SUPPLEMENTARY DIGITAL MATERIAL 6

Supplementary Table VI.---Standardization of the Clinical Practice Guidelines grading system.

		Classification of the strength of recommendation			Classification of the quality of the evidence			
N°	Guideline's short Title	Strong	Weak	No recommendation possible	High	Moderate	Low	Very Low
1	NICE_Rehabilitation, 2022	In recommendations on activities or interventions that should (or should not) be offered, use directive language such as 'offer' (or 'do not offer'), 'advise', or 'ask about'. In keeping with the principles of shared decision-making, people may choose whether or not to accept what they are offered or advised. If there is a legal duty to apply a recommendation, or the consequences of not following a recommendation are extremely serious, the recommendation should use 'must' or 'must not' and be worded in the passive voice.	If there is a closer balance between benefits and harms (activities or interventions that could be used), use 'consider'.		**High:** We are very confident that the true effect lies close to that of the estimate of the effect	**Moderate:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different	**Low:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect	**Very low:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect
2	Consortium_Bone health, 2022	**1:** Strong recommendation ("We recommend…")	**2:** Weak recommendation ("We suggest…"/"One may…")		**A:** High-quality evidence. Consistent evidence from RCTs without	**B:** Moderate-quality evidence. Evidence from RCTs with important limitations (inconsistent results,	**C:** Low-quality evidence. Evidence for at least one critical outcome from	**D:** Very low-quality evidence: Lack of evidence for at least 1

					important limitations or exceptionally strong evidence from observational studies	methodologic flaws, indirect or imprecise) or very strong evidence from observational studies	observational studies, case series, RCTs with serious flaws, or indirect evidence	critical outcome from observational studies, case series, or RCTs with serious flaws or indirect evidence
3	German speaking society_Lifelong follow-up, 2022	**A:** Strongly recommended (shall/shall not) (Soll/soll nicht)	**B:** Recommended (should/should not) (Sollte/sollte nicht)	**0:** Open (Can be considered/can be waived)	Not reported	Not reported	Not reported	If only strength of consensus is given
4	Can-SCIP, 2021	**Strong:** if a directive language is used (e.g., provide)[a]	**Weak:** if an indrect language is used (e.g., consider providing)[a]		**Level A:** Recommendation supported by at least 1 meta-analysis, systematic review, or randomized controlled trial of appropriate size with relevant control group.	**Level B**: Recommendation supported by cohort studies that at minimum have a comparison group, well-designed single subject experimental designs, or small sample size randomized controlled trials.		**Level C:** Recommendation supported primarily by expert opinion based on their experience, though uncontrolled case series without comparison groups that support the recommendations are also classified here.
5	Sekido N_Urinary dysfunction, 2020	**A:** this action is strongly recommended **B:** this action is recommended **D:** Not performing this action is recommended	**C:** There is no clear evidence for recommending this action **C1:** the action can still be	Pending: No decision has been made regarding the GoR	**Level 1:** Supported by multiple level I clinical studies (I: Large-scale RCTs (≥100 participants in	**Level 2:** Supported by a single level I clinical study or multiple level II clinical studies (II: Small-scale RCTs or RCTs with	**Level 3:** Supported by multiple level III clinical studies (III: Controlled studies carried out without	**Level 5**: Supported by multiple level V clinical studies (V: Retrospective

