Bilaga 2. **Sökstrategier**

Sökstrategier medicinska aspekter

Sökstrategi för behandling av ulcus respektive eradikering av Helicobacter pylori

PubMed 2004–2005

Peptic ulcer /therapy	AND	Meta-analysis /PT Review /PT	AND	Systematic /TW Systematically /TW Databases /TW PubMed /TW Medline /TW
Peptic ulcer hemorrhage /therapy				
Helicobacter infections /drug therapy				

Limit: Humans
English /La
German /La

Söktermerna har utgjorts av MeSH-termer (NLM:s kontrollerade nyckelord, Medical Subject Headings), om inget annat angives, och undergrupper i MeSH-hierarkin har inkluderats, samt i förekommande fall av subheadings (/).
La = Språk; PT = Publikationstyp; TW = Textord

Sökstrategier för GERD och Esofagit

Systematiska översikter
2004-10-28, 29; 2004-12-08; 2005-10-17

PubMed 1999–2005 (oktober)

Gastroesophageal reflux Esophagitis	AND	Meta-analysis /PT Review /PT	AND	Systematic /TW Database /TW Medline /TW

Limit: Human
English

Cochrane Database of Systematic Reviews, DARE, HTA/Cochrane Library, 2004

Gastroesophageal reflux (MeSH)
Esophagitis (MeSH)

Övriga studier
2004-11-29; 2004-12-08; 2005-10-17

PubMed 1966–2005 (oktober)

Gastroesophageal reflux/Major Esophagitis/Major	AND	Natural history /TW Natural course /TW
Limit: English /La Human		

Gastroesophageal reflux Esophagitis	AND	Life style Diet Smoking Alcohol drinking Physical activity /TW /diet therapy

Gastroesophageal reflux	AND	Patient education

Lifestyle /TI	AND	Measures /TI

(Related articles endast vid sökning 2004)

Gastroesophageal reflux Esophagitis	AND	Anti ulcer agents /PA

Gastroesophageal reflux /therapy Esophagitis /therapy	AND	Endoscop* /TW Gastroscop* /TW Esophagoscop* /TW

Gastroesophageal reflux /therapy Esophagitis /therapy	AND	Endoscop* /TW Gastroscop* /TW Esophagoscop* /TW
Limit: 19+ years English /La		

	AND	Cohort /TW Clinical trial /PT		
	AND	Reflux /TI		
	AND	/adverse effects Safety /TW	AND	Cohort studies
	AND	Verification /TW		
	AND	Follow up studies Follow up /TW Monitoring /TW Evaluating /TW Evaluated /TW	AND	Comparative study

PubMed 1999–2005 (oktober)

Gastroesophageal reflux /therapy Esophagitis /therapy	AND	RCT /PT
Limit: 19+ years English /La		

PubMed 2003–2005 (november)

Gastroesophageal Reflux /drug therapy Esophagitis /drug therapy Heartburn /drug therapy	AND	RCT /PT CCT /PT

PubMed 1999–2005 (oktober)

Gastroesophageal reflux /diagnosis Esophagitis /diagnosis	AND	Hydrogen ion concentration
Limit: 19+ years English /La		

SciSearch 1994–2005 (maj)

Citerade arbeten: Polyard T, Ottignon Y, Paphilet C, Agostini H. Gastroenterol Clin Biol 1997;21:497-502

Söktermerna i har utgjorts av MeSH-termer (NLM:s kontrollerade nyckelord, Medical Subject Headings), om inget annat angives, och undergrupper i MeSH-hierarkin har inkluderats, samt i förekommande fall av subheadings (/).

CCT = Kontrollerad studie; La = Språk; Major = MeSH Major topic;
PA = Pharmacological action; PT = Publikationstyp; RCT = Randomiserad kontrollerad undersökning; TI = Titel; TW = Textord

	AND	Sensitivity and specificity Sensitivity /TW Specificity /TW Accuracy /TW

Sökstrategier för Barrett esofagus

Systematiska översikter
2004-10-29

PubMed 1999–2004 (oktober)

Barrett esophagus	AND	Meta-analysis /PT Review /PT

Limit:	Humans English

Cochrane Database of Systematic Reviews, DARE, HTA/Cochrane Library, 2004 (oktober)

Barrett esophagus (MeSH) Barrett /TI

Övriga studier
2004-11-30

PubMed 1966–2004 (november)

Barrett esophagus /therapy	RCT /PT	
Barrett esophagus	AND	Esophageal neoplasms
Barrett esophagus	AND	Mass screening Surveillance /TI

	AND	Systematic /TW Database /TW Medline /TW		
	AND	Risk /TW /prevention and control	NOT	Case report /PT Comment /PT Editorial /PT Letter /PT News /PT Review /PT
	NOT	Case report /PT		

Barrett esophagus	AND	Dysplasia /TW

Limit:	English /La Human

Söktermerna i har utgjorts av MeSH-termer (NLM:s kontrollerade nyckelord, Medical Subject Headings), om inget annat angives, och undergrupper i MeSH-hierarkin har inkluderats, samt i förekommande fall av subheadings (/).
La = Språk; PT = Publikationstyp; TI = Titel; TW = Textord

Sökstrategier för dyspepsi

Systematiska översikter
2004-10-27

PubMed 1999–2004 (oktober)

Dyspepsia	AND	Meta-analysis /PT Review /PT

Limit:	Humans >19 years English

Cochrane Database of Systematic Reviews, DARE, HTA/Cochrane Library, 2004 (oktober)

Dyspepsia
Dyspepsia /TI

	AND	Clinical trial /PT	NOT	Case report /PT Comment /PT Editorial /PT Letter /PT News /PT Review /PT
	AND	Systematic /TW Database /TW Medline /TW		

Övriga studier

PubMed 1999–2004 (december)

Dyspepsia	AND	Medical history taking Diagnosis, Differential
OR		
Dyspepsia	AND	Functional /TW
OR		
Dyspepsia	AND	Irritable bowel syndrome
Dyspepsia	AND	Ulcer like /TW
OR		
Dyspepsia /TW	AND	Dysmotility like /TW
OR		
Dyspepsia	AND	Esophageal neoplasms Stomach neoplasms
OR		
Esophageal neoplasms Stomach neoplasms	AND	Symptoms /TW
Limit: English /La		

Söktermerna har utgjorts av MeSH-termer (NLM:s kontrollerade nyckelord, Medical Subject Headings), om inget annat angives, och undergrupper i MeSH-hierarkin har inkluderats, samt i förekommande fall av subheadings (/).
La = Språk; PT = Publikationstyp; TI = Titel; TW = Textord

	NOT	Case report /PT Comment /PT Editorial /PT Letter /PT News /PT Review /PT
	AND	Reflux /TW
	NOT	Case report /PT Comment /PT Editorial /PT Letter /PT News /PT
	AND	Symptoms /TW
	AND	Alarm /TW Dyspeptic /TW

Sökstrategi för komplettering av Cochrane-översikten "Initial management strategies for dyspepsia"

PubMed 2001–2005 (april)

Dyspepsia	AND	Endoscopy (NoExp) Endoscopy, Digestive system (NoExp) Endoscopy, Gastrointestinal (NoExp) Gastroscopy Helicobacter pylori /therapeutic use /radiography
Limit: RCT /PT English /La		

Exkluderade studier publicerade 2001–2002, som finns som inkluderade i Cochrane-översikten.

Söktermerna har utgjorts av MeSH-termer (NLM:s kontrollerade nyckelord, Medical Subject Headings), om inget annat angives, och undergrupper i MeSH-hierarkin har inkluderats (utom för NoExp), samt i förekommande fall av subheadings (/).
La = Språk; PT = Publikationstyp

Sökstrategi för dostitrering vid refluxbesvär

PubMed 1966–2006 (mars)

Gastroesophageal reflux /drug therapy /prevention and control Esophagitis /drug therapy /prevention and control Heartburn /drug therapy /prevention and control	AND	on demand /TW as needed /TW step up /TW step down /TW titration dose /TW
Limit: Humans English		

	AND	RCT /PT Review /PT	NOT	Endoscopy

Sökstrategi för cancerrisk vid dyspeptiska besvär

PubMed 1990–2005 (april)

History /TW	AND	Stomach neoplasms	AND
Alarm /TW		Esophageal neoplasms	
Alarming /TW		Gastric cancer /TW	
Symptoms* /TW		Esophageal cancer /TW	
Questionnaire* /TW		Digestive nystem	
Dyspepsia		Gastrointestinal neoplasms (NoExp)	

Limit: English /La
All adult (19+ years)

Söktermerna har utgjorts av MeSH-termer (NLM:s kontrollerade nyckelord, Medical Subject Headings), om inget annat angives, och undergrupper i MeSH-hierarkin har inkluderats, samt i förekommande fall av subheadings (/).
* = Trunkering; La = Språk; PT = Publikationstyp; TW = Textord

Appendix GERD

1. Litteratursökning för frågan: Lönar det sig att ge råd om livsstilsförändringar?

PubMed 1966–2005 (oktober)

Gastroesophageal reflux Esophagitis	AND	Life style Diet Smoking Alcohol drinking Physical activity /TW /diet therapy
Gastroesophageal reflux	AND	Patient education
Lifestyle /TI	AND	Measures /TI

Limit: English /La
Human

(Related articles endast vid sökning 2004)

Sökning enligt ovan gav åtta referenser, fem av dessa befanns relevanta vid genomgång av abstrakt och bedömdes i fulltext (se Tabell Livsstilsförändringar). Två referenser användes för att besvara frågeställningen.

