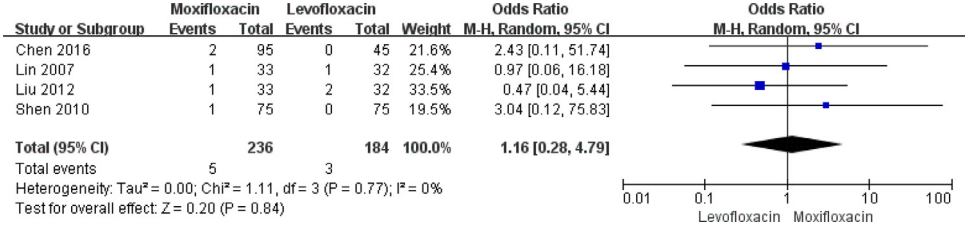


Fig. 8. Forest plot reporting the incidence of drug-related adverse events (impaired liver function) of moxifloxacin and levofloxacin.

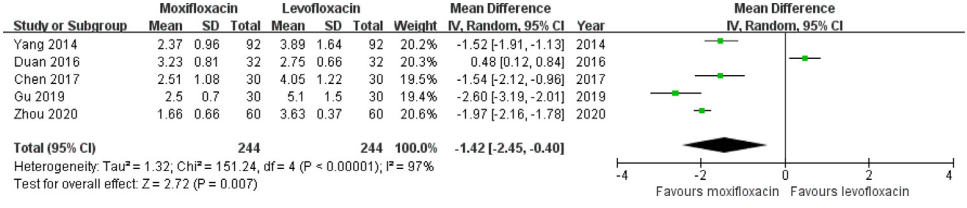


Fig. 9. Forest plot reporting the fever release time of moxifloxacin and levofloxacin.

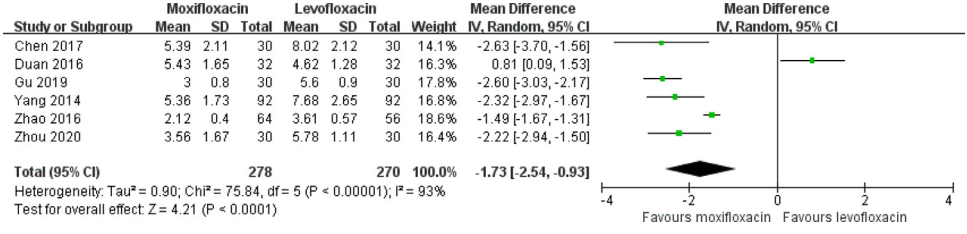


Fig. 10. Forest plot reporting the cough disappear time of moxifloxacin and levofloxacin.

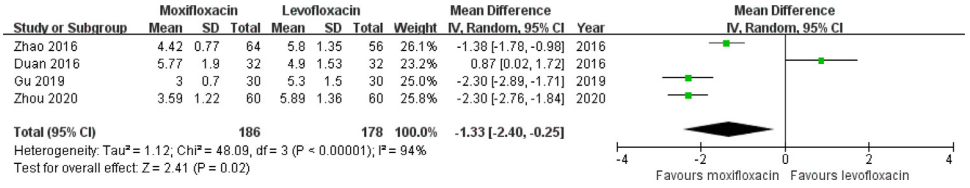


Fig. 11. Forest plot reporting the pulmonary rales disappear time of moxifloxacin and levofloxacin.

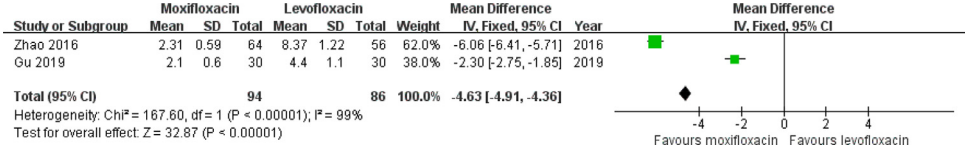


Fig. 12. Forest plot reporting the shortness of breath release time of moxifloxacin and levofloxacin.

