SUPPLEMENTAL DIGITAL CONTENT 12

This table also appears in the Supplemental Digital Content 2 in the complete set of evidence tools.

Table 61. Pharmacologic anticoagulation compared to No anticoagulation for VTE prevention

Question: Pharmacologic anticoagulation compared to No anticoagulation for VTE prevention
Setting: ICU
Bibliography: Alhazzani W et al. Crit Care Med 2013; 41:2088-2098

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Pharmacologic anticoagulation**	**No anticoagulation**	**Relative (95% CI)**	**Absolute (95% CI)**		
Any DVT												
4	randomized trials	not serious [1]	serious [2]	not serious [3]	not serious	none [4]	114/1521 (7.5%)	219/1493 (14.7%)	**RR 0.53** (0.32 to 0.86)	**69 fewer per 1000** (from 21 fewer to 100 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Symptomatic DVT												
1	randomized trials	not serious	not serious	not serious	very serious [5]	none	49/976 (5.0%)	56/959 (5.8%)	**RR 0.86** (0.59 to 1.25)	**8 fewer per 1000** (from 15 more to 24 fewer)	⊕⊕◯◯ LOW	CRITICAL
								5.0%		**7 fewer per 1000** (from 13 more to 21 fewer)		
Pulmonary Embolism												

3	randomized trials	not serious	not serious	not serious [3]	serious [6]	none [4]	15/1461 (1.0%)	28/1434 (2.0%)	**RR 0.53** (0.28 to 0.98)	**9 fewer per 1000** (from 0 fewer to 14 fewer)	⨁⨁⨁◯ MODERATE	CRITICAL
Major Bleeding												
2	randomized trials	serious [7]	serious [8]	not serious	very serious [9]	none [4]	44/1084 (4.1%)	53/1072 (4.9%)	**RR 0.81** (0.55 to 1.21)	**9 fewer per 1000** (from 10 more to 22 fewer)	⨁◯◯◯ VERY LOW	CRITICAL
Mortality												
2	randomized trials	not serious	not serious	not serious	serious [10]	none [4]	283/1080 (26.2%)	313/1068 (29.3%)	**RR 0.89** (0.78 to 1.02)	**32 fewer per 1000** (from 6 more to 64 fewer)	⨁⨁⨁◯ MODERATE	CRITICAL
								25.0%		**27 fewer per 1000** (from 5 more to 55 fewer)		

CI: Confidence interval; **RR:** Risk ratio

1. Two trials were at low risk of bias [Shorr et al., Cade et al.], one trial was at high risk of bias due to incomplete outcome assessment [Fraisse et al.], after excluding this trial there was a residual benefit from the intervention for this outcome
2. We downgraded by one level for inconsistency, unexplained heterogeneity was present I^2= 77%
3. Although studies included mixed ICU population, we did not consider this as a significant indirectness, therefore, we did not downgrade for indirectness
4. We could not reliably assess for publication bias due to small number
5. The CI interval is wide, it includes significant benefit and harm, therefore, we downgraded by two levels for serious imprecision
6. We downgraded by one level for imprecision, the number of event is small and the confidence interval included non-significant benefit
7. We downgraded by one level for risk of bias
8. We downgraded by one level for serious inconsistency, I^2= 50%
9. We downgraded by two levels for serious imprecision, the CI contained significant benefit and harm
10. We downgraded by one level for imprecision, the CI contained significant benefit and small harm