	Endoscopy /TW Gastroscopy /TW Endoscopically /TW Endoscopy (NoExp) Endoscopy, Digestive system (NoExp) Endoscopy, Gastrointestinal (NoExp) Gastroscopy	AND	Meta-Analysis /PT	NOT	Case Report /PT Comment /PT Editorial /PT Letter /PT News /PT Review /PT

AND	Cohort /TW Clinical trial /PT	

AND	Reflux /TI	

2. Litteratursökning för fråga: Vilken är den bästa medicinska behandlingsstrategin?

Systematiska översikter
2004-10-28, 29; 2004-12-08; 2005-10-17

PubMed 1999–2005 (oktober)

Gastroesophageal reflux Esophagitis	AND	Meta-analysis /PT Review /PT

Limit:	Human English

PT = Publikationstyp

Denna sökning gav 76 referenser vars abstrakt bedömdes. Tolv referenser var av intresse för frågeställningen och bedömdes i fulltext (se Tabell Systematiska översikter). Åtta av dessa användes för att besvara frågeställningen.

Cochrane Database of Systematic Reviews, DARE, HTA/Cochrane Library, 2004

Gastroesophageal reflux (MeSH)
Esophagitis (MeSH)

Gav 4 referenser relevanta för frågeställningen, samtliga användes (se Tabell Systematiska översikter).

PubMed 1999–2005 (oktober)

Gastroesophageal reflux /therapy Esophagitis /therapy	AND	RCT /PT

Limit:	19+ years English /La

La = Språk; PT = Publikationstyp; RCT = Randomiserad kontrollerad undersökning

Denna sökning gav 244 referenser vars abstrakt bedömdes. 33 av dessa bedömdes vara relevanta för frågeställningen och bedömdes i fulltext (se tabell Terapistudier). Tre av dessa användes för att besvara frågeställningen.

	AND	Systematic /TW Database /TW Medline /TW

3. Litteratursökning för fråga: Finns indikation för livslång syrahämning oavsett ålder?

PubMed 1966–2005 (oktober)

Gastroesophageal reflux Esophagitis	AND	Anti Ulcer Agents /PA

PA = Pharmocological action; TW = Textord

Sökningen gav 81 referenser som bedömdes i abstraktform. Sjutton av dessa bedömdes relevanta för frågeställningen och bedömdes i fulltext. Inga interventionsstudier hittades men fyra publikationer användes för att besvara frågeställningen (se Tabell Säkerhetsstudier). Dessutom har en Cochrane-rapport använts (Donnellan 2005).

För bedömningen av antirefluxkirurgi kontra medicinsk behandling har en systematisk översikt från 2000 använts, denna uppdaterades 2004. Därefter har en jämförande studie mellan medicinsk och kirurgisk behandling publicerats (se Tabell Terapistudier).

4. Litteratursökning för fråga: Ska man kontrollera utläkning av esofagit?

PubMed 1966–2005 (oktober)

Gastroesophageal Reflux /therapy Esophagitis /therapy	AND	Endoscop* /TW Gastroscop* /TW Esophagoscop* /TW

Gastroesophageal reflux /therapy Esophagitis /therapy	AND	Endoscop* /TW Gastroscop* /TW Esophagoscop* /TW
Limit:	19+ years English/ La	

TW = Textord

Sökningen gav 17 referenser, vid bedömning av abstrakt befanns inga vara relevanta för frågeställningen.

	AND	/adverse effects Safety /TW	AND	Cohort studies
	AND	Verification /TW		
	AND	Follow up studies Follow up /TW Monitoring /TW Evaluating /TW	AND	Comparative study

Helicobacter pylori

Sökvägar inklusive MeSH-termer sökning 1

PubMed

Peptic ulcer Helicobacter pylori	AND	Review /PT

Cochrane

Peptic ulcer duodenal ulcer stomach ulcer Helicobacter pylori

Sökord (MESH term)	**Databas i Cochrane**
”Peptic ulcer OR duodenal ulcer OR stomach ulcer OR Helicobacter pylori”	Complete systematic reviews Quality assessed systematic reviews Health technology assessment database NHS Economic evaluation database

NHS = National Health Services; PT = Publikationstyp

Sökvägar inklusive MeSH-termer sökning 2

PubMed 1998-01-01–2006-04

Peptic ulcer /drug therapy Peptic ulcer hemorrhage /drug therapy Helicobacter infections /drug therapy	AND	/administration and dosage	AND

Limit:	RCT /PT Adults English /La

La = Språk; PT = Publikationstyp; RCT = Randomiserad kontrollerad undersökning;
TW = Textord

	AND	Meta-analysis /PT			

	Antal referenser (relevanta/totalt)
	3/6 25/56 6/15 32/176

	Triple /TW Drug therapy, Combination Anti-ulcer agents	AND	Anti-infective agents Anti-bacterial agents	NOT	Dyspepsia Gastroexophageal reflux Anti-inflammatory agents, non-steroidal

Sökord (MESH term)		**Antal referenser**
Peptic Ulcer /drug therapy		457
Peptic Ulcer Hemorrhage/ drug therapy Helicobacter Infections /drug therapy		
AND		
AND	Triple /TW Drug therapy, Combination Anti-ulcer agents	
AND	Anti-infective agents Anti-bacterial agents	
NOT	Dyspepsia Gastroesophageal reflux Anti-Inflammatory agents, Non-steroidal	
AND	RCT /PT	
AND	Adults	
Limit:	English /La	

La = Språk; PT = Publikationstyp; RCT = Randomiserad kontrollerad undersökning;

TW = Textord

Sökningar i databaser efter studier med ekonomiska aspekter

EkonLittsökn20060528 (NHSEED)

Dyspepsia	AND	structured abstract /TI
Esophagitis		
Barrett esophagus		
Gastroesophageal reflux		

TI = Titel

#1	MeSH descriptor Dyspepsia explode all trees in MeSH products	636
#2	MeSH descriptor Esophagitis explode all trees in MeSH products	481
#3	MeSH descriptor Barrett Esophagus explode all trees in MeSH products	77
#4	MeSH descriptor Gastroesophageal Reflux explode all trees in MeSH products	860
#5	structured abstract in Record Title in NHS EED	4 973
#6	(#5 AND (#1 OR #2 OR #3 OR #4))	108

Sökning i NHSHEED via Cochrane Library: från #6 beställdes 79 referenser som fanns i NHSEED, econNHSEEDCL0512

Peptid ulcer /therapy	AND	Costs and cost analysis	NOT
Peptic ulcer hemorrhage /therapy			
Helicobacter infections /drug therapy			
Dyspepsia /diagnosis /therapy			
Esophagitis /therapy			
Gastroesophageal reflux /therapy			
Barrett esophagus /diagnosis /therapy			
Heartburn /therapy			
Dyspepsia (Major)			
Esophagitis (Major)			
Gastroesophageal reflux (Major)			
Barrett esophagus (Major)			
Heartburn (Major)			

Limits: Publication date from 1999, Danish, English, French, German, Norwegian, Swedish

PT = Publikationstyp

Gastroesophageal reflux /diagnosis Esophagitis /diagnosis Heartburn /diagnosis	NOT	Case reports /PT Comment /PT Editorial /PT Letter /PT News /PT

#17	Search #2 NOT #7 NOT #12 NOT (”case reports” [Publication Type] OR ”comment” [Publication Type] OR ”editorial” [Publication Type] OR ”letter” [Publication Type] OR ”news” [Publication Type]) AND (”danish” [Language] OR ”english” [Language] OR ”french” [Language] OR ”german” [Language] OR ”norwegian” [Language] OR ”swedish” [Language]) Limits: Publication Date from 1999	93
#16	Search #2 NOT #7 NOT #12 Limits: Publication Date from 1999	130
#15	Search #13 OR #9 Limits: Publication Date from 1999	203
#14	Search #13 NOT #9 Limits: Publication Date from 1999	26
#13	Search #11 NOT #7 NOT (”case reports” [Publication Type] OR ”comment” [Publication Type] OR ”editorial” [Publication Type] OR ”letter” [Publication Type] OR ”news” [Publication Type]) AND (”danish” [Language] OR ”english” [Language] OR ”french” [Language] OR ”german” [Language] OR ”norwegian” [Language] OR ”swedish” [Language]) Limits: Publication Date from 1999	181
#12	Search #11 NOT #7 Limits: Publication Date from 1999	223
#11	Search #10 AND ”costs and cost analysis” [MeSH Terms] Limits: Publication Date from 1999	256
#10	Search ”dyspepsia” [MeSH Major Topic] OR ”esophagitis” [MeSH Major Topic] OR ”gastroesophageal reflux” [MeSH Major Topic] OR ”barrett esophagus” [MeSH Major Topic] OR ”heartburn” [MeSH Major Topic] Limits: Publication Date from 1999	7 466
#9	Search #5 NOT #7 NOT (”case reports” [Publication Type] OR ”comment” [Publication Type] OR ”editorial” [Publication Type] OR ”letter” [Publication Type] OR ”news” [Publication Type]) AND (”danish” [Language] OR ”english” [Language] OR ”french” [Language] OR ”german” [Language] OR ”norwegian” [Language] OR ”swedish” [Language]) Limits: Publication Date from 1999	177
#8	Search #5 NOT #7 Limits: Publication Date from 1999	215
#7	Search #6 AND ”costs and cost analysis” [MeSH Terms] Limits: Publication Date from 1999	37

