S1 Table. Evidence assessment scales used by all included clinical practice guidelines.

Last Name of First Author (Year)	Grading System	Strength of Recommendation	Level of Evidence
Debourdeau *et al.* (2013) [1]	Grading of Recommendations Assessment Development and Evaluation (GRADE) [2]	**Strong (Grade 1)**: The panel is confident that the desirable effects of adherence to a recommendation outweigh the undesirable effects **Weak (Grade 2)**: The panel concludes that the desirable effects of adherence to a recommendation probably outweigh the undesirable effects, but is not confident **Best clinical practice (Guidance):** In the absence of any clear scientific evidence and because of undetermined balance between desirable and undesirable effects, judgment was based on the professional experience and consensus of the international experts within the working group	**High (A):** Further research is very unlikely to change our confidence in the estimate of effect **Moderate (B):** Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate **Low (C):** 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 (D):** Any estimate of effect is very uncertain
Farge *et al.* (2016) [3]	Grading of Recommendations Assessment Development and Evaluation (GRADE)[2]	**Strong (Grade 1)**: The panel is confident that the desirable effects of adherence to a recommendation outweigh the undesirable effects **Weak (Grade 2)**: The panel concludes that the desirable effects of adherence to a recommendation probably outweigh the undesirable effects, but is not confident **Best clinical practice (Guidance):** In the absence of any clear scientific evidence and because of undetermined balance between desirable and undesirable effects, judgment was based on the professional experience and consensus of the international experts within the working group	**High (A):** Further research is very unlikely to change our confidence in the estimate of effect **Moderate (B):** Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate **Low (C):** 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 (D):** Any estimate of effect is very uncertain
Keeling *et al.* (2011) [4]	Grading of Recommendations Assessment, Development, and Evaluation (GRADE) [2]	**1- strong:** clinicians are very certain that benefits do, or do not, outweigh risks and burdens. **2- weak:** clinicians believe that benefits and risks and burdens are finely balanced, or appreciable uncertainty exists about the magnitude of benefits and risks	**A- high:** further research is very unlikely to change our confidence in the estimate of effect **B- moderate:** further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate **C- low:** 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 **D- very low:** any estimate of effect is very uncertain, the objective criteria for assigning the quality of evidence shown in the table below should be used

Last Name of First Author (Year)	Grading System	Strength of Recommendation	Level of Evidence
Watson *et al.* (2015) [5]	Grading of Recommendations Assessment Development and Evaluation (GRADE)[2]	**1-Strong:** clinicians are very certain that benefits do, or do not, outweigh risks and burdens. **2- Weak:** clinicians believe that benefits and risks and burdens are finely balanced, or appreciable uncertainty exists about the magnitude of benefits and risks	**A- High:** further research is very unlikely to change our confidence in the estimate of effect **B- Moderate:** further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate **C- Low:** 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 **D- Very Low:** any estimate of effect is very uncertain
Whitlock *et al.* (2012) [6]	American College of Chest Physicians (ACCP) modified approach to Grading of Recommendations Assessment, Development and Evaluation (GRADE) [7]	**1: Strong**- experts are very certain that benefits do or do not outweigh risks, burden, and costs **2: Weak**- experts are less certain that of the magnitude of the benefits and risks, burden, and costs and their relative impacts	**A**: high-quality evidence- randomized controlled trials and high-quality observational studies with large, consistent, effects **B**: moderate-quality evidence **C**: low quality or very low-quality evidence
Bates *et al.* (2012) [8]	American College of Chest Physicians (ACCP) modified approach to Grading of Recommendations Assessment, Development and Evaluation (GRADE) [7]	**1: Strong**- experts are very certain that benefits do or do not outweigh risks, burden, and costs **2: Weak**- experts are less certain that of the magnitude of the benefits and risks, burden, and costs and their relative impacts	**A**: high-quality evidence- randomized controlled trials and high-quality observational studies with large, consistent, effects **B**: moderate-quality evidence **C**: low quality or very low-quality evidence
Douketis *et al.* (2012) [9]	American College of Chest Physicians (ACCP) modified approach to Grading of Recommendations Assessment, Development and Evaluation (GRADE) [7]	**1- strong**: experts are very certain that benefits do or do not outweigh risks, burden, and costs **2- weak:** experts are less certain that of the magnitude of the benefits and risks, burden, and costs and their relative impacts	**A**: high-quality evidence- randomized controlled trials and high-quality observational studies with large, consistent, effects **B**: moderate-quality evidence **C:** low quality or very low-quality evidence
Falck-Ytter *et al.* (2012) [10]	American College of Chest Physicians (ACCP) modified approach to Grading of Recommendations Assessment, Development and Evaluation (GRADE) [7]	**1: Strong**- experts are very certain that benefits do or do not outweigh risks, burden, and costs **2: Weak**- experts are less certain that of the magnitude of the benefits and risks, burden, and costs and their relative impacts	**A**: high-quality evidence- randomized controlled trials and high-quality observational studies with large, consistent, effects **B**: moderate-quality evidence **C**: low quality or very low-quality evidence