			performed **C2:** Performing the action is not recommended		each group) or RCTs with the number of participants fulfilling the pre-calculated statistical power with definitive results)	the number of participants not fulfilling the pre-calculated statistical power with definitive results. If the results were not definitive, then the level was reduced by one)	randomized allocation) **Level 4:** Supported by multiple level IV clinical studies (IV: Prospective observational studies with no control)	case studies or the opinions of specialists)
6	Consortium_Neurogenic bowel, 2020	Strong (panel opinion)	Moderate (panel opinion)		same as Consortium 2018	same as Consortium 2018	same as Consortium 2018	same as Consortium 2018
7	Consortium_Autonomic dysreflexia, 2020	Strong (panel opinion)	Moderate (panel opinion)		same as Consortium 2018	same as Consortium 2018	same as Consortium 2018	same as Consortium 2018
8	MASCIP_Weight management, 2019	Strong ("We recommend")	Conditional ("We suggest")		**A:** Highest quality evidence resulted from consistent results or metaanalysis of multiple randomised controlled trials (RCT)	**B:** The next highest level was defined by at least one well designed RCT.	**C:** Moderate to low level evidence came from controlled trials that were not randomised, cohort- or case-controlled studies, or from multiple time-series trials.	**D:** The lowest evidence (very low) was from expert clinical experience or from descriptive studies
9	International Consultation on Incontinence, 2018	**Grade A** recommendation usually depends on consistent Level 1 evidence and often means that the recommendation is effectively mandatory and placed within a clinical care pathway. Grade A recommendation can	**Grade B** recommendation usually depends on consistent Level 2 and/or 3 studies, or ‘‘majority evidence’’ from RCTs **Grade C**	**Grade D** ‘‘No recommendation possible’’ would be used where the evidence is inadequate or conflicting and when expert opinion is delivered without a formal analytical	**Level 1:** Evidence usually involves meta-analysis of trials (RCTs) or a good quality randomised controlled trial, or ‘‘all or none’’ studies in which no treatment is not an option, for	**Level 2:** Evidence includes ‘‘low’’ quality RCT (e.g., <80% follow-up) or meta-analysis (with homogeneity) of good quality prospective ‘‘cohort studies.’’ These may include a single group when individuals who	**Level 3:** Good quality retrospective ‘‘case–control studies’’ where a group of patients who have a condition are matched appropriately (e.g., for age, sex, etc.) with control	**Level 4:** Evidence includes expert opinion where the opinion is based not on evidence but on ‘‘first principles’’ (e.g., physiological or anatomical)

		follow from Level 2 evidence, but requires a greater body of evidence.	recommendation usually depends on Level 4 studies or ‘‘majority evidence’’ from Level 2/3 studies or Delphi processed expert opinion	process, such as by Delphi	example, in vesicovaginal fistula.	develop the condition are compared with others from within the original cohort group. There can be parallel cohorts, where those with the condition in the first group are compared with those in the second group.	individuals who do not have the condition. Good quality ‘‘case series’’ where a complete group of patients all, with the same condition/disease/therapeutic intervention, are described, without a comparison control group.	or bench research. The Delphi process can be used to give ‘‘expert opinion’’ greater authority. In the Delphi process a series of questions are posed to a panel; the answers are collected into a series of ‘‘options’’; the options are serially ranked; if a 75% agreement is reached then a Delphi consensus statement can be made.
10	UEMS_PRM, 2018	**A:** it must be normally applied	**B:** It is important, but can be applied not in all situations **C:** Less important, it can be applied on a voluntary basis **D:** Very low importance		**I:** Multiple Randomized Controlled Trials or Systematic Reviews of such studies	**II:** One Randomized Controlled Trial	**III:** Multiple Controlled nonrandomized Studies or Systematic Reviews of such studies	**IV:** Other studies

11	International Continence Society_Urodynamics, 2018	Strong[b]	Weak[b]	No classification possible[c]	No classification possible[c]	No classification possible[c]	No classification possible[c]
12	Consortium_Cardiometabolic risk, 2018	Strong (panel opinion)	Moderate (panel opinion) Low (panel opinion)	**A:** The guideline recommendation is supported by one or more level I studies. (I: Evidence based on randomized controlled clinical trials (or meta-analysis of such trials) of adequate size to ensure a low risk of incorporating false-positive or false-negative results.)	**B:** The guideline recommendation is supported by one or more level II studies. (II: Evidence based on randomized controlled trials that are too small to provide level I evidence. These may show either positive trends that are not statistically significant or no trends and are associated with a high risk of false-negative results.)	**C:** The guideline recommendation is supported only by level III (III: Evidence based on nonrandomized, controlled, or cohort studies; case series; case-controlled studies; or cross-sectional studies)	**C:** The guideline recommendation is supported only by level IV or V studies (IV: Evidence based on the opinion of respected authorities or expert committees as indicated in published consensus conferences or guidelines; V: Evidence that expresses the opinion of those individuals who have written and reviewed this guideline, based on experience, knowledge of the relevant literature, and discussions with peers)