#6	Search ”gastroesophageal reflux/diagnosis” [MeSH Terms] OR ”eso-phagitis/diagnosis” [MeSH Terms] OR ”heartburn/diagnosis” [MeSH Terms] Limits: Publication Date from 1999	2 372
#5	Search #4 AND ”costs and cost analysis” [MeSH Terms] Limits: Publication Date from 1999	240
#4	Search (”dyspepsia/diagnosis” [MeSH Terms] OR ”dyspepsia/therapy” [MeSH Terms]) OR ”esophagitis/therapy” [MeSH Terms] OR ”gastro-esophageal reflux/therapy” [MeSH Terms] OR (”barrett esophagus/diagnosis” [MeSH Terms] OR ”barrett esophagus/therapy” [MeSH Terms]) OR ”heartburn/therapy” [MeSH Terms] Limits: Publication Date from 1999	5 664
#2	Search #1 AND ”costs and cost analysis” [MeSH Terms] Limits: Publication Date from 1999	181
#1	Search ”peptic ulcer/therapy” [MeSH Terms] OR ”peptic ulcer hemorrhage/therapy” [MeSH Terms] OR ”helicobacter infections/drug therapy” [MeSH Terms] Field: All Fields, Limits: Publication Date from 1999	5 665

Kompletterande sökning i PubMed på ekonomiska aspekter av dyspepsi, GERD, ulcus etc 2005-12-15, varvid följande togs ut:

#15	203	ref Econ0512a
#17	93	ref Econ0512b

Utöver icke-relevanta studier, relevanta studier som fanns inkluderade i systematiska litteratursammanställningar, exkluderades 168 relevanta studier, och inkluderades slutligen 10 studier varav 4 metaanalyser.

Anmärkning: Barretts esofagus ingick i den ursprungliga litteratursökningen med ekonomiska aspekter enligt ovan, men det ekonomiska avsnittet slopades då kliniska effekter av interventioner inte förelåg enligt litteraturgranskningen.

Bilaga 3. **Granskningsmallar**

Granskningsmall epidemiologiska studier

First author: .....

Title: .....

Journal: .....

Year: .....

Volume: .....

Issue: .....

First page: .....

Last Page: .....

1. Type of study

- ❑ RCT → Section A
- ❑ Controlled trial without randomization → Section B
- ❑ Observational cohort study → Section B
- ❑ Case-control study → Section C
- ❑ Cross-sectional study (exposure and outcome measured simultaneously) → Section C
- ❑ Case series
- ❑ Case report
- ❑ Ecological study
- ❑ Other: .....

2. Type of report

- ❑ Full paper in peer reviewed journal
- ❑ Full paper in book or other type of report
- ❑ Abbreviated paper in meeting proceedings or similar publication
- ❑ Abstract only
- ❑ Other: .....

3. Language

- ❑ English
- ❑ Scandinavian
- ❑ German
- ❑ French
- ❑ Other: .....

Section A (randomized clinical trial)

External validity

Short form answer:

- ❑ Clear external validity (0)
- ❑ Probable external validity (1)
- ❑ Uncertain external validity (3)
- ❑ External validity cannot be assessed (5)

If uncertain, answer questions under Item 1.
Otherwise go to Internal validity (after Item 1)

1. Accrual of study subjects

a. Eligibility/inclusion criteria clearly stated (eg, if trial of treatment of a specified disease, is the definition acceptable)?
   - ❑ Yes = 0
   - ❑ No = 2

b. Consecutive eligible subjects?
   - ❑ Yes = 0
   - ❑ No = 1
   - ❑ Not stated = 1

c. Numbers and reasons for non-participation given?
   - ❑ Yes = 0
   - ❑ No = 2

d. Exclusion criteria clearly stated and acceptable?
   - ❑ Yes = 0
   - ❑ No = 2

e. Are numbers of excluded persons given by reason (as prescribed in the CONSORT statement)?
   - ❑ Yes = 0
   - ❑ No = 2

Total sum of section 1
0 = Clear external validity
1 = Probable external validity
2–3 = Uncertain external validity
≥4 = External validity cannot be assessed

Internal validity

Short form answer:

- ❑ Excellent internal validity (0)
- ❑ Good internal validity (1)
- ❑ Acceptable internal validity (2)
- ❑ Uncertain internal validity (4)
- ❑ Uninformative due to flawed internal validity (10)

If uncertain, answer questions under Items 2–9. Otherwise go to Precision (after Item 9)

2. Treatment/exposure assignment

a. Were details about randomization procedure given?
   - ❑ Yes = 0
   - ❑ No = 1

b. Could the randomization be manipulated?
   - ❑ Yes (eg, tossing of coin or throwing of dice) = 1
   - ❑ No (eg, opaque envelopes, computer-generated list kept by others than investigators) = 0

c. Did randomization lead to unpredictable treatment assignment?
   - ❑ Yes = 0
   - ❑ No, treatment could potentially be deduced in some or all = 2

d. Were there exclusions/withdrawals after randomization?
   - ❑ Yes = 2
   - ❑ No = 0

3. Comparability of groups

a. Was there an account of the comparability of groups with regard to all conceivable factors that might affect the outcome?
   - ❑ Yes = 0
   - ❑ No = 1

b. Were there any important differences?
   - ❑ Yes = 2
   - ❑ No = 0
   - ❑ No data given = 0 (already scored under 3a)

c. Were any attempts in the analysis phase to adjust for imbalances between treatment arms with regard to important determinants for the outcome (eg, through multi-variate modelling)?
   - ❑ Not needed (no important imbalances) = 0
   - ❑ Yes = –1 (subtract 1 if you scored 2 under 3b)
   - ❑ No, despite a need = 1

4. Blinding

a. Were there any attempts to blind the patients/investigators to treatment allocation?
   - ❑ No (open study) = 2
   - ❑ Only study subjects were blinded (single-blind) = 1
   - ❑ Blinding only of investigators who evaluated the outcome ("blind observer") =0
   - ❑ Double-blind = 0
   - ❑ Triple-blind (breaking of the code first after completion of all analyses) = 0

b. Was there any reason to believe that the blinding had failed (eg, due to characteristic side-effects of active treatment or dissimilarities of active and reference tablets)?
   - ❑ Yes = 1
   - ❑ No = 0

c. Was the blinding tested (eg, through asking the subjects at the end of the study what they believed they had received)?
   - ❑ Yes = 0
   - ❑ No = 0

5. Compliance

a. Was there any account of the completeness of treatment/compliance?
   - ❑ Yes = 0
   - ❑ No = 2

b. Was the completeness acceptable (>80% of the subjects receiving >80% of the prescribed treatment)?
   - ❑ Yes = 0
   - ❑ No = 3
   - ❑ Completeness/compliance data not given = 0 (scored under 5a)

6. Drop-outs/losses to follow-up

a. Was there an account of the numbers of subjects who dropped out (and the reasons for dropping out)?
   - ❑ Yes = 0
   - ❑ No = 3

b. What was the drop-out rate?
   - ❑ <10% = 0
   - ❑ 10–19% = 2
   - ❑ 20–29% = 3
   - ❑ ≥30% → study is deemed uninformative, excluded
   - ❑ Drop-out rate not stated = 0 (scored under 6a)

7. Evaluation of outcome

a. Was there an acceptable definition of the outcome?
   - ❑ Yes = 0
   - ❑ No = 3

b. Was the outcome clinically relevant?
   - ❑ Yes = 0
   - ❑ Of questionable relevance = 2
   - ❑ Irrelevant → study is deemed uninformative, excluded

c. Was the reporter of the outcome (eg, the investigator, the study subject) unaware of the treatment given?
   - ❑ Yes = 0
   - ❑ No = 2

d. Are there reasons to believe that there might have been misclassification of the outcome (eg, due to retrospective reporting over too long periods)?
   - ❑ Yes = 1
   - ❑ No = 0

8. Evaluation of side-effects

a. Was there acceptable reporting of side effects?
   - ❑ Yes, with open-ended questions = 0
   - ❑ Yes, with fixed response alternatives = 0
   - ❑ Yes, response alternatives not stated = 0
   - ❑ No = 3

9. Analysis

a. Was the main outcome variable defined in advance and was the conclusion of the study based on the analysis of this variable?
   - ❑ Yes = 0
   - ❑ No (or not mentioned in the report) = 2

b. Was there a prior hypothesis?
   - ❑ Yes = 0
   - ❑ No (or not mentioned in the report) = 1

c. Were the secondary variables defined in advance?
   - ❑ Yes = 0
   - ❑ No (or not mentioned in the report) = 1
   - ❑ Not applicable, there was no secondary outcome variable = 0

d. Were all randomized subjects included in the analysis and retained in the treatment arm to which they were initially allocated ("intention-to-treat analysis")?
   - ❑ Yes = 0
   - ❑ No = 4

Total sum of Items 2–9 (internal validity)
0–1 = Excellent internal validity
2–4 = Good internal validity
5–7 = Acceptable internal validity
8–10 = Uncertain internal validity
≥10 = Uninformative due to flawed internal validity