Last Name of First Author (Year)	Grading System	Strength of Recommendation	Level of Evidence
Gould *et al.* (2012) [11]	American College of Chest Physicians (ACCP) modified approach to Grading of Recommendations Assessment, Development and Evaluation (GRADE) [7]	**1: Strong**- experts are very certain that benefits do or do not outweigh risks, burden, and costs **2: Weak**- experts are less certain that of the magnitude of the benefits and risks, burden, and costs and their relative impacts	**A**: high-quality evidence- randomized controlled trials and high-quality observational studies with large, consistent, effects **B**: moderate-quality evidence **C**: low quality or very low-quality evidence
Holbrook *et al.* (2012) [12]	American College of Chest Physicians (ACCP) modified approach to Grading of Recommendations Assessment, Development and Evaluation (GRADE) [7]	**1: Strong**- experts are very certain that benefits do or do not outweigh risks, burden, and costs **2: Weak**- experts are less certain that of the magnitude of the benefits and risks, burden, and costs and their relative impacts	**A**: high-quality evidence- randomized controlled trials and high-quality observational studies with large, consistent, effects **B**: moderate-quality evidence **C**: low quality or very low-quality evidence
Kahn *et al.* (2012) [13]	American College of Chest Physicians (ACCP) modified approach to Grading of Recommendations Assessment, Development and Evaluation (GRADE) [7]	**1: Strong**- experts are very certain that benefits do or do not outweigh risks, burden, and costs **2: Weak**- experts are less certain that of the magnitude of the benefits and risks, burden, and costs and their relative impacts	**A**: high-quality evidence- randomized controlled trials and high-quality observational studies with large, consistent, effects **B**: moderate-quality evidence **C**: low quality or very low-quality evidence
Kearon *et al.* (2012) [14]	American College of Chest Physicians (ACCP) modified approach to Grading of Recommendations Assessment, Development and Evaluation (GRADE) [7]	**1: Strong**- experts are very certain that benefits do or do not outweigh risks, burden, and costs **2: Weak**- experts are less certain that of the magnitude of the benefits and risks, burden, and costs and their relative impacts	**A**: high-quality evidence- randomized controlled trials and high-quality observational studies with large, consistent, effects **B**: moderate-quality evidence **C**: low quality or very low-quality evidence
Linkins *et al.* (2012) [15]	American College of Chest Physicians (ACCP) modified approach to Grading of Recommendations Assessment, Development and Evaluation (GRADE) [7]	**1: Strong**- experts are very certain that benefits do or do not outweigh risks, burden, and costs **2: Weak**- experts are less certain that of the magnitude of the benefits and risks, burden, and costs and their relative impacts	**A**: high-quality evidence- randomized controlled trials and high-quality observational studies with large, consistent, effects **B**: moderate-quality evidence **C**: low quality or very low-quality evidence

Last Name of First Author (Year)	Grading System	Strength of Recommendation	Level of Evidence
Chan *et al.* (2014) [16]	Adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on Preventative Health Care [17]	**A-** good evidence to recommend the clinical preventive action **B-** fair evidence to recommend the clinical preventive action **C-** evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making **D-** fair evidence to recommend against the clinical preventive action **E-** good evidence to recommend against the clinical preventive action **L-** insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making	**I-** at least one properly randomized controlled trial **II-1-** well-designed controlled trials without randomization **II-2-** well-designed cohort (prospective or retrospective) or case–control studies, preferably from more than one centre or research group **II-3**- comparisons between times or places with or without the intervention or dramatic results in uncontrolled experiments **III-** opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees
Liu *et al.* (2015) [18]	American Heart Association clinical practice methodology Jacobs et al (2013) [19] and the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) system [20-22]	**Strong-** most patients should receive the recommended treatment **Weak-** different choices will be appropriate for different patients; management decision should be made in concert with the patient's values and preferences **I-** benefit >>> risk, procedure or treatment should be performed or administered **IIa-** benefit >> risk- additional studies with focused objectives are needed; it is reasonable to perform the procedure or administer the treatment **IIb-** benefit ≥ risk- additional studies with broad objectives are needed, and additional registry data would be helpful; procedure or treatment may be considered **III-** no benefit or **III**- harm: procedure or treatment should not be performed or administered because it is not helpful and may be harmful	**A-** multiple randomized controlled trials or meta-analyses; multiple populations evaluated **B-** a single randomized controlled trial or non-randomized studies; limited populations evaluated **C-** consensus of experts only, case studies or standard of care; very limited populations evaluated

