Appendix 5 (as supplied by the authors): GRADE Evidence profile for prone ventilation versus supine ventilation for acute respiratory distress syndrome (ARDS)

Quality assessment							Summary of findings					Importance
							No. of deceased patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Prone ventilation	Supine ventilation	Relative (95% CI)	Absolute		
All-cause mortality												
6	randomized trials	serious[1]	no serious inconsistency[2]	no serious indirectness	no serious imprecision[3]	dose response gradient[4]	154/510 (30.2%)	47%[5]	RR 0.74 (0.59 to 0.95)	122 fewer per 1000 (from 24 fewer to 193 fewer)	⊕⊕⊕⊕ HIGH	CRITICAL[6]

[1] 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).
[2] We observed low heterogeneity across studies (I^2 = 29%). In 5 of 6 studies the direction of treatment effect indicated a reduction in mortality.
[3] We did not downgrade due to imprecision because 1) the upper border of the confidence intervals did not include a lack of appreciable benefit or possible harm and 2) the total number of outcomes (363) was not fewer than 300.
[4] 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
[5] The basis for the assumed risk of death with supine ventilation is the median risk across studies
[6] mortality was assessed at hospital discharge or longest follow-up.