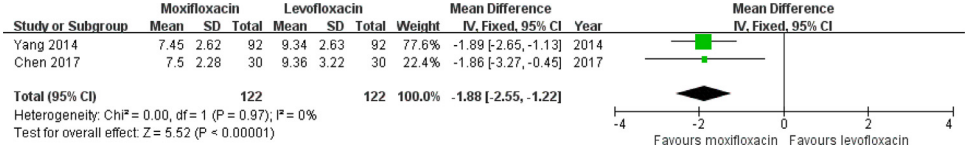


Fig. 13. Forest plot reporting the duration of ≥50% improvement in radiologic findings of moxifloxacin and levofloxacin.

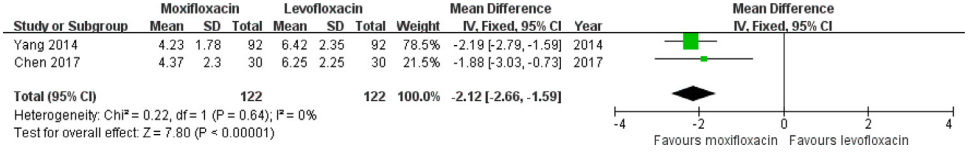


Fig. 14. Forest plot comparing the duration of WBC count decrease to normal level of moxifloxacin and levofloxacin.

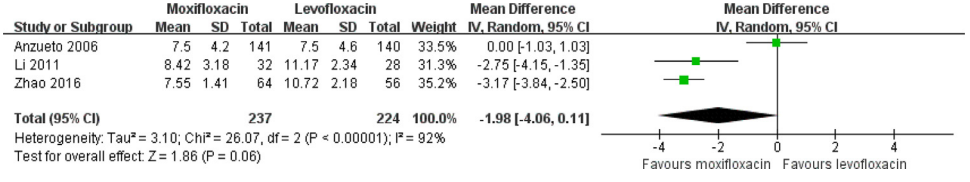
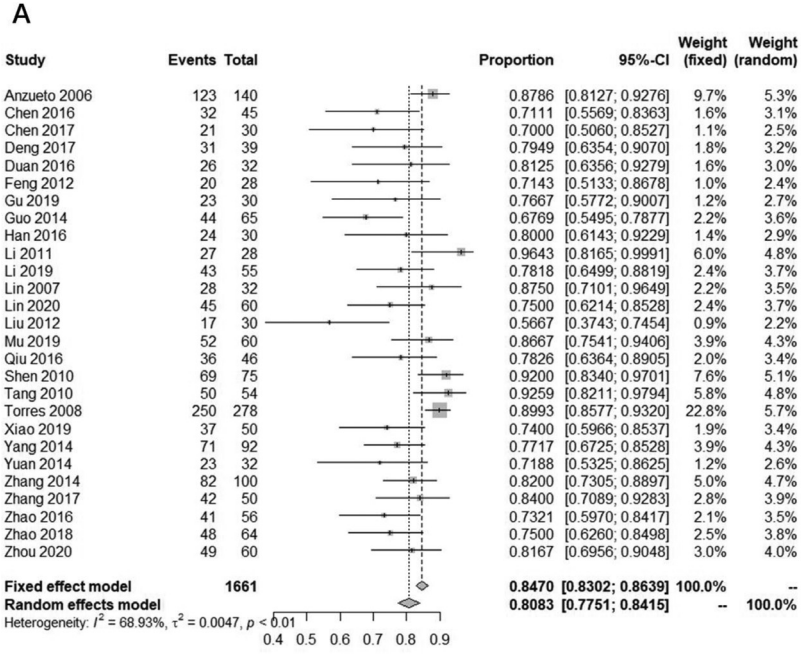


Fig. 15. Forest plot reporting the hospital length-of-time of moxifloxacin and levofloxacin.

- Fig. 12 is the forest plot comparing the shortness of breath release time of moxifloxacin and levofloxacin.
- Fig. 13 is the forest plot comparing the duration of ≥50% improvement in radiologic findings of moxifloxacin and levofloxacin.
- Fig. 14 is the forest plot comparing the duration of WBC count decrease to normal level of moxifloxacin and levofloxacin.
- Fig. 15 is the forest plot comparing the hospital length-of-time of moxifloxacin and levofloxacin.
- Fig. 16 is the forest plot demonstrating the independent clinical response rate of moxifloxacin (A) and levofloxacin (B) at TOC visit calculated from single arm meta-analysis.



