## Age-treatment subgroup analyses in Cochrane intervention reviews: a meta-epidemiological study

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| 29261853 | 28084646 | 26564018 | 25416857 | 24226506 | 21833969 | 19370584 | 16437442 | 11406054 |  |
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| 29099149 | 27933615 | 26457821 | 22895916 | 24151011 | 21735392 | 19160194 | 16235338 | 11034690 |  |

text 1. Search terms for evaluating evidence of statistically significant results included in clinical management guidelines for 7 age-treatment subgroup analyses.
For the review by Rowe et al (Mar 2017):

- Google search terms: "Botulinum toxin for treating strabismus guideline recommendation"
- UpToDate:
- https://www.uptodate.com/contents/evaluation-and-management-of-strabismus-in-children?topicRef=6255\&source=see_link (last updated Sept 13, 2018; literature review current through Jun 2019)
- https://www.uptodate.com/contents/overview-of-
diplopia?search=strabismus\&source=search_result\&selectedTitle=3~150\&usage_type=default\&display_rank=3 (last updated Jan 16, 2019; literature review current through Jun 2019)
- https://www.uptodate.com/contents/third-cranial-nerve-oculomotor-nerve-palsy-inadults?search=strabismus\&source=search_result\&selectedTitle=2~150\&usage_type=default\&display_rank=2 (last updated Jun 19, 2017; literature review current through Jun 2019)
- https://www.uptodate.com/contents/amblyopia-in-children-classification-screening-and-evaluation\#H3058888 (last updated Sept 18, 2018; literature review current through Jun 2019)
- Cochrane Clinical Answers:
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.1687/full (published Jul 25, 2017)
- BMJ Best Practice:
- https://bestpractice.bmj.com/topics/en-us/689 (last updated Nov 2017; last reviewed Jun 2019)

For the review by Kaner et al (Sep 2017):

- Google search terms: "Digital mobile interventions for reducing alcohol consumption guideline recommendation"
- UpToDate:
- https://www.uptodate.com/contents/brief-intervention-for-unhealthy-alcohol-and-other-drug-use-efficacy-adverse-effects-andadministration\#H2495523184 (last updated Jun 3, 2018; literature review current through Jun 2019)
- https://www.uptodate.com/contents/psychosocial-treatment-of-alcohol-usedisorder?search=alcohol\ consumption\ intervention\&source=search_result\&selectedTitle=2~150\&usage_type=default\& display_rank=2 (last updated Sep 6, 2018; literature review current through Jun 2019)
- https://www.uptodate.com/contents/approach-to-treating-alcohol-usedisorder?search=alcohol\ consumption\ intervention\&source=search_result\&selectedTitle=4~150\&usage_type=default\& display_rank $=4$ (last updated Nov 16, 2018; literature review current through Jun 2019)
- Cochrane Clinical Answers:
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.2086/full (published Jul 25, 2018)
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.1449/full (published Dec 28, 2016)
- BMJ Best Practice:
- https://bestpractice.bmj.com/topics/en-us/198 (last updated Jun 2018; last reviewed Jun 2019)

For the review by Mhaskar et al (Oct 2014):

- Google search terms: "Colony-stimulating factors for chemotherapy-induced neutropenia guideline recommendation"
- UpToDate:
- https://www.uptodate.com/contents/use-of-granulocyte-colony-stimulating-factors-in-adult-patients-with-chemotherapy-induced-neutropenia-and-conditions-other-than-acute-leukemia-myelodysplastic-syndrome-and-hematopoietic-celltransplantation (last updated Nov 26, 2018; literature review current through Jun 2019)
- https://www.uptodate.com/contents/fever-in-children-with-chemotherapy-induced-neutropenia/print (last updated Jul 3, 2018; literature review current through Jun 2019)
- https://www.uptodate.com/contents/overview-of-neutropenic-fever-syndromes?topicRef=6051\&source=see_link (last updated Nov 30, 2018; literature review current through Jun 2019)
- https://www.uptodate.com/contents/diagnostic-approach-to-the-adult-cancer-patient-with-neutropenicfever?topicRef=6051\&source=see link (last updated Dec 21, 2018; literature review current through Jun 2019)
- Cochrane Clinical Answers:
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.535/full (published Nov 25, 2014)
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.889/full (published Oct 6, 2015)
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.1743/full (published Aug 4, 2017)
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.1433/full (published Oct 12, 2016)
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.973/full (published Jul 11, 2016)
- https://www.cochrane.org/CD003039/GYNAECA_does-administering-colony-stimulating-factors-plus-antibiotics-people-fever-and-low-white-cell-count (published Oct 30, 2014)
- BMJ Best Practice:
- https://bestpractice.bmj.com/topics/en-us/950 (last updated Oct 2018; last reviewed Jun 2019)