Precision

Short form answer:

- ❑ Premeditated and sufficient study size (0)
- ❑ Sample size of uncertain adequacy (2)
- ❑ Probably underpowered study (4)

If uncertain, answer questions under Items 10–11

10. Smallest clinically relevant effect

a. Was the smallest clinically relevant effect defined?
   - ❑ Yes = 0
   - ❑ No = 1

b. Was the stated smallest clinically relevant effect reasonable?
- ❑ Yes = 0
- ❑ No = 1
- ❑ Not defined = 0 (scored under 10a)

11. Study power

a. Were the deliberations behind the sample size decision clearly described?
- ❑ Yes = 0
- ❑ No = 2

b. What was the power to detect a reasonably-sized smallest clinically relevant effect?
- ❑ Not stated because there was a strong and statistically significant effect = 0
- ❑ ≥90% = 0
- ❑ 80–89% = 1
- ❑ 70–79% = 2
- ❑ <70% = 3
- ❑ Not stated despite a non-significant finding = 4

Total sum of Items 10–11 (precision)
0–1 = Premeditated and sufficient study size
2–3 = Sample size of uncertain adequacy
≥4 = Probably underpowered study

Section B (observational cohort study or controlled clinical trial without randomization)

External validity

Short form answer:

- ❑ Clear external validity (0)
- ❑ Probable external validity (1)
- ❑ Uncertain external validity (3)
- ❑ External validity cannot be assessed (5)

If uncertain, answer questions under Item 1.
Otherwise go to Internal validity (after Item 1)

1. Accrual/selection of study subjects

a. Was the studied exposure well defined (eg, if follow-up of a specified disease, is the definition of the disease acceptable)?
   - ❑ Yes = 0
   - ❑ No = 2

b. Eligibility/inclusion criteria clearly stated?
   - ❑ Yes = 0
   - ❑ No = 1

c. Consecutive eligible subjects included?
   - ❑ Yes = 0
   - ❑ No = 1
   - ❑ Not stated = 1

d. Numbers and reasons for non-participation given?
   - ❑ Yes = 0
   - ❑ No = 1

e. Exclusion criteria clearly stated and acceptable?
   - ❑ Yes = 0
   - ❑ No = 1

f. Are numbers of excluded persons given by reason (as prescribed in the CONSORT statement)?
   - ❑ Yes = 0
   - ❑ No = 1

Total sum of section 1
0 = Clear external validity
1 = Probable external validity
2–3 = Uncertain external validity
≥4 = External validity cannot be assessed

Internal validity

Short form answer:

- ❑ Excellent internal validity (0)
- ❑ Good internal validity (1)
- ❑ Acceptable internal validity (2)
- ❑ Uncertain internal validity (4)
- ❑ Uninformative due to flawed internal validity (10)

If uncertain, answer questions under Items 2–6. Otherwise go to Precision (after Item 6)

2. Exposure assessment

a. Was the studied exposure satisfactorily measured/recorded?
   - ❑ Yes = 0
   - ❑ Yes, with minor criticism = 1
   - ❑ No = 3

b. Were all in the exposed group really exposed?
   - ❑ Yes = 0
   - ❑ Yes, probably = 1
   - ❑ No, probably not = 2
   - ❑ No = 2

c. Were all in the reference category really unexposed?
   - ❑ Yes = 0
   - ❑ Yes, probably = 1
   - ❑ No, probably not = 2
   - ❑ No = 2

3. Comparability of groups/selection bias/confounding

a. Was there an account of the comparability of groups with regard to factors that might conceivably affect the outcome (potential confounding factors)? (If only one cohort was studied and compared with the background population or historical controls – was there data to support the comparability with the reference category).
   - ❑ Yes = 0
   - ❑ No = 3

b. Did the investigators consider all important potential confounding factors (potential confounding factors = factors that are independent causes of/risk factors for/protective factors against the outcome, AND not a link in the causal chain between the studied exposure and the outcome)?
   - ❑ Yes = 0
   - ❑ Probably = 1
   - ❑ No = 3
   - ❑ No data given = 0 (already scored under 3a)

c. Were the relevant confounding factors satisfactorily measured/recorded?
   - ❑ Yes = 0
   - ❑ Yes, with minor criticism = 1
   - ❑ No = 3

d. Were the potential confounding factors unevenly distributed among exposed and /non-exposed/ reference group (confounding arises if factors described under 3b are unevenly distributed among exposed and unexposed [ie, linked to the exposure])?
   - ❑ Yes = 2
   - ❑ No = 0
   - ❑ No data given = 0 (already scored under 3a)

e. Were attempts in the analysis to adjust for imbalances between exposure groups with regard to potential confounding factors (eg, through restriction, stratified analyses, or multivariate modelling)?
   - ❑ Not needed (no important imbalances) = 0
   - ❑ Yes = –2 (subtract 2 if you scored 2 under 3d)
   - ❑ No, despite a need = 2

4. Evaluation of outcome, ascertainment/detection bias

a. Was there an acceptable definition of the outcome?
   - ❑ Yes = 0
   - ❑ No = 3

b. Was the outcome clinically relevant?
   - ❑ Yes = 0
   - ❑ Of questionable relevance = 2
   - ❑ Irrelevant → study is deemed uninformative, excluded

c. Were the evaluators of the outcome aware of exposure status of the cohort members?
   - ❑ Yes = 1
   - ❑ Probably = 1
   - ❑ No = 0

d. Was there any reason to believe that there was important ascertainment/ detection bias (eg, exposure linked to smoking, and smoking, in turn, linked to higher frequency of health care visits, and thus a more intense surveillance)?
   - ❑ Yes = 2
   - ❑ No = 0

5. Losses to follow-up

a. Was there an account of the numbers of subjects who were lost to follow-up?
   - ❑ Yes = 0
   - ❑ No = 3

b. What proportion was lost to follow-up?
- ❑ <10% = 0
- ❑ 10–19% = 1
- ❑ 20–29% = 2
- ❑ 30–39 = 3
- ❑ ≥40% → study is deemed uninformative, excluded
- ❑ Proportion not stated = 0 (scored under 5a)

6. Analysis

a. Was the main outcome variable defined in advance and was the conclusion of the study based on the analysis of this variable?
- ❑ Yes = 0
- ❑ No (or not mentioned in the report) = 1

b. Was there a prior hypothesis?
- ❑ Yes = 0
- ❑ No (or not mentioned in the report) = 1

c. Was the statistical method adequate?
- ❑ Yes = 0
- ❑ No = 3

Total sum of Items 2–6 (internal validity)
0–1= Excellent internal validity
2–3 = Good internal validity
4–6 = Acceptable internal validity
7–9 = Uncertain internal validity
≥10 = Uninformative due to flawed internal validity

Precision

Short form answer:

- ❑ Premeditated and sufficient study size (0)
- ❑ Sample size of uncertain adequacy (2)
- ❑ Probably underpowered study (4)

If uncertain, answer questions under Items 7–8

7. Smallest clinically relevant effect

a. Was the smallest clinically relevant effect defined?
- ❑ Yes = 0
- ❑ No = 1

b. Was the stated smallest clinically relevant effect reasonable?
- ❑ Yes = 0
- ❑ No = 1
- ❑ Not defined = 0 (scored under 10a)

8. Study power

a. Were the deliberations behind the sample size decision clearly described?
- ❑ Yes = 0
- ❑ No = 2

b. What was the power to detect a reasonably-sized smallest clinically relevant effect?
- ❑ Not stated because there was a strong and statistically significant effect = 0
- ❑ ≥90% = 0
- ❑ 80–89% = 1
- ❑ 70–79% = 2
- ❑ <70% = 3
- ❑ Not stated despite a non-significant finding = 4

Total sum of Items 7–8 (precision)
0–1 = Premeditated and sufficient study size
2–3 = Sample size of uncertain adequacy
≥4 = Probably underpowered study

Section C (case-control or cross-sectional studies)

External validity

Short form answer:

- ❑ Clear external validity (0)
- ❑ Probable external validity (1)
- ❑ Uncertain external validity (3)
- ❑ External validity cannot be assessed (5)

If uncertain, answer questions under Item 1.
Otherwise go to Internal validity (after Item 1)

1. Type of cases studied

a. Was there an acceptable definition of the outcome (that rendered subjects case/control status)?
   - ❑ Yes = 0
   - ❑ No = 2

b. Did the studied cases correspond to cases in the population to which the investigators wished to generalize their findings?
   - ❑ Yes = 0
   - ❑ Yes, probably = 1
   - ❑ No, probably not = 2
   - ❑ No, definitely not = 3

Total sum of section 1
0 = Clear external validity
1 = Probable external validity
2–3 = Uncertain external validity
≥4 = External validity cannot be assessed

Internal validity

Short form answer:

- ❑ Excellent internal validity (0)
- ❑ Good internal validity (1)
- ❑ Acceptable internal validity (2)
- ❑ Uncertain internal validity (4)
- ❑ Uninformative due to flawed internal validity (10)

If uncertain, answer questions under Items 2–6. Otherwise go to Precision (after Item 6)

2. Study base (NOTE, not relevant to cross-sectional studies; if so, skip 2–3)

The study base is defined as the group of people [the "virtual cohort"] who – if they developed the outcome condition – would necessarily have become cases in the study.

