SORT: Evidence Table of Key Clinical Recommendations

We would like each article to include an Evidence Table (also called a "SORT" or "Strength of Recommendations Table") as shown below. This table will help readers understand the main points of your article, and the strength of evidence that supports its recommendations. The table should contain the key clinical recommendations and strength of recommendation ratings for your article as shown in the sample below:

KEY CLINICAL RECOMMENDATION	STRENGTH OF RECOMMENDATION	REFERENCES	COMMENTS (OPTIONAL)
Ambulatory blood pressure monitoring is recommended for patients with labile blood pressure and suspected white coat hypertension.	C	2	Recommendation from consensus guideline based on observational studies
Diuretics are recommended as a first-line agent for hypertension.	A	3	Meta-analysis of randomized trials
Angiotensin receptor blockers provide similar clinical outcomes to ACE inhibitors A.	A	4, 5, 6	Consistent findings from randomized controlled trials and recommendation from evidence-based practice guideline

In general, you should choose approximately three to seven key recommendations for your article. Do not choose statements that merely summarize research findings or represent statements of fact; choose important clinical recommendations that reflect the best available evidence. Comments to justify your choice of references are helpful to the editors. If you are not comfortable assigning the Strength of Recommendation (below), our medical editors will do that for you.

To rate the strength of evidence supporting key clinical recommendations, please use the following guidelines:

In general, only key recommendations for readers require a grade of the Strength of Recommendation. Recommendations should be based on the highest quality evidence available. For example, Vitamin E was found in some cohort studies (Level 2 study quality) to have benefit for cardiovascular protection, but good-quality randomized trials (Level 1) have not confirmed this effect.

It is therefore preferable to base clinical recommendations in a manuscript on the level 1 studies.

STRENGTH OF RECOMMENDATION	DEFINITION	IMPLICATION FOR PRACTICE
A	Recommendation based on consistent and good quality patient-oriented evidence*	You should generally recommend this unless there is a compelling reason not to.
B	Recommendation based on inconsistent or limited quality patient-oriented evidence*	You should strongly consider recommending this.
C	Recommendation based on consensus, usual practice, expert opinion, disease-oriented evidence,** and case series for studies of diagnosis, treatment, prevention, or screening	The evidence that this improves patient outcomes is weaker for this recommendation.
Patient-oriented evidence measures outcomes that matter to patients: morbidity, mortality, symptom improvement, cost reduction, and quality of life. *** Disease-oriented evidence measures intermediate, physiologic, or surrogate endpoints that may or may not reflect improvements in patient outcomes (e.g., blood pressure, blood chemistry, physiological function, and pathological findings).*		

Use the table below to determine whether a study measuring patient-oriented outcomes is of good or limited quality, and whether the results are consistent or inconsistent between studies:

Type of Study			
STUDY QUALITY	**DIAGNOSIS**	**TREATMENT/PREVENTION/SCREENING**	**PROGNOSIS**
Level	Validated	Systematic review/meta-analysis of	Systematic

1 Good quality patient-oriented evidence	clinical decision rule	randomized controlled trials (RCTs) with consistent findings	review/meta-analysis of good quality cohort studies
	Systematic review/meta-analysis of high-quality studies	High quality individual RCT +	Prospective cohort study with good follow-up
	High quality diagnostic cohort study *	All or none study ++	
Level 2 Limited quality patient-oriented evidence	Unvalidated clinical decision rule	Systematic review/meta-analysis of lower quality clinical trials or of studies with inconsistent findings	Systematic review/meta-analysis of lower quality cohort studies or with inconsistent results
	Systematic review/meta-analysis of lower quality studies or studies with inconsistent findings	Lower quality clinical trial +	Retrospective cohort study or prospective cohort study with poor follow-up
	Lower quality diagnostic cohort study or diagnostic case-control	Cohort study	Case-control study