For the review by Hemmingsen et al (Dec 2017):

- Google search terms: "Diet physical activity for incidence of type 2 diabetes guideline recommendation" \& "Diet physical activity for two hour plasma glucose guideline recommendation"
- UpToDate:
- https://www.uptodate.com/contents/epidemiology-presentation-and-diagnosis-of-type-2-diabetes-mellitus-in-children-andadolescents (last updated Mar 2018; literature review current through Jun 2019)
- https://www.uptodate.com/contents/risk-factors-for-type-2-diabetes-mellitus (last updated Oct 2, 2018; literature review current through Jun 2019)
- https://www.uptodate.com/contents/prevention-of-type-2-diabetes-mellitus (last updated Jul 3, 2019; literature review current through Jun 2019)
- https://www.uptodate.com/contents/pathogenesis-of-type-2-diabetes-mellitus (last updated Nov 5, 2018; literature review current through Jun 2019)
- Cochrane Clinical Answers:
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.1859/full (published Nov 15, 2017)
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.1860/full (published Nov 15, 2017)
- BMJ Best Practice:
- https://bestpractice.bmj.com/topics/en-gb/24 (last updated May 2019; last reviewed Jun 2019)

For the review by Sguassero et al (Jun 2012):

- Google search terms: "Supplementary feeding for weight gain children low middle income country guideline recommendation"
- UpToDate:
- https://www.uptodate.com/contents/management-of-moderate-acute-malnutrition-in-children-in-resource-limited-countries (last updated Oct 19, 2018; literature review current through Jun 2019)
- Cochrane Clinical Answers:
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.2207/full (published Oct 10, 2018)
- BMJ Best Practice:
- https://bestpractice.bmj.com/topics/en-us/1307 (last updated Mar, 2019; last reviewed Jun 2019)
- https://bestpractice.bmj.com/topics/en-us/747 (last updated Jan 2018; last reviewed Jun 2019)

For the review by Adams et al (Oct 2007):

- Google search terms: "Fluticasone beclomethasone budesonide forced expiratory volume guideline recommendation"
- UpToDate:
- https://www.uptodate.com/contents/asthma-treatment-in-adolescents-and-adults-beyond-the-basics (last updated Jan 8, 2019; literature review current through Jun 2019)
- https://www.uptodate.com/contents/treatment-of-severe-asthma-in-adolescents-and-adults (last updated Mar 28, 2018; literature review current through Jun 2019)
- https://www.uptodate.com/contents/asthma-in-children-younger-than-12-years-treatment-of-persistent-asthma-with-controllermedications (last updated Jan 8, 2018; literature review current through Jun 2019)
- Cochrane Clinical Answers:
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.349/full (published May 28, 2014)
- https://www.cochranelibrary.com/cca/doi/10.1002/cca.350/full (published May 28, 2014)
- BMJ Best Practice:
- https://bestpractice.bmj.com/topics/en-us/782 (last updated Jul 2018; last reviewed Jun 2019)
- https://bestpractice.bmj.com/topics/en-us/44 (last updated Jun 2018; last reviewed Jun 2019)

