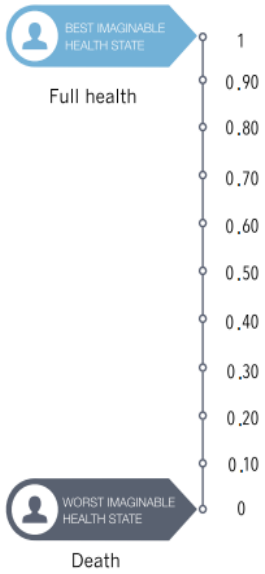

*Utilities represent the strength of an individual's preferences for different outcomes. They are measured on an interval scale, with zero reflecting states of health equivalent to death/worst imaginable health and one (or 100 in some cases) reflecting perfect health/ best imaginable health.

Summary of finding table

Research Question: What are the views about the relative value/importance of outcomes of interest in decision making for patients with antithrombotic treatment?

Setting: not specified **Bibliography:** MacLean S. Chest 2012; 141:e1S-e23S.

Health state/Outcome (Categories of values and preferences)	**Estimates of outcome importance**	**No. of participants /studies**	**Certainty (Quality) of evidence**[Δ]	**Interpretation of findings**
Severe stroke (Utility*[1])	range across included studies: 0.1-0.39 pooled mean: 0.149, 95% CI: 0.135-0.163	580 participants 7 studies	⊕⊕⊕⊕ High certainty [2,3]	Most people find severe stroke has a larg impact on lives. There is likely no importa variability [§] for this assessment.
Moderate stroke (Utility[4])	range across included studies: 0.29-0.77 pooled mean: 0.664, 95% CI: 0.643 - 0.684	339 participants 5 studies	⊕⊕⊕◯ Moderate certainty due to inconsistency [5]	People find moderate stroke probably ha moderate impact on lives. There is likely important variability[§] for this assessment
Major (unspecified) gastrointestinal bleeding (Utility[1])	range across included studies: 0.65-0.84 pooled mean: 0.789, 95% CI: 0.758 - 0.820	153 participants 3 studies	⊕⊕⊕⊕ High certainty [2,6]	People find major GI bleeding has moderate impact on lives. There is likely important variability[§] for this assessment
Severe postphlebitic syndrome (Utility[7])	range across included studies: 0.93 - 0.982 pooled mean: 0.973, 95% CI: 0.964 - 0.982	66 participants 2 studies	⊕⊕◯◯ Low certainty due to indirectness and imprecision [8, 9]	People find severe PPS appears to have trivial impact on lives. There is likely no important variability[§] for this assessment

Deep venous thrombosis and venous thromboembolism, and bleeding (probability trade off)[10]	Patients were asked to advise a hypothetical close friend for treatment with vitamin K antagonists (VKA) after an episode of venous thromboembolism. Continuation of treatment would involve regular blood tests, a tendency to bruise and bleed more readily, a 3% chance of a major bleeding event, and a 2% chance of a recurrent episode of venous thromboembolism in the next 2 years. When the probability of a recurrent episode of venous thromboembolism without treatment were changed to 5%, 10% and 15%, 21%, 23% and 8% of participants would advise to stop the treatment. Meanwhile, 25% of the participants would always advise cessation of treatment, and 23% would always advise continue treatment.	124 participants 1 study [10]	⊕⊕⊕⊕ High certainty	People would prefer VKA treatment more when the risk of DVT recurrence increases. There is likely important variability[§] for this assessment.
Burden of treatment: warfarin (Utility[1])	range across included studies: 0.66-1 pooled mean: 0.938, 95% CI: 0.934-0.942[11]	466 participants 7 studies	⊕⊕⊕⊕ High certainty [2,3]	People find taking warfarin has trivial impact on lives. There is likely important variability[§] for this assessment.
Burden of treatment: warfarin (Qualitative evidence [12])	The majority (specific percentage not reported) of participants had not experienced complications due to warfarin. Many participants reported only minor inconveniences, such as taking a pill every day, regular blood tests, and dietary changes.	21 participants 1 study [12]	⊕⊕⊕◯ Moderate certainty due to imprecision (inadequacy of data) [13]	People find the inconveniences of warfar treatment probably has minor impact on lives. There is likely no important variability[§] for this assessment.

[Δ]GRADE Working Group grades of evidence: here we assess the certainty of evidence on mean outcome importance. We use "certainty of evidenc "certainty in estimates", "quality of evidence" and "strength of evidence" interchangeably.

High certainty: We are very confident that the true value of outcome importance lies close to that of the estimate.

Moderate certainty: We are moderately confident in the estimate: The true value of outcome importance is likely to be close to the estimate, but there is a possibility that it is substantially different

Low certainty: Our confidence in the estimate is limited: The true value of outcome importance may be substantially different from the estimate

Very low certainty: We have very little confidence in the estimate: The true value of outcome importance is likely to be substantially different fror the estimate

§ By variability, we refer to the differences in outcome importance across individuals and decision making scenarios. It is independent from the assessment of inconsistency, which is an assessment across studies.

AF: Atrial Fibrillation; CI: Confidence interval; GI bleeding: Gastrointestinal bleeding; SG: Standard Gamble; TTO: Time Trade Off; VAS: Visual Analogue Scale.

1. Utilities measured with visual analogue scale, time trade off and standard gamble.
2. Of the studies included, most studies were judged to be low risk of bias. The representativeness in some studies was compromised because of risk of bias. However, this only impacted a small proportion of the included study population.
3. Three studies were subject to high risk of bias due to either low response rate or not understanding of the technique. In Protheroe 2000, 97 of 260 invited patients responded. In Thomson 2000, 57 of the 180 invited patients completed the interview. 17.4% of participants in Gage 1995 did not understand the time trade off technique.
4. Utilities measured with time trade off and standard gamble.
5. The study population were different across the included studies. The studied population included patients with atrial fibrillation (Gage 1996), 30 community volunteer (Lenert 1997), three different patient population (patients with a 1st or 2nd episode of venous thromboembolism, with oral anticoagulants had been started, patients who had experienced an episode of major bleeding during oral anticoagulant treatment, and patients with a postthrombotic syndrome in Locadia 2004), both patients with DVT and without DVT (O'Mera 1994) as well as ischemic stroke survivors and age-matched control subjects (Slot 2009). However, there are too few studies to find a reasonable explanation for the heterogeneity observed.
6. One study was subject to high risk of bias due to low response rate. In Thomson 2000, 57 of the 180 invited patients completed the interview.
7. Utilities measured with standard gamble.
8. The included studies have different population than the patients facing the choice: 30 community volunteer (Lenert 1997), 36 patients with DVT (16 of 36 participants) and without DVT (O'Mera 1994).
9. In total, the sample size was too small; there were only 66 participants from 2 studies.
10. Locadia 2004 is a cross-sectional study interviewing participants with decision analysis.
11. Only one study reported utility value lower than 0.9 and was considered an outliner; all the other studies reported utility values higher than 0.9.
12. Dantas 2004 is a qualitative study (a semi-structured interview) on the burden of anticoagulant/ warfarin treatment.
13. Only one qualitative study with a small sample size (21 participants) identified to address this phenomenon.