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# Accepted Manuscript

A third of systematic reviews changed or did not specify the primary outcome: A PROSPERO register study

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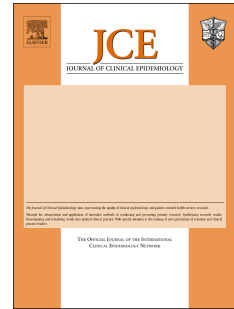
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**A third of systematic reviews changed or did not specify the primary outcome: A****PROSPERO register study**

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36 **ABSTRACT**

37 **Objectives:** To examine outcome reporting bias of systematic reviews registered in PROSPERO.

38 **Study Design and Setting:** Retrospective cohort study. The primary outcomes from systematic  
39 review publications were compared with those reported in the corresponding PROSPERO  
40 records; discrepancies in the primary outcomes were assessed as upgrades, additions, omissions  
41 or downgrades. Relative risks (RR) and 95% confidence intervals (CI) were calculated to  
42 determine the likelihood of having a change in primary outcome when the meta-analysis result  
43 was favourable and statistically significant.

44 **Results:** 96 systematic reviews were published. A discrepancy in the primary outcome occurred  
45 in 32% of the included reviews and 39% of the reviews did not explicitly specify a primary  
46 outcome(s); 6% of the primary outcomes were omitted. There was no significant increased risk  
47 of adding/upgrading (RR 2.14, 95% CI 0.53 to 8.63) or decreased risk of downgrading (RR 0.76,  
48 0.27-2.17) an outcome when the meta-analysis result was favourable and statistically significant.  
49 As well, there was no significant increased risk of adding/upgrading (RR 0.89, 0.31-2.53) or  
50 decreased risk of downgrading (RR 0.56, 0.29-1.08) an outcome when the conclusion was  
51 positive.

52 **Conclusions:** We recommend review authors carefully consider primary outcome selection and  
53 journals are encouraged to focus acceptance on registered systematic reviews.

54

55 **Word count:** 200 (abstract), 3286 (main text), 2 figures, 3 tables, 14 appendices.

56 **Keywords:** bias, methodology, quality, reporting, systematic reviews, outcome reporting bias

57 **Running title:** Examining outcome reporting bias in systematic reviews

ACCEPTED MANUSCRIPT

**What is new?****Key finding**

- Many systematic reviews that are registered in PROSPERO have discrepancies in primary outcomes between their record and review publication.

**What this study adds to what is known?**

- This is the first study to examine outcome reporting bias using the PROSPERO register, a database for prospectively registering systematic reviews that was established in 2011.
- Previous studies have compared outcomes reported in Cochrane reviews to those reported in the corresponding review protocols. These studies found that more than 1/3 of published systematic reviews had a discrepancy between the outcomes reported in the protocol versus final publication. One study found evidence of outcome reporting bias, in which statistically significant outcomes were more likely to be upgraded (i.e. promoted from secondary to primary) or added in the final publication compared to the protocol.
- We found that approximately 1/3 of published systematic reviews had a discrepancy between the outcomes reported in the PROSPERO record versus the review publication. However, evidence of outcome reporting bias was not observed.

**What is the implication, and what should change now?**

- Our study suggests that non-Cochrane review authors have similar outcome reporting behaviours to Cochrane review authors. We recommend that all non-Cochrane reviews are registered with PROSPERO, review authors carefully consider the selection of primary outcomes, peer reviewers should check PROSPERO to see if there are any discrepancies between the record and review publication, and journals are encouraged to focus acceptance on registered systematic reviews.

## 58 1. INTRODUCTION

59 The Cochrane Handbook for Systematic Reviews of Interventions [1] states that  
60 systematic reviewers should prepare a systematic review protocol prior to their review conduct,  
61 to encourage transparency of reporting hypotheses and methods (including outcomes) and avoid  
62 outcome reporting bias. This is consistent with the Institute of Medicine Standards for  
63 Systematic Reviews [2]. As well, the Cochrane Handbook [1] and Preferred Reporting Items for  
64 Systematic reviews and Meta-Analyses Statement [3] state that any changes to the protocol  
65 should be fully documented and explained in the systematic review publication. Despite this  
66 guidance, research consistently has found that more than 1/3 of published systematic reviews  
67 have an undisclosed discrepancy between the outcomes reported in the protocol versus final  
68 review [4-7].

69 In the most simplistic definition, outcome reporting bias “occurs when a study in which  
70 multiple outcomes were measured reports only those that are [statistically] significant” [8].  
71 Previous studies have compared final Cochrane review methods to those reported in the review  
72 protocols [4-7], including a recent Cochrane methodology review on outcome reporting bias [9].  
73 One of these studies found evidence of outcome reporting bias, in which statistically significant  
74 outcomes were more likely to be upgraded (i.e. promoted from secondary to primary) or added in  
75 the final publication compared to the protocol [5]. All of these studies included a sample of  
76 systematic reviews published in the Cochrane Database of Systematic Reviews prior to the year  
77 2009.