| table S2: Reasons for not performing age-treatment subgroup analyses among 162 Cochrane intervention reviews. |  |
| :--- | :---: |
| Reason | No. of Articles (\%) |
| No eligible studies found using inclusion criteria; <br> therefore, subgroup analyses not possible | $16(9.9)$ |
| Eligible studies found but no meta-analyses <br> conducted | $22(13.6)$ |
| Insufficient data identified for subgroup analyses | $71(43.6)$ |
| Identified studies were not able to be pooled in a <br> way that allowed for subgroup analyses | $8(4.9)$ |
| Pre-specified some criteria for heterogeneity level <br> required to perform analyses, and that threshold <br> was not met | $5(3.1)$ |
| Stated that age would be a factor considered for <br> exploration if heterogeneity was identified | $13(8.0)$ |
| No statement given, and the reason was not clearly <br> inferable from the text | $20(12.4)$ |
| Age-treatment analyses appeared to be performed <br> in the text but not reported in forest plots | $2(1.2)$ |
| Stated only one age-treatment subgroup level to <br> identify without explicitly stating the comparison <br> group | $3(1.9)$ |
| Other reason | $2(1.2)$ |


| PubMed <br> Identifier <br> (Year) | Indication | Population Characteristics | Comparison | Outcome | Subgroup Levels | No. of Unique Trials Included | Reported <br> $P$ value? |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| $\begin{array}{\|l} 11279769 \\ (2001) \end{array}$ | Respiratory | Children (>2 years) and adults with a clinical diagnosis of asthma, only including participants with both chronic obstructive pulmonary disease and asthma if data for asthma were reported separately | Beclomethasone dipropionate vs beclomethasone dipropionate: Parallel design, no oral steroids, $400 \mathrm{mcg} / \mathrm{d}$ v $800 \mathrm{mcg} / \mathrm{d}$ | Change in Morning peak expiratory flow rate (liters/min) compared to baseline (2.4) | Children; Adults | 2 | Y |
|  |  |  |  | Change in Evening peak expiratory flow rate (liters $/ \mathrm{min}$ ) compared to baseline (2.5) | Children; Adults | 2 | Y |
|  |  |  | Beclomethasone dipropionate vs beclomethasone dipropionate: Crossover design, no oral steroids, 400 $\mathrm{mcg} / \mathrm{d} v 800 \mathrm{mcg} / \mathrm{d}$ | Forced expiratory volume 1 (liters) (5.1) | Children; Adults | 2 | Y |
|  |  |  |  | Morning peak expiratory flow rate (liters/min) (5.3) | Children; Adults | 2 | Y |
|  |  |  |  | Evening peak expiratory flow rate (liters $/ \mathrm{min}$ ) (5.4) | Children; Adults | 2 | Y |
| $\begin{aligned} & 11687182 \\ & (2001) \end{aligned}$ | Respiratory | Children ( $>2$ years) and adults with chronic asthma, only including participants with both chronic obstructive pulmonary disease and asthma if data for asthma were reported separately | Budesonide vs budesonide: Parallel design, not on oral steroids: 400 v 800 $\mathrm{mcg} / \mathrm{d}$ | Withdrawal due to asthma exacerbation (No. of patients) (3.12) | Children; Adults | 2 | N |
|  |  |  | Budesonide vs budesonide: Parallel design, not on oral steroids: 200 v 800 mcg/d | Withdrawal due to asthma exacerbation (No. of patients) (5.9) | Children; Adults | 4 | N |
|  |  |  | Budesonide vs budesonide: Parallel | Withdrawal due to asthma exacerbation | Children; Adults | 2 | N |