a. Was the study base *(*the "virtual cohort" [a defined source population followed for a defined time period] *that generated the cases)* well defined (geographically, age-wise, gender, other characteristics)?
   - ❑ Yes, quite clear (eg, an already established cohort, or definition through an existing, well-functioning population register) = 0

- ❑ Yes, reasonably (eg, hospital-based study with strict catchment areas and no important selections of cases or controls) = 1
- ❑ Yes, probably (eg, hospital-based study without clear catchment areas, and/or inability to rule out some less important selection among cases and/or controls; control selection via random digit dialing or through neighbourhood controls whereupon some minor mismatch [for instance socioeconomic] between cases and controls might have occurred) = 2
- ❑ No, it is impossible to tell if the cases and controls come from the same study base and if there are important selection mechanisms for either of these categories = 4

b. Are the cases representative of all cases in the study base?
- ❑ Yes, they represent all or virtually all new (incident) cases of the outcome that occurred in the study base = 0
- ❑ Yes, although it is difficult to tell if they represent all cases, there is no reason to suspect that they are unrepresentative of all cases in the study base = 1
- ❑ Yes, they represent prevalent cases in the study base, but there is no reason to suspect that they are unrepresentative = 1
- ❑ No, there are reasons to suspect that they are unrepresentative of all cases in the study base = 3
- ❑ No, definitely unrepresentative → study is deemed uninformative, excluded

c. Do the control subjects come from the very same study base as the cases?
- ❑ Yes, definitely = 0
- ❑ Yes, probably = 1
- ❑ Uncertain = 3
- ❑ Probably not = 4
- ❑ No, definitely not → study is deemed uninformative, excluded

d. Were the control subjects representative of the entire study base?
- ❑ Yes, they were selected randomly from a defined sampling frame (note that stratified random sampling in order to achieve frequency matching is acceptable) = 0
- ❑ Yes, probably, but they were selected in some other way = 1
- ❑ Uncertain = 3
- ❑ Probably not = 4
- ❑ No, the probability of being selected as control is linked to the subjects' exposure status → study is deemed uninformative, excluded

3. Non-participation

a. Were all eligible cases occurring in the study base identified and enumerated?
- ❑ Yes = 0
- ❑ Yes, probably = 1
- ❑ No = 3

b. What was the participation rate among all eligible cases?
   - ❑ ≥90% = 0
   - ❑ 80–89% = 1
   - ❑ 70–79% = 2
   - ❑ 60–69% = 3
   - ❑ 50–59% = 4
   - ❑ <50% → study is deemed uninformative, excluded
   - ❑ Proportion not stated → study is deemed uninformative, excluded

c. Was anything done to insure that major selection bias was not introduced through non-participation among cases?
   - ❑ Not needed because participation among cases was >80% = 0
   - ❑ Participation ≤80%, but authors provide data about non-participants that seem to rule out important selection bias = –1 (subtract from sum)
   - ❑ Participation ≤80%, and no data is given about non-participants = 0

d. What was the participation rate among all selected controls?
   - ❑ ≥90% = 0
   - ❑ 80–89% = 1
   - ❑ 70–79% = 2
   - ❑ 60–69% = 3
   - ❑ 50–59% = 4
   - ❑ <50% → study is deemed uninformative, excluded
   - ❑ Proportion not stated → study is deemed uninformative, excluded

e. Was anything done to insure that major selection bias was not introduced through non-participation among controls?
   - ❑ Not needed because participation among controls was >80% = 0
   - ❑ Participation ≤80%, but authors provide data about non-participants that seem to rule out important selection bias = –1 (subtract from sum)
   - ❑ Participation ≤80%, and no data is given about non-participants = 0

4. Participation in cross-sectional study (skip if regular case-control study)

- ❑ ≥90% = 0
- ❑ 80–89% = 1
- ❑ 70–79% = 2
- ❑ 60–69% = 3
- ❑ 50–59% = 4
- ❑ <50% → study is deemed uninformative, excluded
- ❑ Proportion not stated → study is deemed uninformative, excluded

5. Exposure assessment

a. How was exposure information collected?
- ❑ From existing databases with data obtained before cases developed outcome = 0
- ❑ Face-to-face or telephone interviews with interviewers blinded to case/control status = 0
- ❑ Face-to-face or telephone interviews where interviewers were aware of case/control status = 1
- ❑ Postal questionnaire = 2
- ❑ Other ways or not stated = 3

b. Use of substitute responders?
- ❑ No = 0
- ❑ ≤20% = 1
- ❑ >20% = 3

c. Are there good reasons to suspect biased recall (ie, cases remember/report exposures systematically different compared to controls)?
- ❑ No = 0
- ❑ No, probably not = 1
- ❑ Uncertain = 2
- ❑ Yes, recall bias likely = 4
- ❑ Yes, high probability of recall bias → study is deemed uninformative, excluded

6. Confounding

a. Did the investigators consider all important potential confounding factors (potential confounding factors = factors that are independent causes of/risk factors for/protective factors against the outcome, AND not a link in the causal chain between the studied exposure and the outcome)?
- ❑ Yes = 0
- ❑ Probably = 1
- ❑ No = 3
- ❑ No data given = 4

b. Were the relevant confounding factors satisfactorily measured/recorded?
- ❑ Yes = 0
- ❑ Yes, with minor criticism = 1
- ❑ No = 3

c. Were attempts in the study design or analysis to identify and handle confounding factors (eg, through matching, restriction, stratified analyses, or multivariate modelling)?
- ❑ Yes, adequately = 0
- ❑ Yes, but not sufficiently = 2
- ❑ No → study is deemed uninformative, excluded

7. Ascertainment/detection bias

a. Was there any reason to believe that there was important ascertainment/detection bias (eg, exposure linked to smoking, and smoking, in turn, linked to higher frequency of health care visits, and thus a more intense surveillance)?
   - ❑ Yes = 2
   - ❑ No = 0

8. Rare disease assumption

a. Was the rare disease assumption fulfilled (the outcome affected less than 10% of the population in the study base)?
   - ❑ Yes = 0
   - ❑ Unknown = 1
   - ❑ No or probably not = 3 (effects are likely exaggerated!)

9. Analysis

a. Was there a prior hypothesis?
   - ❑ Yes = 0
   - ❑ No (or not mentioned in the report) = 1

b. Was the statistical method adequate?
   - ❑ Yes = 0
   - ❑ No = 3

Total sum of Items 2–9 (internal validity) – CASE-CONTROL STUDY
0–2 = Excellent internal validity
3–4 = Good internal validity
5–7 = Acceptable internal validity
8–10 = Uncertain internal validity
≥11 = Uninformative due to flawed internal validity

Total sum of Items 2–9 (internal validity) – CROSS-SECTIONAL STUDY
0–1 = Excellent internal validity
2–3 = Good internal validity
4–5 = Acceptable internal validity
6–8 = Uncertain internal validity
≥9 = Uninformative due to flawed internal validity

Precision

Short form answer:

- ❑ Premediated and sufficient study size (0)
- ❑ Sample size of uncertain adequacy (2)
- ❑ Probably underpowered study (4)

If uncertain, answer questions under Items 10–11

10. Smallest clinically relevant effect

a. Was the smallest clinically relevant effect defined?
   - ❑ Yes = 0
   - ❑ No = 1

b. Was the stated smallest clinically relevant effect reasonable?
   - ❑ Yes = 0
   - ❑ No = 1
   - ❑ Not defined = 0 (scored under 10a)

11. Study power

a. Were the deliberations behind the sample size decision clearly described?
   - ❑ Yes = 0
   - ❑ No = 2

b. What was the power to detect a reasonably-sized smallest clinically relevant effect?
   - ❑ Not stated because there was a strong and statistically significant effect = 0
   - ❑ ≥90% = 0
   - ❑ 80–89% = 1
   - ❑ 70–79% = 2
   - ❑ <70% = 3
   - ❑ Not stated despite a non-significant finding = 4

Total sum of Items 10–11 (precision)
0–1 = Premeditated and sufficient study size
2–3 = Sample size of uncertain adequacy
≥4 = Probably underpowered study

Section D (systematic reviews)

Topic/external validity

Is it an overview of the topic that you are interested in?

- ❑ Yes, completely = 0
- ❑ Yes, partly = 1
- ❑ Only to a small extent = 3
- ❑ No = 6

Is the research question clearly stated?

- ❑ Yes = 0
- ❑ Uncertain = 2
- ❑ No = 4

Internal validity

1. Literature search

Is the search strategy clearly stated?

a. Types of publications?
   - ❑ Yes = 0
   - ❑ No = 1

b. Years?
   - ❑ Yes = 0
   - ❑ No = 1

c. Languages?
   - ❑ Yes = 0
   - ❑ No = 1

d. Procedures?
   - ❑ Yes = 0
   - ❑ No = 1

Was the reproducibility of search efforts tested and reported?

- ❑ Yes = 0
- ❑ No = 1

In your opinion, did the authors succeed in capturing all of the targeted literature?

- ❑ Yes, definitely = 0
- ❑ Yes, probably = 2
- ❑ Probably not = 4
- ❑ Definitely not = 5

2. Evaluation of captured literature

Was there a defined scheme for validity assessment of captured literature?

- ❑ Yes, shown or published previously = 0
- ❑ Probably, but not shown = 1
- ❑ Probably not = 3
- ❑ Definitely not = 4

Were the criteria for accepting/rejecting papers clearly defined?

