APPENDIX: ADDITIONAL DESCRIPTION OF THE METHODS

Management of conflict of interest

The panel filled out intellectual, institutional, and financial conflict of interest forms[e1] in November 2020. The forms were reviewed by methodologists at American Dental Association Science and Research Institute, members of a subcommittee of the American Dental Association Council on Scientific Affairs, and officers at the US Food and Drug Administration for disqualifying conflicts. The guideline panel was asked to orally disclose and report any updates to their conflicts before each panel meeting began. When formulating recommendations, if a panel member had conflicts related to a particular recommendation statement, they abstained from participating in the discussion. On several occasions, members of the panel who were investigators on studies included in the evidence synthesis abstained from weighing in on conversations in which their potential biases could affect the final consensus.

Certainty of the evidence assessment

To evaluate the certainty of the evidence,[e2] we used the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach defined as "extent of our confidence that the estimates of an effect are adequate to support a particular decision or recommendation."[e3] When applying the GRADE approach, data coming from randomized controlled trials begin at high certainty and can decrease to moderate, low, or very low. The certainty or confidence can be lowered if there is evidence of indirectness, risk of bias, publication bias, inconsistency, or imprecision.

Methodologists guided the panel through the GRADE Evidence to Decision framework as they formulated recommendations.[e4] To aid in decision making, these factors were considered as part of this framework: desirable effects, undesirable effects, certainty of the evidence, net balance between desirable and undesirable effects, patient's values and preferences, acceptability, feasibility, resources required, and equity.

Updating process

If new evidence emerges that could change the recommendation strength or direction or after 5 years, whichever comes first, staff from the American Dental Association Science and Research Institute team will initiate an update of the guideline, and these will be posted at https://www.ada.org/en/resources/research/science-and-research-institute/evidence-based-dental-research.

e1. Traversy G, Barnieh L, Akl EA, et al. Managing conflicts of interest in the development of health guidelines. *CMAJ*. 2021;193(2):E49-E54.
e2. Guyatt GH, Oxman AD, Kunz R, Vist GE, Falck-Ytter Y, Schünemann HJ; GRADE Working Group. What is "quality of evidence" and why is it important to clinicians? *BMJ*. 2008;336(7651):995-998.
e3. Balshem H, Helfand M, Schünemann HJ, et al. GRADE guidelines, 3: rating the quality of evidence. *JCEI*. 2011;64(4):401-406.
e4. Alonso-Coello P, Oxman AD, Moberg J, et al. GRADE Evidence to Decision (EtD) frameworks: a systematic and transparent approach to making well informed healthcare choices—2, clinical practice guidelines. *BMJ*. 2016;353:i2089.

eBox. List of stakeholder organizations contacted and responses.

1. Academy of General Dentistry (AGD)*
2. American Dental Association Council on Dental Benefit Programs (CDBP)*
3. American Dental Association Council on Dental Practice (CDP)*
4. American Academy of Physician Assistants (AAPA)*
5. American Association of Endodontics (AAE)*
6. American College of Clinical Pharmacy (ACCP)*
7. American College of Physicians (ACP)*
8. Health Resources and Services Administration (HRSA)*
9. National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic*
10. Special Care Dentistry Association Geriatrics Council*
11. Veterans Health Administration (VA)*
12. American Academy of Periodontology (AAP)*
13. American Dental Hygienists Association (ADHA)*
14. Association of State and Territorial Dental Directors (ASTDD)*
15. National Institute of Dental and Craniofacial Research (NIDCR)*
16. American Geriatrics Society (AGS)*
17. Agency of Healthcare and Research Quality (AHRQ)*
18. American Dental Association Council on Advocacy for Access and Prevention (CAAP)*
19. Indian Health Services (IHS)*
20. National Rural Health Association (NRHA) and NC Oral Health*
21. National Network for Oral Health Access (NNOHA)*
22. American Public Health Association (APHA)*
23. American Association of Nurse Practitioners (AANP)*
24. American Academy of Ambulatory Care Nursing (AAACN)
25. American Academy of Oral Medicine (AAOM)*
26. American Academy of Orofacial Pain (AAOP)
27. American Academy of Pain Medicine (AAPM)
28. American Association for Dental Research (AADR)
29. American Dental Education Association (ADEA)*
30. American Society of Dentist Anesthesiologists (ASDA)*
31. Emergency Nurses Association (ENA)*

* Indicates organizations from which input was obtained.

eTable 1. Clinical questions addressed by the guideline panel.

CLINICAL SCENARIO	CLINICAL PRACTICE GUIDELINE QUESTION
Simple Tooth Extraction	1. In children undergoing 1 or more simple tooth extractions (without the need for a flap, osteotomy, or tooth sectioning), which analgesic should we recommend to manage postoperative pain?
Surgical Tooth Extraction	2. In children undergoing 1 or more surgical tooth extractions, which analgesic should we recommend to manage postoperative pain? 3. In children undergoing 1 or more surgical tooth extractions, should we recommend corticosteroids vs not using corticosteroids to manage postoperative pain?
Toothache (Symptomatic Pulpitis [That Is, Reversible or Symptomatic Irreversible Pulpitis With or Without Symptomatic Apical Periodontitis or Symptomatic Furcation or Periapical Involvement] or Pulp Necrosis With Symptomatic Apical Periodontitis or Furcation or Periapical Disease, or Acute Apical Abscess) With No Immediate Access to Definitive Dental Treatment	4. In children with toothache (symptomatic pulpitis [that is, reversible or symptomatic irreversible pulpitis with or without symptomatic apical periodontitis or symptomatic furcation or periapical involvement) or pulp necrosis with symptomatic apical periodontitis or furcation or periapical disease, or acute apical abscess) with no immediate access to definitive dental treatment, which analgesic should we recommend to manage acute pain?