COPD and asthma if data for asthma were reported separately

| budesonide, parallel group studies: dose ratio 1:2 | compared to baseline (5.2) |  |  |  |
| :---: | :---: | :---: | :---: | :---: |
|  | Forced expiratory volume 1 predicted (5.3) | Children; Adults | 7 | Y |
|  | Change in forced expiratory volume 1 predicted (5.4) | Children; Adults | 6 | Y |
|  | Forced vital capacity (5.5) | Children; Adults | 9 | Y |
|  | Mean morning peak expiratory flow rate (5.7) | Children; Adults | 12 | Y |
|  | Mean change in morning peak expiratory flow rate (5.8) | Children; Adults | 17 | Y |
|  | Mean evening peak expiratory flow rate (5.9) | Children; Adults | 10 | Y |
|  | Change in evening peak expiratory flow rate compared to baseline (5.10) | Children; Adults | 10 | Y |
|  | Clinic peak expiratory flow (5.11) | Children; Adults | 12 | Y |
|  | Change in Clinic peak expiratory flow rate (5.12) | Children; Adults | 6 | Y |
| Fluticasone propionate versus beclomethasone dipropionate or budesonide, parallel | Forced expiratory volume 1 (6.1) | Children; Adults | 10 | Y |
|  | Change in forced expiratory volume 1 (6.2) | Children; Adults | 5 | Y |


|  |  |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |


|  |  |  |  | atopic dermatitis part C) at the end of treatment (1.16) |  |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  |  |  |  | Global eczema severity score (Total Scoring of atopic dermatitis) at the end of treatment (1.17) | Ages $<2$ years; 2-12 years; Not categorized; Adults only | 24 | N |
| $\begin{aligned} & 20393943 \\ & (2010) \end{aligned}$ | Respiratory | Children ( $>2$ years), adolescents, and adults with recurrent or chronic asthma | Long-acting beta2agonist + inhaled corticosteroids versus higher dose inhaled corticosteroids | No. of patients with exacerbations requiring oral steroids (2.1) | Children; Adults | 25 | N |
|  |  |  |  | No. of patients with exacerbations requiring hospitalization (2.12) | Children; Adults; <br> Children and adults | 33 | N |
| $\begin{aligned} & 20614462 \\ & (2010) \end{aligned}$ | Gastrointesti nal | Children and adults diagnosed with chronic constipation (Rome III criteria) or fecal impaction treated with lactulose or polyethylene glycol | Stool frequency per week | Stool frequency per week (1.3 \& 1.4) | Children; Adults | 5 | N |
|  |  |  | Form of stool | Form of stool (2.3 \& 2.4) | Children; Adults | 2 | N |
|  |  |  | Relief of abdominal pain | Relief of abdominal pain (3.2 \& 3.3) | Children; Adults | 3 | N |
|  |  |  | Did not require additional products | Did not require additional products (4.2 \& 4.3) | Children; Adults | 3 | N |
| $\begin{aligned} & 21069689 \\ & (2010) \end{aligned}$ | Neoplastic | Men with confirmed prostate cancer (verified by cytological or histological examination), which is believed to be still confined to the prostate gland | Radical prostatectomy (RP) versus watchful waiting (WW) | Overall mortality -SPCG-4 Trial (1.2) | $\begin{aligned} & \text { Ages }<65 \text { years } ; \geq 65 \\ & \text { years } \\ & \hline \end{aligned}$ | 1 | N |
|  |  |  |  | Mortality due to prostate cancer - 12 year follow up (1.4) | $\text { Ages }<65 \text { years; } \geq 65$ <br> years | 1 | N |
|  |  |  |  | Distant metastases $(1.5)$ | $\text { Ages }<65 \text { years } ; \geq 65$ <br> years | 1 | N |