13	Consortium_Venous thromboembolism, 2016	**1:** Strong recommendation ("We recommend…")	**2:** Weak recommendation ("We suggest…")	**A:** High-quality evidence. Consistent evidence from RCTs without important limitations or exceptionally strong evidence from observational studies	**B:** Moderate-quality evidence. Evidence from RCTs with important limitations (inconsistent results, methodologic flaws, indirect or imprecise) or very strong evidence from observational studies	**C:** Low-quality evidence. Evidence for at least one critical outcome from observational studies, case series, RCTs with serious flaws, or indirect evidence	
14	Consortium_Pressure ulcers, 2014	Strong (panel opinion)	Moderate (panel opinion) Low (panel opinion)	**Level** I: Large randomized trials with clear-cut results (and low risk of error)	Level II: Small randomized trials with uncertain results (and moderate to high risk of error)	Level III: Nonrandomized trials with concurrent or contemporaneous controls **Level IV:** Nonrandomized trials with historical controls	**Level V:** Case series with no controls
15	Canadian_Pressure ulcers, 2013	Not described	Not described	**Ia:** Evidence from meta-analysis or systematic review of randomized controlled trials	**Ib:** Evidence from at least one randomized controlled trial **IIa:** Evidence from at least one well-designed controlled study without randomization	**IIb:** Evidence from at least one other type of well-designed quasi-experimental study without randomization	**III:** Evidence from well-designed non-experimental descriptive studies, such as comparative, correlation, and case studies **IV:** Evidence from expert committee reports or opinions and/or clinical experiences of

							respected authorities
16	NICE_Urinary incontinence, 2012	In recommendations on activities or interventions that should (or should not) be offered, use directive language such as 'offer' (or 'do not offer'), 'advise', or 'ask about'. In keeping with the principles of shared decision-making, people may choose whether or not to accept what they are offered or advised. If there is a legal duty to apply a recommendation, or the consequences of not following a recommendation are extremely serious, the recommendation should use 'must' or 'must not' and be worded in the passive voice.	If there is a closer balance between benefits and harms (activities or interventions that could be used), use 'consider'.	**High:** We are very confident that the true effect lies close to that of the estimate of the effect	**Moderate:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different	**Low:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect	**Very low:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

[a] No strength of recommendation is given in the guideline. The author's assume that a directive language indicates a strong and an indirective language a weak recommendation.

[b] In the guideline it is stated that recommendations are given a grade, according to the classfication system adopted by the European Association of Urology (EAU) modified from the Oxford Centre for Evidence-Based Medicine Levels of Evidence and the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach. However the link given in the guideline is no longer available. The actual version (March 2022) of the Guidelines Office Development Handbook from the European Association of Urology does not match with the gradings given in the guideline.
However what they do is rating the recommendation either strong or weak. Therefore, the strength of recommendation of this guidelie will be infered by the wording of the recommendation (e.g., we recommend = strong, we suggest = weak).

[c] In the guideline it is stated that they graded the quality of evidence, according to the classfication system adopted by the European Association of Urology (EAU) modified from the Oxford Centre for Evidence-Based Medicine Levels of Evidence and the Grading of Recommendations Assessment, Development and Evaluation (GRADE)

approach. However the link given in the guideline is no longer available. The actual version (March 2022) of the Guidelines Office Development Handbook from the European Association of Urology does not match with the gradings given in the guideline. It was therefore not possible to infer the quality of evidence.