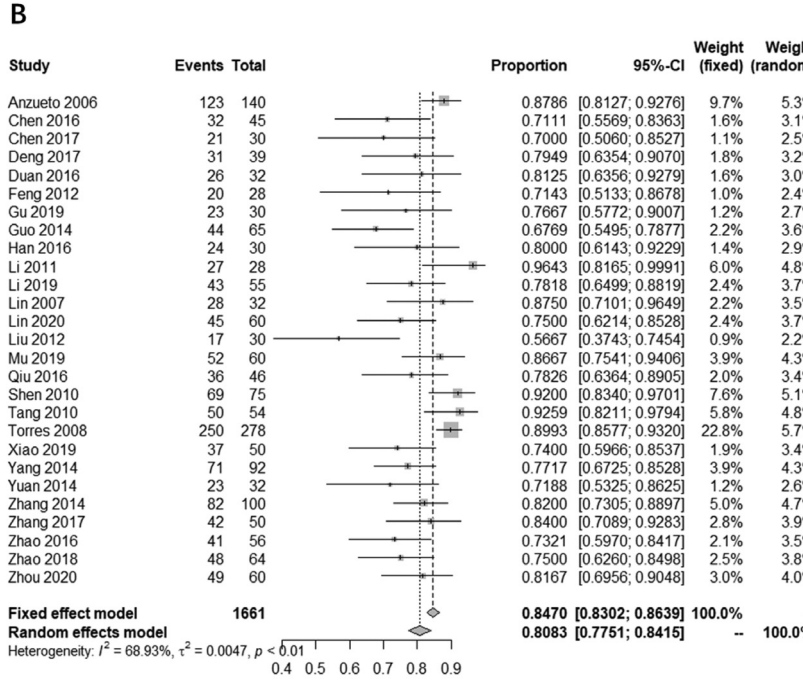


Fig. 16. Forest plot reporting the independent clinical response rate of moxifloxacin (A) and levofloxacin (B) at TOC visit calculated from single arm meta-analysis.