| $\begin{aligned} & 22696347 \\ & (2012) \end{aligned}$ | Dietary | Children from low and middle income countries born at term ( $\geq 37$ completed weeks of gestation), from birth to five years old, excluding children with malnutrition not resulting from insufficient dietary intake | Supplementary feeding | Weight (kg) gain during the intervention (12.3) | Children younger than 24 months; older than 24 months | 5 | Y |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  |  |  |  | Length/height (cm) gain during the intervention (12.4) | Children younger than 24 months; older than 24 months | 5 | Y |
|  |  |  |  | Weight-forlength/height z-score at the end of the intervention (12.7) | Children younger than 24 months; other age range ( 6 months to 6 years) | 3 | Y |
| $\begin{aligned} & 22895947 \\ & (2012) \end{aligned}$ | Neoplastic | Women with advanced epithelial ovarian cancer (stage III/IV, as defined by the Federation of International Gynecologists and Obstetricians) | Neoadjuvant chemotherapy versus primary debulking surgery | Overall survival (1.2) | $\begin{aligned} & \text { Ages }<50 \text { years; } 50-70 \\ & \text { years; > } 70 \text { years } \end{aligned}$ | 1 | Y |
| $\begin{aligned} & 24242360 \\ & (2013) \end{aligned}$ | Psychiatric | Any individual with schizophrenia or similar serious, non-affective psychosis diagnosed by any criteria, and any trial where the majority of participants suffered from serious functional psychotic illness, such as schizophrenia | Haloperidol versus placebo | Global state: Overall improvement: No marked global improvement, > 624 weeks (clinician rated) (1.19) | Ages $<18$ years; 18-65 years | 8 | Y |
| $\begin{aligned} & 24310847 \\ & (2013) \end{aligned}$ | Dental | Children ( $<16$ years) or adults ( $>16$ years), excluding participants with periodontitis at baseline, patients selected due to a pre-existing health condition, and studies where the majority of participants had orthodontic appliances, and those taking another prophylactic regimen for plaque/gingivitis unless separate data for triclosan/copolymer/fluoride | Caries | Caries increment at 30 to 36 months (DFT) (4.1) | Children (1100 ppm F, $0.243 \% \mathrm{NaF}$ ); Adults <br> (1100 ppm F, $0.243 \%$ <br> NaF ); Adults ( 1500 ppm <br> F, $0.331 \% \mathrm{NaF}$ ) | 3 | Y |
|  |  |  |  | Caries increment at 24 to 36 months (DFS) (4.2) | Children (1100 ppm F, $0.243 \% \mathrm{NaF}$ ); Adults <br> (1100 ppm F, 0.243\% <br> NaF ); Adults ( 1500 ppm F, $0.331 \% \mathrm{NaF}$ ) | 4 | Y |


|  |  | and fluoride arms were reported separately |  |  |  |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| $\begin{aligned} & 25356786 \\ & (2014) \end{aligned}$ | Infectious | Individuals undergoing chemotherapy for cancer who experienced neutropenia (absolute neutrophil count $<$ $1 \times 10^{9} / \mathrm{L}\left(1000 / \mathrm{mm}^{3}\right)$ ) and fever (body temperature higher than 38.5 degrees Celsius on one occasion or higher than 38 degrees Celsius on two or more occasions) | Colony-stimulating factor plus antibiotics versus antibiotics alone | Patients with hospitalizations for greater than 10 days (2.1) | Children; Adults | 7 | Y |
|  |  |  |  | Time to neutrophil recovery (2.2) | Children; Adults | 5 | Y |
|  |  |  |  | Duration of grade IV neutropenia (2.3) | Children; Adults | 10 | Y |
|  |  |  |  | Time to recovering from fever (2.4) | Children; Adults; Children and adults | 10 | Y |
| $\begin{aligned} & 27055154 \\ & (2016) \end{aligned}$ | Respiratory | Children and adults with defined cystic fibrosis diagnosed clinically and by quantitative sweat chloride testing or genetic testing or both, including people with cystic fibrosis at all stages of lung disease | Oral nonsteroidal antiinflammatory drug versus placebo | Annual rate of change in \% predicted forced expiratory volume 1 (1.2) | Ages $<13$ years at randomization; $\geq 13$ years at randomization | 2 | Y |
|  |  |  |  | Annual rate of change in \% predicted forced vital capacity (1.4) | Ages $<13$ years at randomization; $\geq 13$ years at randomization | 2 | Y |
|  |  |  |  | Annual rate of change in \% predicted forced expiratory flow 25 $75 \%$ (1.6) | Ages $<13$ years at randomization; $\geq 13$ years at randomization | 2 | Y |
|  |  |  |  | Annual rate of change in \% ideal body weight (1.11) | Ages $<13$ years at randomization; $\geq 13$ years at randomization | 1 | Y |
|  |  |  |  | Chest X-ray score (1.13) | Ages $<13$ years at randomization; $\geq 13$ years at randomization | 1 | Y |
| $\begin{aligned} & 27258214 \\ & (2016) \end{aligned}$ | Cardiovascul ar | Individuals (>40 years), including patients with implantable pacemakers or defibrillators or a previous | Screening versus routine practice | Detection of new cases of atrial fibrillation (systematic) (1.4) | $\begin{aligned} & \text { Ages 65-74 years; > } 74 \\ & \text { years } \end{aligned}$ | 1 | Y |