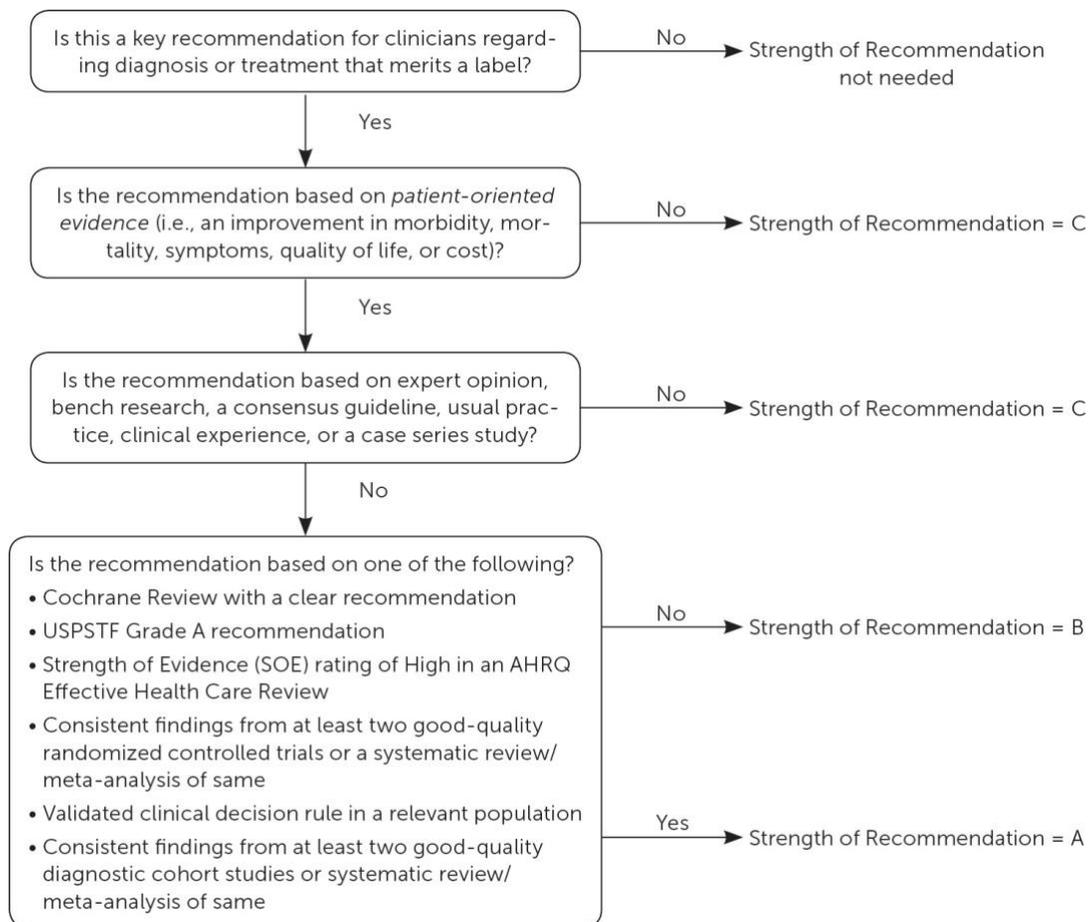|			
	study *		
		Case-control study	Case series
Level 3 Other evidence	Consensus guidelines, extrapolations from bench research, usual practice, opinion, disease-oriented evidence (intermediate or physiologic outcomes only), and case series for studies of diagnosis, treatment, prevention, or screening.		

* High quality diagnostic cohort study: cohort design, adequate size, adequate spectrum of patients, blinding, and a consistent, well-defined reference standard.
\+ High quality RCT: allocation concealed, blinding if possible, intention-to-treat analysis, adequate statistical power, adequate follow-up (> 80%).
\++ An all-or-none study is one where the treatment causes a dramatic change in outcomes, such as antibiotics for meningitis or surgery for appendicitis, which precludes study in a controlled trial.

Consistency Across Studies	
Consistent	Most studies found similar or at least coherent conclusions (coherence means that differences are explainable).
	OR
	If high quality and up-to-date systematic reviews or meta-analyses exist; they support the recommendation.
Inconsistent	Considerable variation among study findings and lack of coherence.
	OR
	If high quality and up-to-date systematic reviews or meta-analyses exist, they do not find consistent evidence in favor of the recommendation.

Please use the following algorithm for rating the strength of evidence. For more information on how to apply these ratings, please see the explanatory article published in the February 1, 2004, issue of *AFP*. Again, if you are unsure how to apply these ratings, the medical editors will do this for you. At a minimum, though, you should create a summary table with recommendations and references for each recommendation.

Is this a key recommendation for clinicians regarding diagnosis or treatment that merits a label?
— No → Strength of Recommendation not needed
— Yes ↓

Is the recommendation based on *patient-oriented evidence* (i.e., an improvement in morbidity, mortality, symptoms, quality of life, or cost)?
— No → Strength of Recommendation = C
— Yes ↓

Is the recommendation based on expert opinion, bench research, a consensus guideline, usual practice, clinical experience, or a case series study?
— No → Strength of Recommendation = C
— No ↓

Is the recommendation based on one of the following?
- Cochrane Review with a clear recommendation
- USPSTF Grade A recommendation
- Strength of Evidence (SOE) rating of High in an AHRQ Effective Health Care Review
- Consistent findings from at least two good-quality randomized controlled trials or a systematic review/meta-analysis of same
- Validated clinical decision rule in a relevant population
- Consistent findings from at least two good-quality diagnostic cohort studies or systematic review/meta-analysis of same

— No → Strength of Recommendation = B
— Yes → Strength of Recommendation = A

Shown above is an algorithm for determining the strength of a recommendation based on a body of evidence (applies to clinical recommendations regarding diagnosis, treatment, prevention, or screening). While this provides a general guideline, authors and editors should feel free to adjust the strength of recommendation based on the benefits, harms, and costs of the intervention being recommended.