- ❑ Yes = 0
- ❑ Probably = 1
- ❑ Probably not = 3
- ❑ Definitely not = 4

Were rejected papers listed with reasons for rejection?

- ❑ Yes = 0
- ❑ No = 2

Was there any attempt to document the reproducibility of the validity assessment (eg inter- and/or intra-observer variation)?

- ❑ Yes, with acceptable reproducibility = 0
- ❑ Yes, with poor reproducibility = 2
- ❑ No = 2

3. Summary of findings

Were there any attempts to pool data or to perform a formal meta-analysis?

- ❑ Yes = 0
- ❑ No = 3

Was the choice of statistical method appropriate?

- ❑ Yes, definitely = 0
- ❑ Yes, probably = 0
- ❑ Uncertain = 1
- ❑ Probably not = 2
- ❑ Definitely not = 2
- ❑ Not applicable (no formal statistical testing) = 0

Was lack of consistency between studies evaluated (eg, tests of heterogeneity) and explained?

- ❑ Yes, satisfactorily = 0
- ❑ Yes, but poorly explained = 2
- ❑ No = 3

Were there any attempts to estimate possible publication bias (eg, through funnel plots)?

❑ Yes = 0

❑ No = 2

Total sum of internal validity

0–1 = Excellent validity

2–3 = Good validity

4–5 = Acceptable validity

6–8 = Uncertain validity

≥9 = Uninformative due to flawed validity

Kriterier för bedömning av ekonomiska studier

Typ av kriterier	Empiriska studier	Modellstudier
1. Basala data an-gående studiens design, patienter, bortfall, effekt av behandling	Extern validitet, intern validitet, precision enligt mall/medicinsk (se tidigare i denna bilaga): <4 poäng: högt bevisvärde 4–7 poäng: medelhögt bevisvärde 8–12 poäng: lågt bevis-värde >12 poäng: ej acceptabel kvalitet	Tydlighet angående: frågeställning, perspektiv, jämförda alternativ, effektdata, epidemiologi, diskontering, marginalanalys, matematisk struktur för modell, cykeluppbyggnad >90% JA: högt bevisvärde 70<90% JA: medelhögt bevisvärde >50<70% JA: lågt bevisvärde <0% JA: ej acceptabelt
2. Relevans för svensk sjukvård	a) Basala data relevanta (enligt ovan) (JA krav) b) Relativpriser (-kostna-der) relevanta (JA krav) c) Sjukvårdsorganisation enligt empirisk studie relevant (JA möjliggör högt bevisvärde)	a) Basala data relevanta (enligt ovan) (JA krav) b) Relativpriser (-kostnader) relevanta (JA krav) c) Sjukvårdsorganisation enligt modellförslag relevant (JA möjliggör högt bevisvärde)
3. Jävsförhållande	a) Jävsdeklaration föreligger (JA krav) b) Utan problem för studien (JA möjliggör högt bevisvärde)	a) Jävsdeklaration föreligger (JA krav) b) Utan problem för studien (JA möjliggör högt bevisvärde)
4. Känslighetsanalys	a) Typ av analys tydligt visad (JA krav) b) Uppgifter om utfall av analys väl redovisade (JA möjliggör högt bevisvärde)	a) Typ av analys tydligt visad (JA krav) b) Uppgifter om utfall av analys (JA möjliggör högt bevisvärde)

Summering av de fyra delarna till ett bevisvärde (study quality), se nästa sida.

Empiriska studier

Högt bevisvärde: Punkt 1 har <4 poäng; punkt 2 har 3 av 3 JA; punkt 3 har 2 av 2 JA; punkt 4 har 2 av 2 JA.

Medelhögt bevisvärde: Punkt 1 har 4–7 poäng; punkt 2 har 3 av 3 JA; punkt 3 har 1 av 2 JA; punkt 4 har 2 av 2 JA.

Lågt bevisvärde: Punkt 1 har 8–12 poäng; punkt 2 har 2 av 3 JA; punkt 3 har 1 av 2 JA; punkt 4 har 1 av 2 JA.

Modellstudier

Högt bevisvärde: Punkt 1 har >90% JA; punkt 2 har 3 av 3 JA; punkt 3 har 2 av 2 JA; punkt 4 har 2 av 2 JA.

Medelhögt bevisvärde: Punkt 1 har 70–90% JA; punkt 2 har 3 av 3 JA; punkt 3 har 1 av 2 JA; punkt 4 har 2 av 2 JA.

Lågt bevisvärde: Punkt 1 har 50–70% JA; punkt 2 har 2 av 3 JA; punkt 3 har 1 av 2 JA; punkt 4 har 1 av 2 JA.

Bilaga 4. **Exluderade studier**

Exkluderade studier outredda refluxbesvär (Kapitel 3)

Sökningen försvårades av att ”ej gastroskoperade” inte går att använda som sökkriterium.

Översikter

Författare, år, referens	Orsak till exklusion
Zacny, 2005 [1]	Gastroskopi inklusionskriterium
Inadomi, 2002 [2]	Slutsats kan ej dras dras om ej gastroskoperade
Lee, 2004 [3]	Opoolade data om studier på både gastroskoperade och ej skoperade
Vakil, 2005 [4]	Relevanta kriterier saknades
Raghunath, 2005 [5]	Relevanta kriterier saknades
Inadomi, 2005 [6]	Relevanta kriterier saknades
Bytzer, 2004 [7]	Relevanta kriterier saknades
Bardhan, 2003 [8]	Relevanta kriterier saknades
Bytzer, 2001 [9]	Relevanta kriterier saknades
DeVault, 2000 [10]	Relevanta kriterier saknades
Richter, 2005 [11]	Gravida
Robinson, 2005 [12]	Gastroskoperade
Galmiche, 2004 [13]	Gastroskoperade
Lim, 2004 [14]	Gastroskoperade
Tytgat, 2003 [15]	Gastroskoperade
Pace, 2002 [16]	Gastroskoperade
Vakil, 2002 [17]	Gastroskoperade
Scott, 2002 [18]	Gastroskoperade

Tabellen fortsätter på nästa sida

Översikter, fortsättning

Författare, år, referens	Orsak till exklusion
Vakil, 2002 [19]	Gastroskoperade
Thitiphuree, 2000 [20]	Gastroskoperade
Lanas, 2001 [21]	Gastroskoperade
Pohle, 2000 [22]	Gastroskoperade
Spencer, 2000 [23]	Gastroskoperade
Bardhan, 1995 [24]	Gastroskoperade
Tytgat, 2004 [25]	Ej relevant frågeställning
Horn, 2004 [26]	Ej relevant frågeställning
Dent, 2003 [27]	Ej relevant frågeställning
Johnson, 2002 [28]	Ej relevant frågeställning
Baker, 2001 [29]	Ej relevant frågeställning
Storr, 2001 [30]	Ej relevant frågeställning
Tytgat, 2001 [31]	Ej relevant frågeställning
Tytgat, 1999 [32]	Ej relevant frågeställning
Da Costa, 1997 [33]	Ej relevant frågeställning
Hatlebakk, 1996 [34]	Ej relevant frågeställning
Reynolds, 1995 [35]	Ej relevant frågeställning
Ching, 1994 [36]	Ej relevant frågeställning
Hixson, 1992 [37]	Ej relevant frågeställning

RCT

Författare, år, referens	Orsak till exklusion
Scholten, 2005 [38]	Gastroskopi inklusionskriterium
Pace, 2005 [39]	Gastroskopi inklusionskriterium
Kaspari, 2005 [40]	Gastroskopi inklusionskriterium
Tsai, 2004 [41]	Gastroskopi inklusionskriterium

Tabellen fortsätter på nästa sida

***RCT**, fortsättning*

Författare, år, referens	**Orsak till exklusion**
Bytzer, 2004 [42]	Gastroskopi inklusionskriterium
Kao, 2003 [43]	Gastroskopi inklusionskriterium
Johnsson, 2002 [44]	Gastroskopi inklusionskriterium
Earnest, 2000 [45]	Gastroskopi inklusionskriterium
Stalhammar, 1999 [46]	Gastroskopi inklusionskriterium
Lind, 1999 [47]	Gastroskopi inklusionskriterium
Wiklund, 1998 [48]	Gastroskopi inklusionskriterium
Cloud, 1994 [49]	Gastroskopi inklusionskriterium
Cloud, 1991 [50]	Gastroskopi inklusionskriterium
Galmiche, 1998 [51]	Sannolikt bara gastroskoperade
Meineche-Schmidt, 2004 [52]	Ej relevant frågeställning
Elm, 1998 [53]	Ej relevant frågeställning
Inamori, 2005 [54]	Ej relevant frågeställning
Collings, 2002 [55]	Ej relevant frågeställning
Faaij, 1999 [56]	Ej relevant frågeställning
Khoury, 1999 [57]	Ej relevant frågeställning
Hatlebakk, 1997 [58]	Ej relevant frågeställning
Johannessen, 1997 [59]	Ej relevant frågeställning
Silvis, 1996 [60]	Ej relevant frågeställning
Johannessen, 1992 [61]	Ej relevant frågeställning
Berkowitz, 1990 [62]	Ej relevant frågeställning
Pappa, 1999 [63]	Ej relevant frågeställning
Ciociola, 2001 [64]	Ej relevant frågeställning

