Appendix 4 (as supplied by the authors): Summary of findings: Prone ventilation versus supine ventilation for acute respiratory distress syndrome (ARDS)

Prone ventilation versus supine ventilation for the treatment of ARDS

Patient or population: Patients with ARDS receiving protective lung ventilation
Settings: Critical care units
Intervention: Prone ventilation
Comparison: Supine ventilation

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Quality of evidence (GRADE)
	Assumed risk **supine ventilation**	Corresponding risk **prone ventilation**			
All-cause mortality	**Medium risk population**[1]		**RR 0.74** (0.59 to 0.95)	1016 (6 studies)	⊕⊕⊕⊕ **high**[2,3,4,5]
	470 per 1000	**348 per 1000** (277 to 446)			

*The basis for the **assumed risk** (e.g. the median control group risk across studies) is provided in footnotes. The **corresponding risk** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: Confidence interval; **RR:** Risk ratio.

GRADE Working Group grades of evidence
High quality: Further research is very unlikely to change our confidence in the estimate of effect.
Moderate quality: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
Low quality: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low quality: We are very uncertain about the estimate.

[1] The basis for the assumed risk of death with supine ventilation is the median risk across studies
[2] Because of the nature of the intervention, no study could be blinded. However, the primary outcome (all-cause mortality) is unlikely to be biased due to lack of blinding. One trial (Chan et al) did not conceal allocation. Excluding this study in sensitivity analyses did not alter our findings (see Table 3 in the full article).
[3] We observed low heterogeneity across studies (I^2 = 29%). In 5 of 6 studies the direction of treatment effect indicated a reduction in mortality.
[4] We did not downgrade due to imprecision because: 1) the upper border of the 95% confidence interval did not include a lack of appreciable benefit or possible harm and 2) the total number of outcomes (n=363) was not fewer than 300.
[5] In an *a priori* subgroup analysis we found a greater mortality benefit in trials that used a longer duration (i.e. higher dose) of prone ventilation compared to those that used a shorter duration of prone ventilation, strengthening our findings.

Appendix to: Sud S, Friedrich JO, Adhikari NKJ, et al. Effect of prone positioning during mechanical ventilation on mortality among patients with acute respiratory distress syndrome: a systematic review and meta-analysis. *CMAJ* 2014. DOI:10.1503/cmaj.140081.