Last Name of First Author (Year)	Grading System	Strength of Recommendation	Level of Evidence
Easaw *et al.* (2015) [23]	University of Oxford Centre for Evidence-Based Medicine (CEBM) Levels of Evidence (March 2009) [24]	**A:** consistent level 1 studies **B:** consistent level 2 or 3 studies or extrapolations from level 1 studies **C:** level 4 studies or extrapolations from level 2 or 3 studies **D:** level 5 or troublingly inconsistent or inconclusive studies of any level	**1a:** systematic review (with homogeneity) of randomized controlled trials **1b**: individual randomized controlled trials (with narrow confidence interval) **1c**: all or none **2a:** Systematic review (with homogeneity) of cohort studies **2b**: Individual cohort study (including low quality randomized controlled trials) **2c:** "Outcomes" research; ecological studies **3a:** Systematic reviews with homogeneity of case-control studies **3b:** Individual case-control study **4:** Case-series (and poor quality cohort and case-control studies) **5:** Expert opinion without explicit critical appraisal or based on physiology, bench research or "first principles"
Easaw *et al.* (2015) [25]	University of Oxford Centre for Evidence-Based Medicine (CEBM) Levels of Evidence (March 2009) [24]	**A:** consistent level 1 studies **B:** consistent level 2 or 3 studies or extrapolations from level 1 studies **C:** level 4 studies or extrapolations from level 2 or 3 studies **D:** inconsistent or inconclusive studies of any level	**1:** a systematic review of homogenous randomized controlled trials or a single randomized controlled trial with a narrow confidence interval **2:** a systematic review of homogenous cohort studies, or an individual cohort study or a low-quality randomized controlled trials **3:** a systematic review of case–control studies or an individual case–control study **4:** case series and poor-quality cohort and case–control studies **5:** expert opinion without explicit critical appraisal
James *et al.* (2011, re-affirmed 2017) [26]	Method outlined by the United States Preventative Services Task Force [27]	**A**: based on good and consistent scientific evidence **B:** based on limited or inconsistent scientific evidence **C:** based primarily on consensus and expert opinion	**I**- at least one properly designed randomized controlled trial **II-**1: well-designed controlled trials without randomization **II-2:** well-designed cohort or case-control analytic studies, preferably from more than one center or research group **II-3:** multiple time-series with or without the intervention. Could include 'dramatic' results in uncontrolled experiments also could be regarded as this type of evidence **III:** opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

Last Name of First Author (Year)	Grading System	Strength of Recommendation	Level of Evidence
Siragusa *et al.* (2012) [28]	Modified from: Scottish Intercollegiate Guidelines Network (SIGN) 50 Grading System [29] and the National Institute for Clinical Excellence (NICE) system [30]	**A -** At least one systematic reviews of randomized controlled trials or a single randomized controlled trial of level 1++ directly relevant for the target population, or level 1+ studies directly relevant for the target population yet with consistent results **B -** Level 2++ studies directly relevant for the target population, or indirect evidence from level 1++ o 1+ studies **C -** Level 2+ studies directly relevant for the target population, or indirect evidence from level 2++ studies **D -** Level 3 or 4 directly relevant for the target population, or indirect evidence from level 2+ studies	**1++** High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias **1+** Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias **1-** Meta-analyses, systematic reviews, or RCTs with a high risk of bias **2++** High quality systematic reviews of case control or cohort or studies High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal **2+** Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal **2-** Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal **3** Non-analytic studies, e.g. case reports, case series **4** Expert opinion
Streiff *et al.* (2011) [31]	NCCN Categories of Evidence and Consensus [32]	**1-** uniform NCCN consensus **2A-** uniform NCCN consensus **2B-** non- uniform NCCN consensus (but no major disagreement) **3-** major disagreement	**1-** high-level evidence (e.g., randomized controlled trials) **2A-** lower level evidence **2B-** lower level evidence **3-** any level of evidence