|  |  | diagnosis of atrial fibrillation as long as these patients were excluded |  | Detection of new cases of atrial fibrillation (opportunistic) (1.6) | Ages 65-74 years; > 74 years | 1 | Y |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  |  |  | Systematic versus opportunistic screening | Age subgroups (2.3) | Ages 65-74 years; > 74 years | 1 | Y |
| $\begin{aligned} & 27627458 \\ & (2016) \end{aligned}$ | Procedural | Infants and adolescents ( $>1$ month, $<18$ years) undergoing arterial line placement, excluding neonates | Ultrasound-guided arterial cannulation versus other techniques (palpation/Doppler) | Successful cannulation at the first attempt (1.2) | Infants and small children; Older children | 4 | Y |
| $\begin{aligned} & 28253424 \\ & (2017) \end{aligned}$ | Ophthalmolo gical | Children and adults with strabismus suitable for treatment with botulinum toxin to align the angle of deviation | Botulinum toxin versus surgery | Primary outcome improved ocular alignment $\leq 10$ prism dioptres (1.1) | Children; Adults | 3 | Y |
| $\begin{aligned} & 28388808 \\ & (2017) \end{aligned}$ | Procedural | All participants who have undergone lumbar puncture for medical reasons | Larger gauge traumatic needles versus smaller gauge traumatic needles | Post-dural puncture headache (2.3) | No distinctions about age; children; ages $>60$ years | 10 | N |
| $\begin{aligned} & 28453187 \\ & (2017) \end{aligned}$ | Cardiovascul | Adults ( $>18$ years) with or without a prior history of cardiovascular disease, | Proprotein convertase subtillisin/kexin type 9 inhibitors versus placebo | Mean percentage change in low density lipoprotein cholesterol (9) | Ages $<65$ years; $\geq 65$ years | 1 | Y |
|  |  | including participants with normal lipid levels or hypercholesterolemia | Proprotein convertase subtillisin/kexin type 9 inhibitors versus ezetimibe | Mean percentage change in low density lipoprotein cholesterol (10) | $\begin{aligned} & \text { Ages }<65 \text { years } ; \geq 65 \\ & \text { years } \end{aligned}$ | 1 | Y |
| $\begin{aligned} & 28944453 \\ & (2017) \end{aligned}$ | Behavioral | Only people in the community whose alcohol consumption had been screened as hazardous or harmful and were directed toward any digital intervention | Digital intervention versus no or minimal intervention | Quantity of drinking (grams/week), based on longest follow-up (1.3) | Adolescents/young adults; Adults | 42 | Y |
| $\begin{aligned} & 29205264 \\ & (2017) \end{aligned}$ | Endocrinal | Individuals diagnosed with intermediate hyperglycemia or |  | All-cause mortality (2.4) | $\begin{aligned} & \text { Ages }<50 \text { years } ; \geq 50 \\ & \text { years } \end{aligned}$ | 10 | Y |