78 The International Prospective Register of Systematic Reviews (PROSPERO) was  
79 established in 2011 [10] and is the only open access online facility to prospectively register non-  
80 Cochrane systematic reviews. Since most published systematic reviews are not Cochrane reviews



81 [11], this register of review protocol details is likely a more representative sample of systematic  
82 reviews in the literature. No previous study has explored outcome reporting bias of systematic  
83 reviews registered in PROSPERO. As such, we aimed to 1) examine whether outcome reporting  
84 bias exists, and to what extent, in published systematic reviews registered in PROSPERO, as  
85 well as 2) assess the methodological quality of published systematic reviews that were registered  
86 in PROSPERO.

## 87 2. METHODS

### 88 2.1 Protocol

89 Prior to conducting this retrospective cohort study, we created a project plan, which  
90 outlined our study methods. Our protocol was revised after receiving feedback from all authors.  
91 The final protocol can be found in Appendix A. Since this study was not a systematic review, it  
92 was not eligible to be registered with the PROSPERO repository.

### 93 2.2 Sample of systematic reviews

94 We aimed to identify all completed systematic reviews of interventions that were  
95 registered in PROSPERO. On November 29, 2013, all records from the PROSPERO database  
96 identified as “Completed and Published” were downloaded. These records also include the  
97 citation/link to the final publication. PROSPERO includes an audit trail for protocol amendments  
98 and progress reports. For the purpose of our study, the protocol record used was the version  
99 immediately prior to the version where the Named Contact updated the record to report that the  
100 review had been completed. Our scope was limited to systematic reviews of interventions to  
101 allow the comparison of statistically significant meta-analysis results, which would not be  
102 feasible for other review products (e.g., diagnostic reviews, prognostic reviews, prevalence  
103 reviews). Only non-Cochrane reviews were included. Completed reviews not published in  
104 English were also excluded, due to resource limitations.

### 105 2.3 Data abstraction process

106 A data abstraction form with an explanation guide was developed (Appendix Table A)  
107 and calibrated through a team exercise. Specifically, the team independently pilot-tested the  
108 forms using a random sample of 10 included systematic reviews. Data abstraction did not  
109 commence until high agreement (>90%) was achieved. Subsequently, 3 pairs of reviewers  
110 abstracted each of the systematic review publications, independently. In order to ensure

111 consistency across the team regarding the classification of outcomes, one team member verified  
112 all of the data (EC) and resolved discrepancies.

#### 113 *2.4 Data items*

114 The data items were abstracted from both the protocol details and the publication, and  
115 included study characteristics (e.g., year of publication, number of studies included, type of  
116 studies included, whether meta-analysis was conducted, source of funding), number of primary  
117 outcomes, changes in primary outcomes from the PROSPERO record to review publication,  
118 reasons for changes in primary outcomes (if reported), meta-analysis results, and conclusions.  
119 The reason we focused on primary outcomes is because this is the outcome of greatest interest  
120 and importance. Similar research on outcome reporting bias has used this approach [4-7].

121 If the primary outcome(s) was not explicitly stated in the publication (i.e. not specifically  
122 called a “primary” outcome), the following decision-tree approach [12, 13] was used to “derive”  
123 the primary outcome(s), by selecting the outcome that met the first of the following criteria: (1)  
124 the outcome(s) listed in the title; (2) the outcome(s) listed in the objectives; (3) the most serious  
125 outcome (e.g., mortality). To facilitate comparison across studies, all changes in primary  
126 outcomes from the PROSPERO record to the systematic review publication were coded using  
127 the same classification scheme used in the Parmelli *et al.* [7] and Kirkham *et al.* [5] studies.  
128 These categories were new inclusion of outcomes (or additions), exclusion, upgrade, and  
129 downgrade of outcomes (Box). The meta-analysis results were categorized using a previous  
130 approach [13], including favourable and statistically significant, favourable and not statistically  
131 significant, neutral, unfavourable and not statistically significant, and unfavourable and  
132 statistically significant (Box, Appendix Figure A). The conclusions were obtained from the

133 abstract and discussion sections from the systematic reviews and were categorized using a  
134 previous approach [13], including positive, neutral, negative, and indeterminate (Box).

135 We used the same hierarchy reported by Kirkham *et al.* to select meta-analyses from  
136 systematic reviews with multiple treatment group comparisons [5]. Specifically, we selected the  
137 first intervention comparison which met the following criteria: “(1) an intervention comparison  
138 described in the protocol as the primary review comparison; (2) the first intervention comparison  
139 mentioned in the title of the protocol; (3) an intervention comparison described in the review as  
140 the primary review comparison; (4) the first intervention comparison mentioned in the objectives  
141 of the review; (5) the intervention comparison used in the first meta-analysis presented in the  
142 review.”

