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| **CATEGORY** | **DATA/ANALYSIS** |
| Does the RCT state a clear primary hypothesis? |  |
| Does the hypothesis seem implausible? If so, discount any support the RCT creates for the hypothesis. |  |
| Equivalence to my patients |  |
| Validated rating scales |  |
| Blinding |  |
| Randomization |  |
| Similarity at baseline |  |
| Equal treatment post-randomization |  |
| Follow-up duration |  |
| Sample size |  |
| Intent-to-treat?  *Drop-out rate.*  *Imputation method(s)?* |  |
| Statistical significance: p value set at what level? (Don’t overvalue statistical significance.) |  |
| Bonferroni or other correction for multiple statistical comparisons |  |
| Effect sizes and how they were measured  *Absolute change in a biological parameter or rating scale*  *Percent change in a biological parameter or rating scale*  *Percentage of subjects reaching a prospectively defined outcome, e.g., absolute or percentage change in a biological parameter or rating scale or a particular benchmark with respect to a biological parameter or rating scale (might then be converted into a number needed to treat, risk ratio or odds ratio)*  *Standardized mean difference*  *Number needed to treat*  *Risk ratio*  *Odds ratio*  *Hazard ratio*  *How heterogeneous are the effect sizes? For the primary outcome, did the study report a prediction interval? The 95% PI = M ± 1.96SD with M being the mean effect size and SD being the standard deviation of the effect size. If so, what does the PI suggest about whether the effect is clinically meaningful and whether I should offer the treatment to a given patient?* |  |
| Bottom line  *After considering costs and benefits, should I offer the treatment to a given patient?* |  |