|  |  |  | Higher polyunsaturated fatty acids (PUFA) versus lower PUFA intake continuous secondary outcomes | Body weight, kg (3.10) | Mean age < 50 years; 50 to $<65$ years; $65+$ years | 15 | Y |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  |  |  |  | BMI, $\mathrm{kg} / \mathrm{m}^{2}$ (3.22) | Mean age < 50 years; 50 to $<65$ years; $65+$ years | 11 | Y |
|  |  |  |  | Total cholesterol, $\mathrm{mmoL} / \mathrm{L}$ (3.37) | Mean age $<50$ years; 50 to $<65$ years; $65+$ years; Unclear | 29 | Y |
|  |  |  |  | Total glycerides, mmoL/L (3.49) | Mean age < 50 years; 50 to < 65 years; $65+$ years; Unclear | 22 | Y |
|  |  |  |  | High density lipoprotein, mmoL/L (3.61) | Mean age $<50$ years; 50 to < 65 years; $65+$ years; Unclear | 20 | Y |
|  |  |  |  | Low density lipoprotein, mmoL/L (3.73) | Mean age < 50 years; 50 to $<65$ years; $65+$ years; Unclear | 17 | Y |
| $\begin{aligned} & 30036453 \\ & (2018) \end{aligned}$ | Neoplastic | Participants with locally advanced or metastatic urothelial carcinoma of the bladder as determined by imaging or biopsy, whose disease progressed during or following platinum-containing chemotherapy, excluding participants receiving pembrolizumab as first-line therapy | Pembrolizumab versus chemotherapy (posthoc) | Overall survival based on age (3.1) | $\begin{aligned} & \text { Ages }<65 \text { years; } \geq 65 \\ & \text { years } \end{aligned}$ | 1 | Y |


| table S4: Meta-analytical methods used by authors in their age-treatment interactions. |  |  |
| :--- | :--- | :--- |
| Method Used | Subgroup analyses with non-overlapping <br> subgroup levels | Subgroup analyses with overlapping subgroup levels |
| All age-treatment analyses | 65 |  |
| Effect Measure |  |  |
| Mean Difference | 40 |  |
| Risk Ratio | 15 | 17 |
| Statistical Method |  | 13 |
| Inverse Variance | 46 | 19 |
| Mantel-Haenszel | 18 | 13 |
| Analysis Model |  |  |
| Fixed | 52 | 6 |
| Random | 13 | 26 |



[^0]text 2. Standardization using only fixed and only random effects models.
After excluding two subgroup analyses that did not provide information on which studies were included in the subgroup analyses and standardizing the calculations using only fixed and only random effects (Dersimonian and Laird) models with standard effect measures (risk ratio or mean difference), eight ( 8 of $49,16.3 \%$ ) and seven ( 7 of $49,14.3 \%$ ) of the 49 analyses were statistically significant, respectively. Among the 14 analyses that did not report a $P$ value from an interaction test, four $(28.6 \%)$ were statistically significant using the authors' outlined methods and a random effects model, and five using a fixed effects model.

In both sensitivity analyses, after excluding the two subgroup analyses that did not provide information regarding the individual studies included in the analyses, standardization using the random effects model did not change the number of analyses with statistically significant agetreatment interactions ( 9 of $36,25.0 \%$; 6 of $19,31.6 \%$ ) (Additional file 1: Supplementary Table 5). Standardization using a fixed effects model resulted in 11 ( 11 of $36,30.6 \%$ ) and seven ( 7 of $19,36.8 \%$ ) analyses with a statistically significant $P$ value from an interaction test when selecting one analysis per treatment comparison and one analysis per Cochrane review, respectively (Additional file 1: Supplementary Table 5).


[^0]:    ${ }^{\text {a }}$ We recreated the forest plots using the same methods outlined in the original Cochrane review (i.e., if the authors applied the Dersimonian \& Laird random effects model to summarize risk ratios, we use the same effect measure and model).
    ${ }^{\mathrm{b}}$ When standardizing using fixed and random effects models, we excluded two subgroup analyses from one Cochrane review that did not provide information on which studies were included in the subgroup analyses or the methodology for the subgroup analyses that they conducted.
    ${ }^{\text {c }}$ Using the primary outcome described in the text, if available, and otherwise using the outcome with the most data included (number of trials, or, in the event of a tie, the smallest variance in the summary effect).