Referenser Outredda refluxbesvär (Kapitel 3)

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Exkluderade systematiska översikter Helicobacter pylori (Kapitel 5)

Författare, år, referens	Orsak till exklusion
Sharma, 2001 [1]	Samma referens som i Gisbert 2004 [9]
Ford, 2004 [2]	Samma referens och analys vad avser läkning som Ford 2003 ref nr
Gisbert, 2000 [3]	Utvärderar huvudsakligen terapi med vismut vilket ej är registrerat i Sverige
Gene, 2003 [4]	Utvärderar huvudsakligen terapi med vismut vilket ej är registrerat i Sverige
Gene, 2003 [5]	Utvärderar huvudsakligen terapi med vismut vilket ej är registrerat i Sverige
Gisbert, 2005 [6]	Utvärderar huvudsakligen terapi med vismut vilket ej är registrerat i Sverige
Fishbach, 2004 [7]	Utvärderar huvudsakligen terapi med vismut vilket ej är registrerat i Sverige
Van Oijen, 2000 [8]	Utvärderar huvudsakligen terapi med vismut vilket ej är registrerat i Sverige
Gisbert, 2004 [9]	Samma som i Cochrane reviderad av Gisbert ref nr
Houben, 1999 [10]	Endast poolad analys av eradikeringsfrekvens. Ej direkta jämförelser. Vismut
Hojo, 2001, [11]	Endast poolad analys av eradikeringsfrekvens. Ej direkta jämförelser
Houben, 1999 [12]	Endast poolad analys av eradikeringsfrekvens. Ej direkta jämförelser
Oderda, 2000 [13]	Barn ingår ej i uppdraget
Ulmer, 2003 [14]	Endast poolad analys av eradikeringsfrekvens. Ej direkta jämförelser
Wang, 2000 [15]	Endast poolad analys av eradikeringsfrekvens. Ej direkta jämförelser
Huang, 1999 [16]	Endast poolad analys av eradikeringsfrekvens. Ej direkta jämförelser

Tabellen fortsätter på nästa sida

Exkluderade systematiska översikter Helicobacter pylori (Kapitel 5), fortsättning

Författare, år, referens	**Orsak till exklusion**
van der Wouden, 1999 [17]	Endast poolad analys av eradikeringsfrekvens. Ej direkta jämförelser
Laheij, 1999 [18]	Endast poolad analys av eradikeringsfrekvens. Ej direkta jämförelser
Dore, 2000 [19]	Endast poolad analys av eradikeringsfrekvens. Ej direkta jämförelser
Graham, 2003 [20]	Saknar beskrivning av kvalitetsbedömning
Bhasin, 2000 [21]	Ulcusläkning och symtom ej utvärderade
De Francesco, 2004 [22]	Ulcusläkning och symtom ej utvärderade
Fennerty, 1998 [23]	Ulcusläkning och symtom ej utvärderade
Gisbert, 2005 [24]	Ulcusläkning och symtom ej utvärderade
Maconi, 2001 [25]	Ulcusläkning och symtom ej utvärderade
Calvet, 1999 [26]	Ulcusläkning och symtom ej utvärderade
Kamberoglou, 2001 [27]	Ulcusläkning och symtom ej utvärderade
Kaviani, 2001 [28]	Vismutberedning
Knigge, 1999 [29]	Vismutberedning. Ulcusläkning och symtom ej utvärderade
Marchi, 2001 [30]	Vismutberedning
Mesquita, 2005 [31]	Vismutberedning
Vakil, 2004 [32]	Ulcusläkning eller ulcussymtom ej utvärderade
de Silva, 2004 [33]	Ulcusläkning och symtom ej utvärderade
Calvet, 2005 [34]	Ulcusläkning och symtom ej utvärderade
Chu, 1998 [35]	Ulcusläkning och symtom ej utvärderade
Graham, 1998 [36]	Vismutberedning. Ofullständig redovisning av ulcusläkning och symtom

Referenser Helicobacter pylori (Kapitel 5)

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Exkluderade studier gastroesofageal sjukdom (Kapitel 6)

Ej använda studier, bedömda i fulltext

Författare, år, referens	Orsak till exklusion
Meining, 2000 [1]	Ej systematisk översikt
Murray, 1991 [2]	Viktminskningen okontrollerad
Kuster, 1994 [3]	Okontrollerad kohortstudie

Ej använda publikationer, bedömda i fulltext

Författare, år, referens	Orsak till exklusion
Coughlan, 2001 [4]	Reflux och astma
Edwards, 2002 [5]	Tillför ingen information jämfört med Donnellan ref nr
Kale-Pradhan, 2002 [6]	Ej systematisk översikt
Raghunath, 2003 [7]	Framför allt ekonomisk analys

Ej använda studier, bedömda i fulltext

Författare, år, referens	Orsak till exklusion
Baldi, 2002 [8]	Finns i NICE ref nr
Bardhan, 1999 [9]	Finns i Zacny ref nr
Bytzer, 2004 [10]	Finns i Zacny ref nr
Castell, 2005 [11]	Ej intressant för frågeställningen
Cross, 2002 [12]	Översikt, ej systematisk
Farup, 2001 [13]	Ej intressant för frågeställningen
Howden, 2001 [14]	Outredda patienter
Johnsson, 2002 [15]	Finns i NICE och Zacny ref nr

Tabellen fortsätter på nästa sida

Ej använda studier, bedömda i fulltext, fortsättning

Författare, år, referens	**Orsak till exklusion**
Kahrilas, 1999 [16]	Outredda patienter
Kaplan-Machlis, 2000 [17]	Kostnadsanalys
Katz, 2004 [18]	Ej intressant för frågeställningen
Lauritsen, 2003 [19]	Finns i NICE
Lind, 1999 [20]	Finns i NICE
Lundell, 2000 [21]	Finns i NICE och Allgood
Meineche-Schmidt, 2004 [22]	Kostnadsanalys
Myrvold, 2001 [23]	Kostnadsanalys
Norman Hansen, 2005 [24]	Oundersökta patienter
Ofman, 2002 [25]	Kostnadsanalys
O'Leary, 2003 [26]	Ej intressant för frågeställningen
Pilotto, 2003 [27]	Ej intressant för frågeställningen
Richter, 2001 [28]	Finns i Vakil [34]
Spechler, 2001 [29]	Finns i NICE
Stålhammar, 1999 [30]	Kostnadsanalys
Talley, 2001 [31]	Finns i NICE och Zacny
Tsai, 2004 [32]	Finns i Zacny
Vakil, 2002 [33]	Kostnadsanalys
van Hout, 2003 [34]	Kostnadsanalys
Vivian, 2000 [35]	Översikt, ej systematisk

Ej använda studier, bedömda i fulltext

Författare, år, referens	**Orsak till exklusion**
Castell, 2001 [36]	Översikt, ej systematisk
Cats, 2000 [37]	Okontrollerad observationsstudie
Creutzfeldt, 1992 [38]	Okontrollerad observationsstudie

Ej använda studier, bedömda i fulltext, fortsättning

Författare, år, referens	**Orsak till exklusion**
Diav-Citrin, 2005 [39]	Ej intressant för frågeställningen
Kuster, 1994 [3]	Okontrollerad observationsstudie
Ligumsky, 2001 [40]	Ingen definierad kontrollgrupp
Schenk, 1999 [41]	Okontrollerad kohortstudie
Solcia, 1992 [42]	Okontrollerad kohortstudie
Sonnenberg, 2002 [43]	Översikt, ej systematisk
Swanstrom, 2002 [44]	Översikt, ej systematisk
van Grieken, 2001 [45]	Ej intressant för frågeställningen
van Grieken, 2004 [46]	Ej intressant för frågeställningen
Thjodleifsson, 2003 [47]	Ej intressant för frågeställningen

Referenser Gastroesofageal sjukdom (Kapitel 6)

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pantoprazole. Aliment Pharmacol Ther 2003;17:1399-406.

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Exkluderade studier avseende prevalensen Barretts esofagus som exkluderats från analys (Kapitel 7)

Författare, år, referens	Prevalensen går inte klart att fastställa	Ingen eller bristande histologisk utvärdering	Skiljer inte på BE och IM vid endoskopiskt normal gastroesofageal övergång	Icke västerländsk studiepopulation
Sarr, 1985 [1]		X		
Cameron, 1990 [2]		X		
Lööf, 1993 [3]		X		
Johnston, 1996 [4]			X	
Yeh, 1997 [5]				X
Macdonald, 1997 [6]		X		
Nandurkar, 1997 [7]			X	
Robinson, 1998 [8]	X	X		
Voutilainen, 1999 [9]			X	
Azuma, 2000 [10]				X
Conio, 2001 [11]		X		
Dhawan, 2001 [12]				X
Lee, 2003 [13]				X
Loffeld, 2003 [14]		X		
Hurschler, 2003 [15]	X			
Rajendra, 2004 [16]				X
Lieberman, 2004 [17]	X			
Zhang, 2004 [18]				X
van Soest, 2005 [19]		X		
Nandurkar, 2005 [20]		X		
Ford, 2005 [21]	X	X		

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Studier avseende prevalensen Barretts esofagus som exkluderats från analys (Kapitel 7), fortsättning

Författare, år, referens	Prevalensen går inte klart att fastställa	Ingen eller bristande histologisk utvärdering	Skiljer inte på BE och IM vid endoskopiskt normal gastroesofageal övergång	Icke västerländsk studiepopulation
van Blankenstein, 2005 [22]	X			
Kim, 2005 [23]				X
Malfertheiner, 2005 [24]		X		

BE = Barretts esofagus; IM = Intestinal metaplasi

Exkluderade publikationer med uppgifter om risken för adenocarcinom hos populationer med Barretts esofagus (Kapitel 7)

Författare, år, referens	Orsak till exklusion
Cooper, 1987 [25]	Uppföljningen kortare än ett år
Weston, 1997 [26]	Först publicerade artikeln i en serie av publikationer baserade på samma studiepopulation
Nilsson, 2000 [27]	Först publicerade artikeln i en serie av publikationer baserade på samma studiepopulation
Gudlaugsdottir, 2001 [28]	Risken för EAC går ej klart att klarlägga
Weston, 2004 [29]	Risken för EAC går ej klart att klarlägga
van Blankenstein, 2004 [30]	Förekomsten av BE ej känd utan uppskattad

BE = Barretts esofagus; EAC = Adenocarcinom i esofagus

Referenser Barretts esofagus (Kapitel 7)

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Exkluderade studier, ekonomiska aspekter

Följande studier har exkluderats, med angivna orsaker. Modellstudier från Nordamerika och Japan har exkluderats men anges inte nedan.