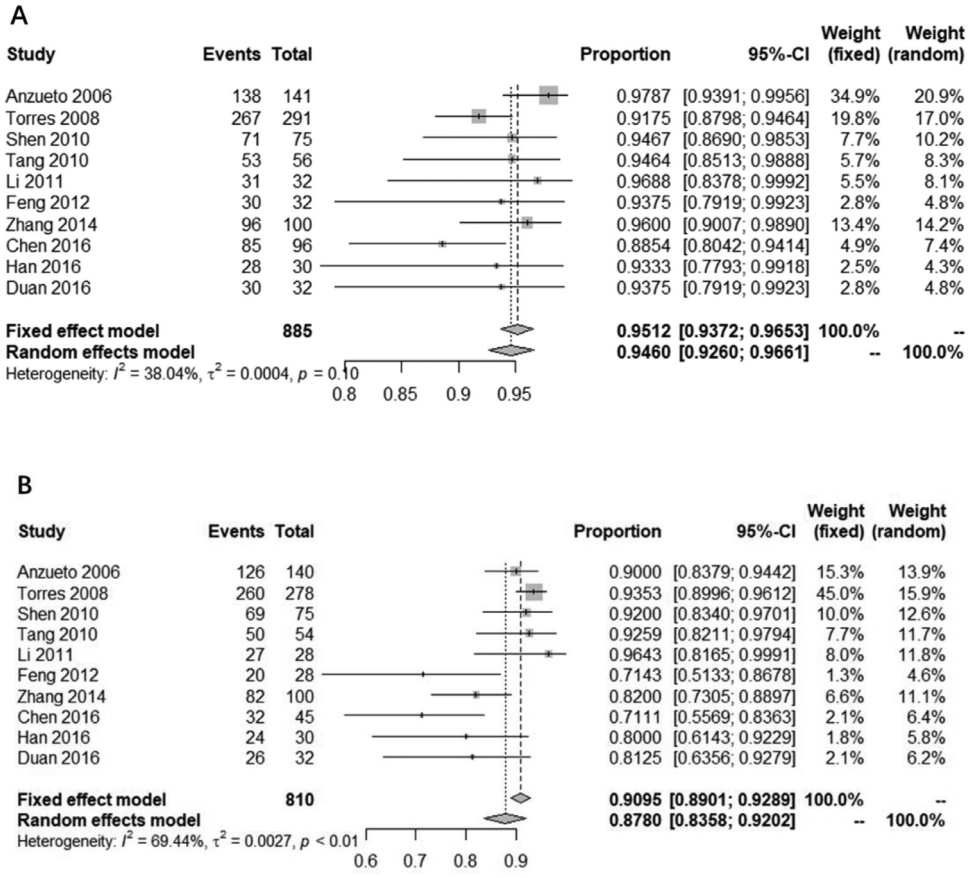


Fig. 17. Forest plot resporting the independent clinical response rate of moxifloxacin (A) and levofloxacin (B) during 3∼5 days of treatment calculated from single arm meta-analysis.

- Fig. 17 is the forest plot demonstrating the independent clinical response rate of moxifloxacin (A) and levofloxacin (B) during 3∼5 days of treatment calculated from single arm meta-analysis.
- Fig. 18 is the forest plot demonstrating the independent clinical response rate of moxifloxacin (A) and levofloxacin (B) at TOC visit in the elderly population calculated from single arm meta-analysis.
- Fig. 19 is the forest plot demonstrating the independent clinical response rate of moxifloxacin (A) and levofloxacin (B) during 3∼5 days of treatment in the elderly population calculated from single arm meta-analysis.

2. Experimental Design, Materials and Methods

In the related research, a meta-analysis was performed to compare the efficacy and safety profiles of moxifloxacin and levofloxacin in the treatment of community-acquired pneumonia. To begin with, search strategies were developed and applied to 6 electronic bibliographic databases (CNKI, CSTJ-VIP, Wanfang, PubMed, Embase, and Cochrane Library) for publications from January 2000 to August 2020, using search terms ‘moxifloxacin’, ‘levofloxacin’ and ‘community-acquired