#### 143 *2.5 Methodological quality appraisal*

144 The overall methodological quality of the systematic reviews was assessed using the  
145 Assessment of Multiple SysTemAtic Reviews (AMSTAR) tool (Appendix Table B) [14]. The  
146 scores range from 0 to 11, with higher scores indicating superior quality. For our study, a score  
147 of 8 or higher was considered higher quality. This assessment was conducted to ascertain the  
148 overall quality of completed and published systematic reviews that were registered in  
149 PROSPERO.

#### 150 *2.6 Analysis*

151 We explored the association between statistical significance of meta-analysis results and  
152 adding, upgrading or downgrading of outcomes compared to no discrepancies, by calculating a  
153 relative risk (RR) and 95% confidence interval (CI), where the meta-analysis results were  
154 dichotomised into favourable and statistically significant versus any of the other 4 categories.  
155 The formula is  $RR = [a/(a+b)] \div [c/(c+d)]$ , where a is the number of meta-analysis outcomes that

156 are discrepant and have a favourable and statistically significant result, b is the number of meta-  
157 analysis outcomes that are not discrepant and have a favourable and statistically significant  
158 result, c is the number of meta-analysis outcomes that are discrepant and do not have a  
159 favourable and statistically significant result, and d is the number of meta-analysis outcomes that  
160 are not discrepant and do not have favourable and statistically significant result. This analysis  
161 was similar to those conducted by Page and colleagues in their Cochrane review of outcome  
162 reporting bias [9]. The RR and 95% CI were calculated for outcomes that were explicitly  
163 reported as primary outcomes, as well as including those that were derived using the  
164 classification scheme reported above. Our hypotheses were that when the meta-analysis result  
165 was favourable and statistically significant, adding/upgrading of outcomes would be more likely  
166 while downgrading of outcomes would be less likely. A sensitivity analysis was also conducted  
167 consistent with the analysis method used by Kirkham and colleagues [5], to allow comparability  
168 of results. For this analysis, the meta-analysis results were dichotomised into statistically  
169 significant versus not statistically significant and the hypotheses were that new/upgraded  
170 outcomes would be more likely to have statistically significant meta-analysis results while  
171 downgraded outcomes would be less likely, than if there was no discrepancy.

172 We also conducted a post-hoc analysis for systematic reviews that were funded. Similar  
173 to our primary analysis, we explored the association between statistical significance of meta-  
174 analysis results and adding, upgrading or downgrading of outcomes compared to no  
175 discrepancies by calculating a RR and 95% CI, where the meta-analysis results were  
176 dichotomised into favourable and statistically significant versus any of the other 4 categories.  
177 This analysis was repeated for systematic reviews that did not have funding. Sensitivity analyses  
178 were also conducted using the Kirkham *et al.* approach [5].

179           The RR and 95% CI were calculated for obtaining a positive conclusion for new primary  
180 outcomes or upgrades, and downgrades compared to no discrepancies (where conclusions were  
181 categorised as positive versus all other conclusion types). Our hypotheses were that when the  
182 conclusion was positive, adding/upgrading of outcomes would be more likely while  
183 downgrading of outcomes would be less likely. A sensitivity analysis was also conducted to  
184 calculate the RR and 95% CI using a similar approach as to Kirkham *et al.* [5]. For this  
185 sensitivity analysis, our hypothesis was that when outcomes were added or upgraded, a positive  
186 conclusion would be more likely, while when outcomes were downgraded, a positive conclusion  
187 would be less likely.

### 188 3. RESULTS

#### 189 3.1 Sample of PROSPERO records

190 In November 2013, 2,426 protocol records were registered with PROSPERO and 344  
191 were completed systematic reviews (Figure 1). Of the completed reviews, 140 were potentially  
192 relevant (i.e., published or *in press*), and of these 44 were excluded because they were not  
193 systematic reviews of interventions or the final review was not written in English (Appendix  
194 Table C). Ninety-six systematic reviews fulfilled the eligibility criteria and were subsequently  
195 included (Appendix Table C).

#### 196 3.2 Systematic review characteristics

197 Eighty-nine (92.7%) of the systematic reviews were published between 2012 and 2013,  
198 and 4 (4.2%) were published in 2014, as they were *in press* at the time we downloaded their  
199 PROSPERO records. 81 (84.3%) included 2 to 30 studies, 56 (58.3%) limited inclusion to  
200 randomized controlled trials, and 67 (68.8%) conducted a meta-analysis (Table 1). In addition,  
201 36 (37.5%) reported no source of funding, 45 (46.9%) were conducted in the United Kingdom or  
202 North America, and 5 (5.2%) published their protocol in a journal.