Last Name of First Author (Year)	Grading System	Strength of Recommendation	Level of Evidence
Mandala *et al.* (2011) [33]	The American Society of Clinical Oncology [34]	**A-** evidence of type I or consistent findings from multiple studies of types II, III, IV **B-** evidence of types II, III, or IV and findings are generally consistent **C-** evidence of types II, III, or IV but findings are inconsistent **D-** little or no systematic empirical evidence	**I-** meta-analysis of multiple, well-designed, controlled studies - randomised trials with low false positive and low false-negative errors **II-** at least one well-designed experimental study - randomised trials with high false-positive and/or negative errors (low power) **III-** well-designed, quasi-experimental studies such as non-randomised, controlled single group, pre-post, cohort, time, or matched case–control studies **IV-** evidence is from well-designed, non-experimental studies such as comparative and correlational descriptive and case studies **V-** evidence from case reports and clinical examples
Greenberg *et al.* (2014) [35]	Not reported	**I-** generally should be performed **II-** may be reasonable to perform **III-** generally should not be performed	**A-** randomized controlled trials **B-** controlled trials with no randomization **C-** observational studies **D-** opinion of expert panel
Lyman *et al.* (2015) [36]	Not reported	**Strong:** high confidence the recommendation reflects best practice, based on: 1: strong evidence for a true net effect 2: consistent results with no or minor exceptions 3: minor or no concerns about study quality 4: the extent of panelists agreement 5: other considerations may also warrant a strong recommendation **Moderate:** moderate confidence the recommendation reflects best practice, based on: 1: good evidence for a true net effect 2: consistent results, with minor and/or few exceptions 3: minor and/or few concerns about study quality 4: the extent of panellists' agreement 5: other considerations may also warrant a moderate recommendation **Weak:** some confidence that the recommendation offers the best current guidance for practice, based on: 1: limited evidence for a true net effect 2: consistent results, but with important exceptions 3: concerns about study quality	**High:** High confidence that available evidence reflects true magnitude and direct of net effect. Further research is very unlikely to change either the magnitude or direction of this net effect **Intermediate:** Moderate confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research is unlikely to alter the direction of the net effect but might alter the magnitude of the net effect **Low:** Low confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research may change either the magnitude and direction of the net effect

Last Name of First Author (Year)	Grading System	Strength of Recommendation	Level of Evidence
		4: the extent of panelists' agreement 5: other considerations may also warrant a weak recommendation	
Carrier *et al.* (2015) [37]	Not reported	**1.** Strongly agree ("strongly recommend") **2.** Somewhat agree ("recommend") **3.** Neutral ("recommend") **4.** Somewhat disagree ("recommend") **5.** Strongly disagree ("suggest")	**Ia**- systematic review of randomized controlled trials **Ib-** individual randomized controlled trials with narrow confidence intervals **IIa-** systematic reviews of cohort studies **IIb**- individual cohort studies or low-quality randomized controlled trials **IIIa**- systematic reviews of case–control studies **IIIb-** individual case–control studies **IV-** case series **V-** expert opinion or formal consensus
Nicolaides *et al.* (2013) [38]	Three main reference articles were used as guidance [39-41]	**Not reported**	**High-** randomized controlled trials with consistent results, or systematic reviews that were directly applicable to the target population. **Moderate-** randomized controlled trials with less consistent results, limited power or other methodological problems, which were directly applicable to the target population - randomized controlled trials extrapolated to the target population from different group of patients **Low-** well-conducted observational studies with consistent results that were directly applicable to the target population
The Scottish Intercollegiate Guidelines Network (SIGN) (2014) [16]	Grading of Recommendations Assessment Development and Evaluation (GRADE)[2, 29]	**A:** At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results **B:** A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1++ or 1+ **C:** A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2++ **D:** Evidence level 3 or 4; or Extrapolated evidence from studies	**1++** High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias **1+** High quality meta-analyses, systematic reviews, or RCTs with a low risk of bias **1-** Meta-analyses, systematic reviews, or RCTs with a high risk of bias **2++** High quality systematic reviews of case control or cohort studies High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal **2+** Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal **2-** Case control or cohort studies with a high risk of confounding or

Last Name of First Author (Year)	Grading System	Strength of Recommendation	Level of Evidence
		rated as 2+ **GOOD PRACTICE POINTS** Recommended best practice based on the clinical experience of the guideline development group	bias and a significant risk that the relationship is not causal **3** Non-analytic studies, eg case reports, case series **4** Expert opinion
Urbanek et al. (2016) [42]	Grading of Recommendations Assessment Development and Evaluation (GRADE) [2]	1A — strong recommendation 1B — strong recommendation 1C — strong recommendation 2A — weak recommendation 2B — weak recommendation 2C — weak recommendation	1A- high-quality evidence according to EBM* 1B- moderate-quality evidence according to EBM 1C- low- or very low-quality scientific evidence 2A- high-quality evidence according to EBM (further studies probably will not have any significant influence on changes in suggested treatment method) 2B- moderate-quality evidence according to EBM (further studies may have significant influence on changes in suggested treatment method) 2C- low- or very low-quality scientific evidence (further studies probably will have significant influence on changes in suggested treatment method)

S1 Table References

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