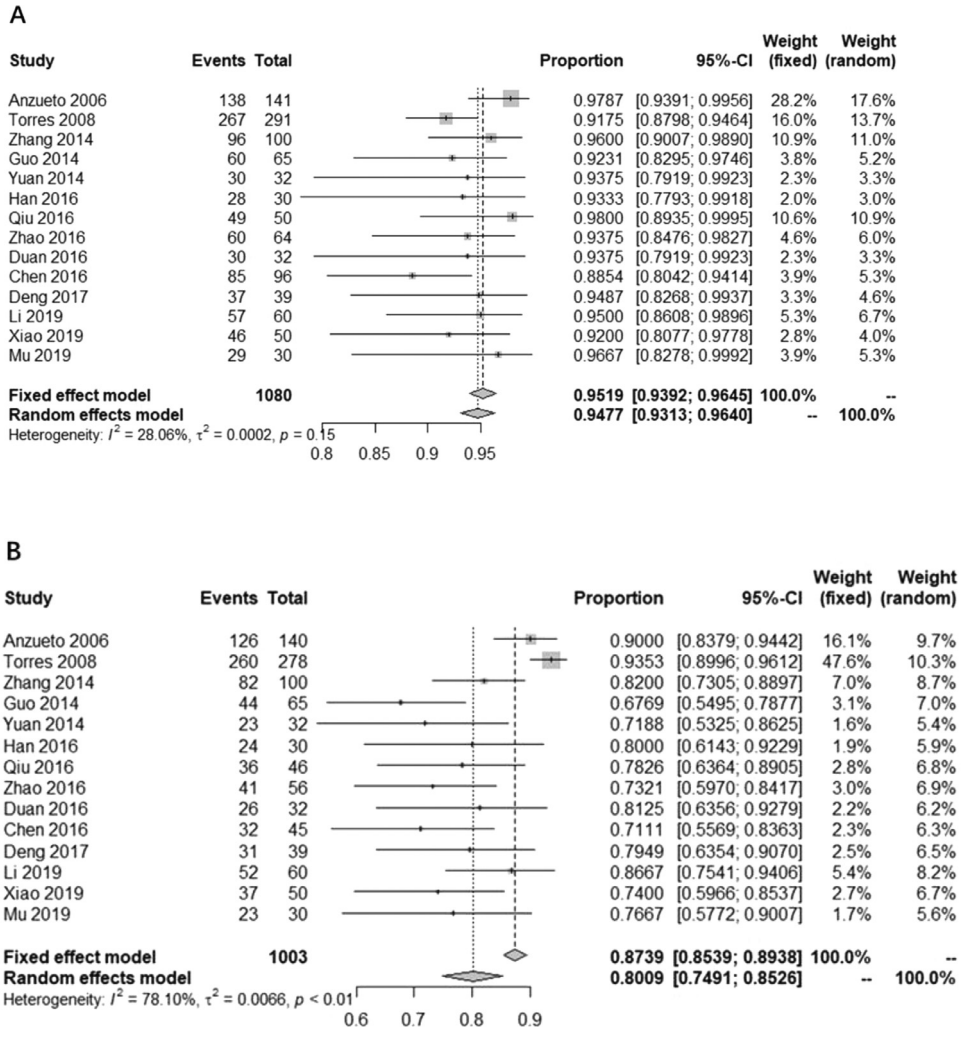


Fig. 18. Forest plot reporting the independent clinical response rate of moxifloxacin (A) and levofloxacin (B) at TOC visit in the elderly population calculated from single arm meta-analysis.

pneumonia' in the title, abstract or keywords (shown in Table 1). The literature search for meta-analysis was limited to randomized controlled trials, and eligible participants were adult patients with a confirmed diagnosis of CAP treated with moxifloxacin and levofloxacin. Language restrictions were English and Chinese.

Three reviewers (XD, YJ, and LC) independently searched the literature and examined all relevant studies. Trials that fulfilled the following inclusion criteria were included in the meta-analysis: (1) comparison of efficacy and safety of moxifloxacin and levofloxacin in adult patients with CAP; (2) study is a randomized controlled trial; (3) study reported clinical efficacy and safety data (including but not limited to clinical cure rate, bacteriological eradication rate, AEs); (4) moxifloxacin was used as monotherapy. Retrospective, pharmacokinetic, pharmacodynamic studies, clinical practice guidelines, animal models, or literature reviews were excluded. We also excluded studies in which moxifloxacin was not used as an initial treatment.