#### 203 3.3 Methodological quality

204 Eight of the 11 AMSTAR items were adequately addressed by more than 72 (75%) of the  
205 systematic reviews (Figure 2, Appendix Table D). However, 72 (75%) of the reviews did not  
206 state conflicts of interest for included studies and review authors, 63 (66%) did not provide a list  
207 of excluded studies, 39 (41%) did not assess publication bias where it would have been  
208 appropriate to do so, and 14 (15%) did not consider methodological quality or risk of bias results  
209 in their conclusion statements.

#### 210 3.4 Outcome reporting

211 Although the primary outcome was indicated in PROSPERO, which is structured to  
212 separate primary and secondary outcomes, it was not explicitly reported for 37 (38.5%) of the  
213 completed systematic reviews, so was derived for the purpose of our study (Table 2). The  
214 primary outcomes were derived using the title (35.2%), objectives (24.3%), or were the most  
215 serious outcomes (40.5%). Thirty-one (32.3%) of the systematic reviews had a discrepancy  
216 between the primary outcomes reported in the PROSPERO record and final publication, while 65  
217 (67.7%) had no discrepancies (Table 3). Of the reviews with discrepancies, 6 (5.9%) had a new  
218 primary outcome, 6 (5.9%) excluded a primary outcome, 6 (5.9%) upgraded an outcome, and 22  
219 (21.8%) downgraded a primary outcome. One (1.0%) of the systematic reviews reported a reason  
220 for changing their primary outcome. Six (5.9%) systematic reviews reported a change in their  
221 primary outcome definition and 1 (1.0%) changed the measurement method for the primary  
222 outcome.

### 223 *3.5 Meta-analysis results*

224 The results of 139 meta-analyses in 67 systematic reviews are presented in Appendix  
225 Table E. There was no significant increased risk of adding or upgrading an outcome when the  
226 meta-analysis result was favourable and statistically significant (RR 2.14, 95% CI 0.53 to 8.63),  
227 which was the same result as found in our sensitivity analysis (Appendix Table F). This result  
228 was unchanged when only the primary outcomes that were explicitly reported were included in  
229 our analysis (RR 2.02, 95% CI 0.35 to 11.56; Appendix Table G). Further, there was no  
230 significant decreased risk of downgrading an outcome when the meta-analysis result was  
231 favourable and statistically significant (RR 0.76, 95% CI 0.27 to 2.17) and the same result was  
232 observed in our sensitivity analysis. Similarly, when only the primary outcomes that were  
233 explicitly reported were included in our analysis, no statistically significant results were



234 observed for downgrades (RR 1.37, 95% CI 0.20 to 9.42). Calculations were not possible for  
235 excluded primary outcomes since they were absent from the publications (by definition).

236 A post-hoc analysis was conducted for systematic reviews with funding, as well as for  
237 systematic reviews without funding (Appendix Tables H-J). No statistically significant results  
238 were observed in our overall analysis or sensitivity analyses.

### 239 *3.6 Conclusion statements*

240 The categorisation of conclusions for all included systematic reviews is presented in  
241 Appendix Table K. There was no significant increased risk of adding or upgrading outcomes  
242 when the conclusion was positive (RR 0.89, 95% CI 0.31 to 2.53). Further, there was no  
243 significant decreased risk of downgrading an outcome when the conclusion was positive (RR  
244 0.56, 95% CI 0.29 to 1.08). Our sensitivity analyses also found no significant risk of a positive  
245 conclusion when the outcomes were added/upgraded or downgraded (Appendix Table L).

#### 246 4. DISCUSSION

247 One-third of published systematic reviews that were registered with PROSPERO had a  
248 discrepancy between the primary outcome reported in their record and the primary outcome  
249 reported in the review publication. Of the discrepancies, downgrading of primary outcomes was  
250 most common (22%), and 6% of reviews omitted a protocol-specified primary outcome from the  
251 review. In addition, 39% of reviews did not explicitly specify a primary outcome(s) in the  
252 review. Although a lot of discrepancies were observed, we did not find statistically significant  
253 associations between discrepant outcome reporting and having a favourable and statistically  
254 significant meta-analysis result or positive conclusion. However, the small number of reviews  
255 within each subgroup of discrepancy classification likely limited the statistical power to detect  
256 statistically significant results. PROSPERO has now passed 5,000 registrants and repeating this  
257 study is likely to yield a larger number of published systematic reviews to examine.

258 Our study is the first to measure outcome reporting bias of systematic reviews that were  
259 registered in PROSPERO. To examine this issue, we systematically searched for 96 systematic  
260 reviews published between 2011 and 2014. We abstracted data in duplicate, which were triple-  
261 checked by a third reviewer, and appraised the included reviews using the AMSTAR tool. The  
262 included systematic reviews were of high methodological quality, on average. Areas for  
263 improvement included providing a list of excluded studies, assessing publication bias when  
264 appropriate (as per the AMSTAR criterion), and reporting conflicts of interest for the systematic  
265 review authors, as well as for the included studies.

266 Our results are only generalizable to intervention reviews, as the risk of outcome  
267 reporting bias in other types of reviews (e.g., diagnostic reviews) remains unknown. As well, we  
268 only included non-Cochrane reviews. We considered only primary outcomes, which may have  
269 underestimated the occurrence of outcome reporting bias for all types of outcomes. However,

270 this is the same approach to other studies examining outcome reporting bias [4-7]. Limited  
271 resources meant that we were unable to contact authors of the discrepant systematic reviews to  
272 determine the reason for these inconsistencies. Only one review reported a rationale for changing  
273 the outcome, which makes it difficult to provide definitive conclusions as to why these changes  
274 may occur [15]. The reason that was reported by the authors was that the clinical experts on their  
275 team selected the most clinically important outcomes, which did not align with what was  
276 reported in their PROSPERO record. We were unable to include a larger sample of published  
277 and completed systematic reviews, due to resource restraints. Due to the small number of  
278 included reviews in our analyses, we were unable to examine possible sources of heterogeneity  
279 that may have confounded our results or conduct sub-group analysis for outcome reporting bias  
280 for systematic reviews with active comparators versus placebo, “high” versus “low” quality as  
281 per the AMSTAR tool, and randomized trials versus non-randomized studies. As well, there is a  
282 chance that there were more completed systematic reviews that were published but the authors of  
283 the review failed to update their PROSPERO record (although they are sent 3 auto- reminders to  
284 update their information in PROSPERO). We were only able to include the systematic reviews  
285 with meta-analyses in our statistical analysis of outcome reporting bias, which is consistent with  
286 previous studies [4-7]. Finally, we calculated risk ratios instead of odds ratios to compare our  
287 study with previous studies conducted in this area.

288 A recent Cochrane review [9] included 4 previous studies that examined discrepancies in  
289 outcome reporting between systematic review protocols and published systematic reviews [4-7].  
290 All of these studies included Cochrane reviews that were published between 2000 and 2009 and  
291 none appraised the methodological quality of included systematic reviews using the AMSTAR  
292 tool. A total of 485 Cochrane Reviews were included and discrepancies were identified in 38%

293 of these. A meta-analysis of two of the studies was conducted and no statistically significant  
294 association between statistical significance of meta-analysis results and discrepant outcome  
295 reporting (adding, upgrading or downgrading) was found. These results are consistent with those  
296 observed in our study.

297 Our results suggest that authors of non-Cochrane reviews are similar to Cochrane review  
298 authors in their outcome reporting behaviours. It is possible that systematic review authors are  
299 not focused on identifying primary outcomes of interest at the protocol stage, and are instead just  
300 completing the PROSPERO form. Further, as registration in PROSPERO is voluntary (and is  
301 relatively new) it is possible that our sample (as well as studies using samples of Cochrane  
302 reviews) underestimated the overall number of primary outcome discrepancies in systematic  
303 reviews in general.

304 Using pre-established methods [16], we estimate that 17,399 systematic reviews were  
305 published in 2013. During this time, 1,612 Cochrane reviews were registered and 1,526 non-  
306 Cochrane reviews were registered with PROSPERO. This means that only 18% of published  
307 systematic review authors registered their protocol. As such, we recommend that all non-  
308 Cochrane reviews are registered with PROSPERO. Furthermore, review authors are advised to  
309 consider the selection of primary outcomes carefully and report the explanations for protocol  
310 modifications in the final review publication. Review authors should think about the importance  
311 of outcomes prior to embarking on their review and limit the number of outcomes to ensure that  
312 those selected are both necessary and meaningful. Core outcome sets have been recommended  
313 for trials (COMET initiative, <http://www.comet-initiative.org/>) and it is recommended that  
314 systematic review authors are familiar with this guidance when selecting outcomes for inclusion  
315 in their review. Peer reviewers should check PROSPERO to see if there are any discrepancies

316 between the record and review publication and ensure that the author explains these. Finally,  
317 journals are encouraged to focus acceptance on registered systematic reviews, as we found that  
318 these are likely to be of high methodological quality.

319 Few studies have examined outcome reporting bias in systematic reviews [9]. There has  
320 been no study of systematic reviews that are not registered with the Cochrane Collaboration or  
321 PROSPERO. This could be done by contacting review authors to obtain their unpublished  
322 protocol, if one exists. Future research should examine a larger sample of PROSPERO records as  
323 this database matures, as well as examine the discrepancies in primary outcomes reported in the  
324 abstract and full-text of the published systematic reviews.