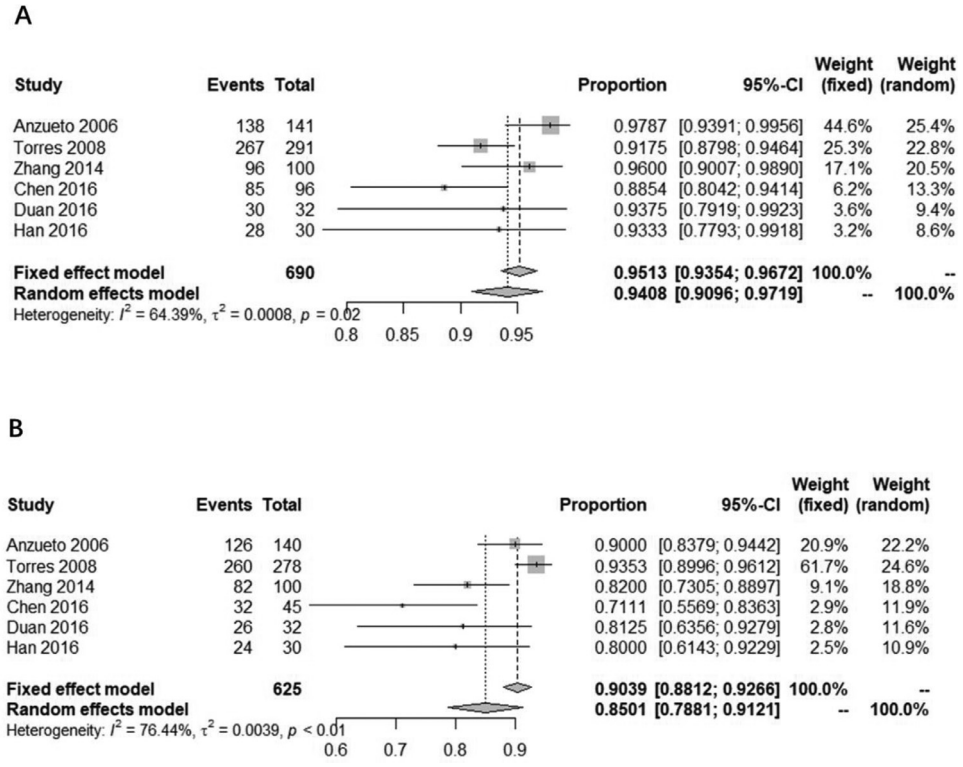


Fig. 19. Forest plot reporting the independent clinical response rate of moxifloxacin (A) and levofloxacin (B) during 3∼5 days of treatment in the elderly population calculated from single arm meta-analysis.

For included trials, extracted data included study details (trial design, country, publication date, and sample size), participant demographics (age, gender, ethnicity, and disease severity), interventions (dosage, treatment duration), and clinical outcomes reported (efficacy and safety). The methodological quality of the RCTs included in the meta-analysis was rated using the JADAD scoring system by two reviewers independently (YJ and LC). JADAD scoring system assesses each article by answering five questions with the following domains: randomization, blinding, and withdrawal. One point will be added for a "yes" answer to each of the five questions, for an overall score of 0∼5 [3]. In this study, trials with JADAD score lower than 2 were excluded. Table 2 displays the study characteristics and their JADAD score.

Data synthesis and statistical analyses were performed using Review Manager 5.4 (RevMan; The Cochrane Collaboration, 2014). Dichotomous data and continuous data were analyzed using odd ratio (OR) and mean difference (MD) respectively with 95% confidence interval (CI). Pooled results and 95% CIs were calculated by Mantel-Haenszel fixed effects model (FEM) only when analyses included trials fewer than three; otherwise, results were calculated using DerSimonian-Laird random effects model (REM).

Heterogeneity between trials was assessed using the chi-square and I^2 tests. Mild, moderate, and significant heterogeneity was determined by the I^2 value for $<$ 25%, 25%∼50%, and $>$ 50%, respectively.

Moreover, single arm meta-analysis was also performed by R software (version 3.5.2) to obtain the independent clinical response rates of moxifloxacin and levofloxacin during 3∼5 days of treatment and at TOC visit. The relevant R code is provided below.

```
library(meta)
library(readxl)
rate <- read_excel("rate.xlsx")
transform(X3_5_lev, p = Event/n,
  log=log(Event/n),
  logit=log((Event/n)/(1-Event/n)),
  arcsin=asin(sqrt(Event/(n + 1))),
  darcsin = 0.5*(asin(sqrt(Event/(n + 1)))+asin(sqrt((Event+1)/(n + 1))))->X3_5_lev
shapiro.test (X3_5_lev$p)
shapiro.test (X3_5_lev$log)
shapiro.test (X3_5_lev$logit)
shapiro.test (X3_5_lev$arcsin)
shapiro.test (X3_5_lev$darcsin)
metarate <-
metaprop(Event,n,Study,data = X3_5_lev,sm = "Praw",incr = 0.5,allincr = TRUE,addincr =
FALSE,title = "")
forest(metarate,digits = 4,digits.I2 = 2)
```

Ethics Statement

None.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Supplementary Materials

Supplementary material associated with this article can be found in the online version at doi:10.1016/j.dib.2021.107352.

CRediT Author Statement

Xiwen Du: Project administration, Validation, Writing – original draft; **Yi Han:** Conceptualization, Methodology; **Yifei Jian:** Software, Visualization; **Liping Chen:** Formal analysis, Visualization; **Jianwei Xuan:** Validation, Writing – review & editing.

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