**325 AUTHORS' CONTRIBUTIONS**

326 All authors conceptualized the study. ACT pilot-tested the data abstraction form, resolved  
327 discrepancies, analyzed the results, interpreted the results, wrote the paper, and approved the  
328 final paper. EC coordinated the review, pilot-tested the data abstraction form, resolved  
329 discrepancies, checked all of the cleaned data, helped write the paper, and approved the final  
330 paper. AB, JP, TC, KD, MJP, and HM pilot-tested the data abstraction form, conducted data  
331 abstraction, appraised the quality of the articles, edited the paper, and approved the final paper.  
332 MJP also analyzed the data, AB screened the records for inclusion, and HM helped clean the data  
333 and resolve discrepancies. TC, LAS, SES, and DM edited the paper and approved the final paper.

334 ACT accepts full responsibility for the finished article, had access to all of the data, and  
335 controlled the decision to publish. ACT affirms that this manuscript is an honest, accurate, and  
336 transparent account of the study being reported; that no important aspects of the study have been  
337 omitted; and that no discrepancies from the study as planned occurred.

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**342 COMPETING INTERESTS**

343 All authors have completed the ICMJE uniform disclosure form at  
344 [www.icmje.org/coi\\_disclosure.pdf](http://www.icmje.org/coi_disclosure.pdf) and declare: no financial support for the submitted work; no  
345 financial relationships with any organizations that might have an interest in the submitted work  
346 in the previous three years; AB, LAS, and DM are members of the PROSPERO Advisory Group;  
347 ACT is an author of one of the included systematic reviews but was not involved with the

348 AMSTAR appraisal or data abstraction for this review and was blinded to the author names  
349 during the analysis, she is also an Associate Editor for the journal but was not involved with the  
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## 357 **ETHICS APPROVAL**

358 Ethics approval was not required.

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**Box 1 Classification: Primary outcomes, Meta-analysis results, and Conclusion statements**Classification of changes to primary outcomes:

- New (Inclusion or Addition): the addition of a completely new primary outcome;
- Exclusion: the omission of a primary outcome in the publication;
- Upgrade: when a secondary outcome in the protocol was changed to a primary outcome in the publication;
- Downgrade: when a primary outcome in the protocol was changed to a secondary or undefined outcome in the publication.

Classification of meta-analysis results:

- Favourable, statistically significant (i.e. effect in favour of the intervention with  $p \leq 0.05$ );
- Favourable, non-statistically significant;
- Neutral (effect size between 0.95-1.05 and the confidence interval crosses 1);
- Unfavourable, statistically significant (i.e. effect in favour of the non-intervention comparator with  $p \leq 0.05$ );
- Unfavourable, non-statistically significant.

Categorization of conclusion statements

- Positive (authors stated that there is evidence of effectiveness);
- Neutral (no evidence of effectiveness or they reported no opinion);
- Negative (authors advised against the use of the intervention or it was not recommended); or
- Indeterminate (authors stated that there is insufficient evidence or that more research is required).



370 **FIGURE LEGENDS**

371 **Figure 1: Flow of systematic reviews through the study**

372 **Figure 2: AMSTAR methodological quality results**

373 Note: NA = not applicable.

374 Items:

375 1. A priori design

376 2. Duplicate selection/DA

377 3. Literature search

378 4. Publication status

379 5. List of studies

380 6. Study characteristics

381 7. Quality assessed

382 8. Quality used

383 9. Methods appropriate

384 10. Publication bias assessed

385 11. Conflicts stated

386 **Table 1. Characteristics of the 96 included systematic reviews**

Characteristic	# of systematic reviews (%)
<b>Publication year</b>	
2011	3 (3.1)
2012	29 (30.2)
2013	60 (62.5)
2014	4 (4.2)
<b>Total # of studies included</b>	
0-20	70 (72.9)
21-40	9 (19.8)
>40	7 (7.3)
<b>Total # of participants in included studies</b>	
≤1000 to 5000	48 (50)
5001-10,000	5 (5.2)
10,001-50,000	7 (7.3)
50,001-100,000	3 (3.1)
>100,000	2 (2.1)
Not Reported	31 (32.3)
<b>Study designs included</b>	
All randomized controlled trials	56 (58.3)
Mixed study designs*	35 (36.5)
All observational studies	5 (5.2)
<b>Meta-analysis conducted</b>	
Yes	67 (69.8)
No	29 (30.2)
<b>Funding†</b>	
Stated no funding received	36 (37.5)
Public funder (e.g., academia, government)	56 (58.4)
Commercial Organization	4 (4.2)
<b>Geographic Region‡</b>	
Europe	47 (49)
North America	20 (20.9)
South America	11 (11.4)
Easter Asia	9 (9.3)
Australia	5 (5.2)
Southern Asia	2 (2.1)
Southern Africa	2 (2.1)
<b>Published protocol in a journal</b>	
Yes	5 (5.2)
No	91 (94.8)
<b>Participant population in publication§</b>	
Healthy or presumed healthy	14 (14.6)
Mixed conditions	11 (11.5)
Musculoskeletal conditions	10 (10.4)
Infectious diseases	9 (9.4)
Present/history of cancer	9 (9.4)
Pregnancy-related or reproductive conditions	8 (8.3)
Psychiatric/mental health conditions	7 (7.3)
Cardiovascular conditions	6 (6.3)
Respiratory conditions	6 (6.3)
Autoimmune diseases	3 (3.1)
Gastrointestinal and abdominal conditions	2 (2.1)
Genetic diseases	2 (2.1)
Neurodegenerative/neurological conditions	2 (2.1)
Oral-related conditions	2 (2.1)
Urinary conditions	2 (2.1)
Auditory conditions	1 (1.0)
Overweight	1 (1.0)
Type 2 diabetes	1 (1.0)

387 **Note:** \*Mixed could indicate, for example, RCT & quasi-RCT (not necessarily mixed with  
388 observational studies); † Source: Cochrane EPOC Group. Available at:  
389 <http://epoc.cochrane.org/sites/epoc.cochrane.org/files/uploads/datacollectionchecklist.pdf>; ‡ If  
390 more than one country was listed (n = 8), only the first country's geographic region is listed here;  
391 §as reported by the review authors.

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392 **Table 2. Number of Primary Outcomes in the Publications**

<b>Outcome details</b>	<b># of systematic reviews (%)</b>
<b>Number explicit per review</b>	
0	37 (38.5)
1	35 (36.5)
2	10 (10.4)
3	6 (6.3)
4	3 (3.1)
5	1 (1.0)
6	2 (2.1)
7	1 (1.0)
8	1 (1.0)
<b>Number derived per review</b>	
NA (were explicit)	59 (61.5)
1	24 (25.0)
2	6 (6.3)
3	5 (5.2)
4	1 (1.0)
5	0 (0)
6	1 (1.0)
<b>Derived Method Used</b>	
NA (were explicit)	59 (61.5)
Method 1-from title	13 (13.5)
Method 2-from objectives	9 (9.4)
Method 3-most serious	15 (15.6)

393 **Abbreviation:** NA = not applicable.

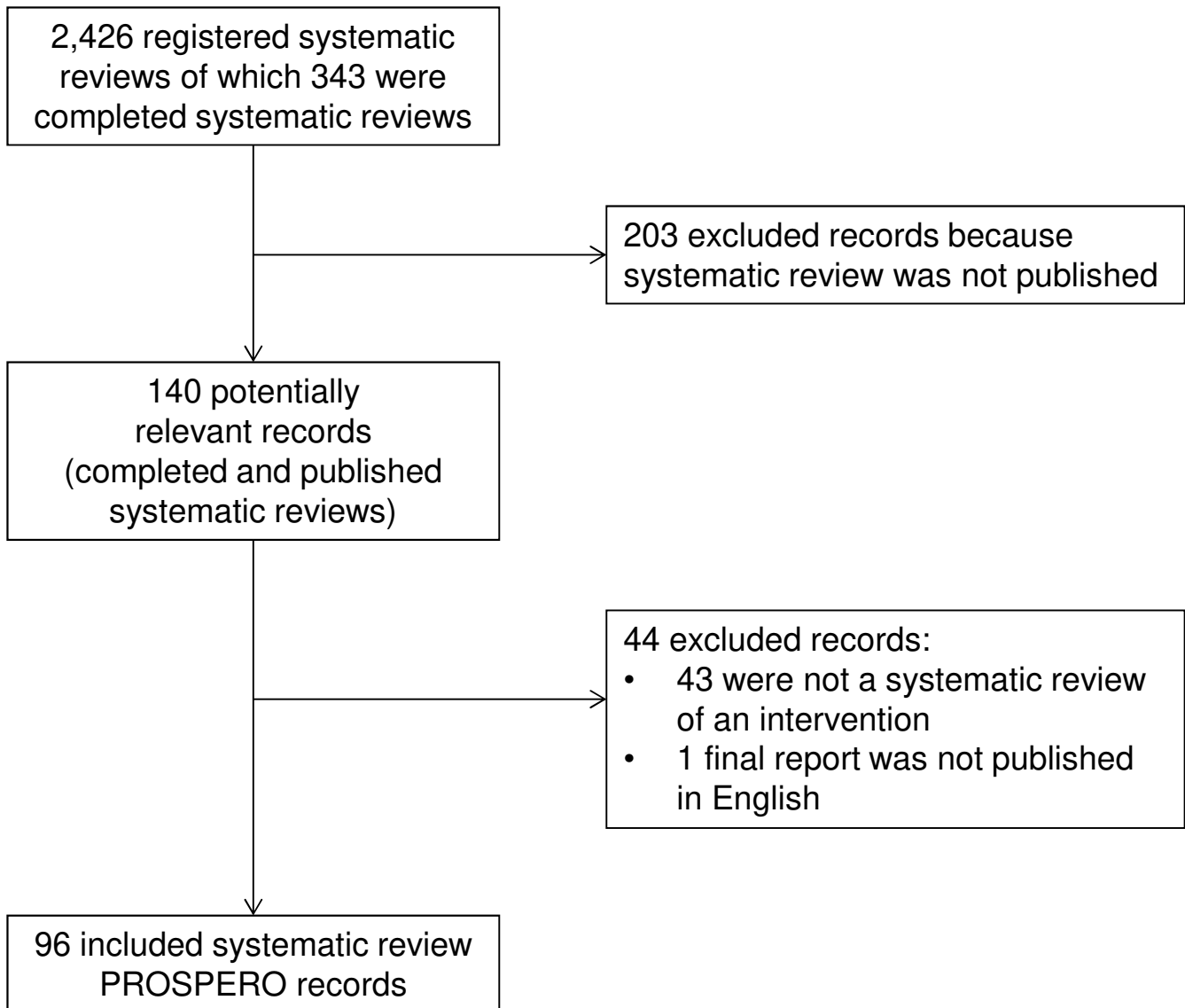
394 **Table 3. Changes in Primary Outcomes**

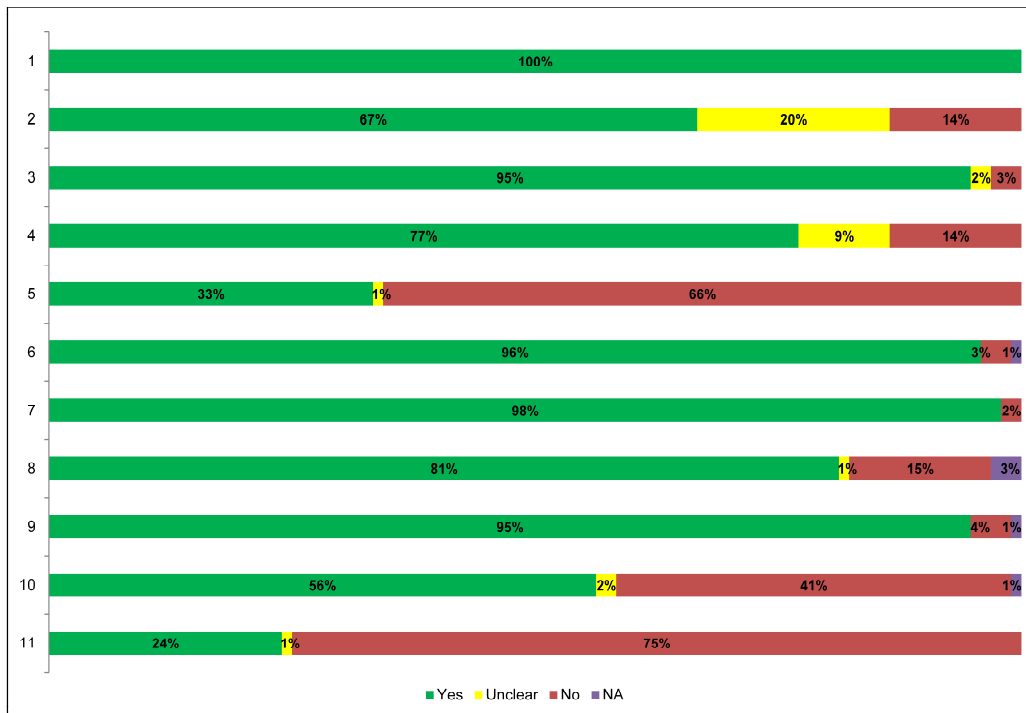
<b>Change Type</b>	<b># of systematic reviews with <math>\geq 1</math> change(s) (%)*</b>
New Primary Outcome(s)	6 (5.9)
Exclusion of Primary Outcome(s)	6 (5.9)
Upgrade of Primary Outcome(s)	6 (5.9)
Downgrade of Primary Outcome(s)	22 (21.8)
Change in Primary Outcome Definition	6 (5.9)
Change in Primary Outcome Measure	1 (1.0)
No Discrepancies	65 (67.7)

395 **Note:** \*Does not add up to 100% because some systematic reviews included more than 1 primary  
396 outcome.

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