Författare, år, referens	Orsak till exklusion
Agréus, 2002 [1]	GERD en av flera diagnoser för en Cost of illness-beräkning för Sverige
Agro, 2001 [2]	Modellanalys där bismut ingår
Alonso Aguirre, 2002 [3]	Översiktsartikel
Arora, 2001 [4]	Översiktsartikel
Bloom, 2001 [5]	Cost of illness för GERD i USA
Breuer, 1999 [6]	Modellanalys, bismut ingår
Briggs, 1996 [7]	Modellanalys, bismut ingår
Briggs, 2002 [8]	Metodbeskrivning av Probabilistic sensitivity analysis, tillämpning på GERD
Brignoli, 1997 [9]	Selektiv vs obligatorisk endoskopi, priser för Schweiz
Bytzer, 2004 [10]	Översiktsartikel med modelldiskussioner
Bytzer, 1999 [11]	Översiktsartikel
Childs, 2000 [12]	Systematisk litteraturgranskning utan redovisning av bedömningskriterier, studier i tabellform eller kostnadsuppgifter
Coster, 1995 [13]	Deskriptiv studie av en intervention
De Gregorio, 1998 [14]	Pilotstudie (n=12)
Delaney, 2001 [15]	RCT med bortfall >30%
Duggan, 1998 [16]	GERD en av flera diagnoser i en modellanalys
Ekelund, 2000 [17]	Översiktsartikel
Fairman, 2003 [18]	Modellstudie där även bismut ingår
Fass, 1999 [19]	Samma patientmaterial som Fass 1998 ref nr
Ford, 2004 [20]	Systematisk litteraturgranskning där 17 av 52 inkluderade studier omfattar bismut

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Exkluderade studier, ekonomiska aspekter, fortsättning

Författare, år, referens	**Orsak till exklusion**
Freston, 1995 [21]	Översiktsartikel
Garcia-Altés, 2001 [22]	Avser metodgranskning, varierande kvalitet på studier
Garcia-Altés, 2000 [23]	Modellanalys med mycket låg kostnad för endoskopi (23 $), tveksamhet om relevans för svensk sjukvård
Garcia Rodriguez LA, 1999 [24]	Praxisstudie om resursanvändning baserad på engelsk databas
Gee, 2002 [25]	Retrospektiv ang praxis, breath test vs endoskopi, enbart kostnader
Gené, 2000 [26]	Modellanalys med bismut
Glise, 1995 [27]	Översiktsartikel
Greenberg, 1996 [28]	Retrospektiv studie
Griffiths, 2001 [29]	Modellstudie med mycket hög kostnad för endoskopi (1 107 $)
Hagen, 2000 [30]	Översiktsartikel
Hassan, 2003 [31]	Inget om ekonomi i Metod el Resultat, endast i Diskussion
Heikkinen, 1999 [32]	Kostnader som medianvärden, kort uppföljning 3 månader efter operation, ej blindad studie
Henke, 2000 [33]	Förlorad arbetstid pga GERD, mätt med telefonenkät, Kaiser Permanente, USA
Hession, 2000 [34]	Ekonomiska beräkningar på andra studier, oklar litteratursökning
Hojo, 2001 [35]	Bismut i ett av läkemedlen
Houcke, 1995 [36]	Kostnader enbart i abstract
Hungin, 2001 [37]	Översiktsartikel
Janssen, 2001 [38]	Systematisk litteraturgranskning, bismut ingår
Jian, 2003 [39]	Översiktsartikel
Jones, 1994 [40]	Modellstudie, sjukvårdsperspektiv England
Jones, 1999 [41]	Inget om effekter, enbart kostnader

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Exkluderade studier, ekonomiska aspekter, fortsättning

Författare, år, referens	**Orsak till exklusion**
Joosen, 2000 [42]	Bismut i ett av läkemedlen
Jönsson, 2000 [43]	Översiktsartikel
Jönsson, 1996 [44]	Se Unge 1995 ref nr
Kaplan-Machlis, 2000 [45]	Öppen RCT (pragmatisk), ersättning enligt the Red Book, USA
Kartman, 2001 [46]	Delvis opublicerade studier från läkemedelsföretag om allmänhetens betalningsvilja (WTP) och livskvalitet (QALY)
Katelaris, 2004 [47]	Översiktsartikel
Kearney, 2003 [48]	Deskriptiv studie utan kontrollgrupp, primärvård i Seattle, priser enligt Veterans Affairs
Kivioja, 2004 [49]	Modellstudie för finska förhållanden baserad på data från workshop
Klok, 2005 [50]	Öppen RCT med bl a bismut som alternativ
Ladabaum, 2002 [51]	Observationsstudie, randomisering på vårdcentraler
Lambert, 1999 [52]	Översiktsartikel
Lane, 2006 [53]	Bismut i ett av läkemedlen
Love, 1997 [54]	Översiktsartikel
Lundell, 1998 [55]	Deskriptiv kostnadsberäkning, cost of illness för ”open antireflux surgery”
Madisch, 2002 [56]	Kostnader enbart i slutsatserna medianvärden för kostnader
Makris, 2003 [57]	Värdet av histopatologisk prov vid *H. pylori*-utredning
Marko, 2005 [58]	Modellanalys där bismut ingår
Marshall, 2000 [59]	Modellanalys för Kanada, höga ersättningspriser, 100% effektiv endoskopi
Martinek, 2000 [60]	Översiktsartikel

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Exkluderade studier, ekonomiska aspekter, fortsättning

Författare, år, referens	**Orsak till exklusion**
Mason, 1999 [61]	Deskriptiv studie med modellanalys, analys av socioekonomiska variablers betydelse för *H. pylori* och därmed sjukvårdskostnader
Mason, 2002 [62]	Modell angående *H. pylori*-screening, kostnad per räddat levnadsår vid undviken cancer, oklart om cancer- incidens och prevalens
McIntyre, 1997 [63]	Modellanalys, sensitivitet och specificitet 100% för endoskopi respektive serologi
McNamara, 2000 [64]	Översiktsartikel
Moayyedi, 1998 [65]	Översiktsartikel
Mushlin, 2001 [66]	Översiktsartikel
Myrvold, 2001 [67]	Sjukskrivningsdata från färre än 50% av patienterna, exakt lika sjukskrivningstid oavsett medverkande center
Narain, 2000 [68]	Liten studie (n=22), annan jämförelsegrupp. Pilot-studie
Naveau, 1989 [69]	Oklar kostnadsredovisning
Nessen, 1999 [70]	Retrospektiv uppföljning
Netzer, 1999 [71]	Deskriptiv studie ang pH-mätning, grov kostnads-kalkyl, Schweiz
O'Connor, 2000 [72]	Översiktsartikel
Ofman, 2003 [73]	Översiktsartikel
Pasta, 1999 [74]	Tillämpning av probabilistisk analys, bismut ingår
Poynard, 1998 [75]	Ej blindad RCT läkemedelsstudie, endast läke-medelskostnader, Frankrike
Raghunath, 2003 [76]	Systematisk litteraturstudie med tillagd budget-analys, engelska priser
Romano, 2003 [77]	Bismut ingår i studien
Schiefke, 2005 [78]	Modellstudie, sjukvårdsperspektiv Tyskland

Tabellen fortsätter på nästa sida

Exkluderade studier, ekonomiska aspekter, fortsättning

Författare, år, referens	**Orsak till exklusion**
Skog, 2004 [79]	Försök utan kontrollgrupp, oklar redovisning
Soni, 2001 [80]	Retrospektiv, liten studie (n=29) vid ett sjukhus
Sonnenberg, 1999 [81]	Amerikanska sjukvårdskostnader, tillämpning i en HMO-organisation
Sonnenberg, 2002 [82]	Översiktsartikel
Swanström, 2002 [83]	Översiktsartikel
Tennvall, 1999 [84]	Jämförelse mellan antibiotika (ett vs två)
Thjodleifsson, 2004 [85]	Översiktsartikel
Vakil, 2002 [86]	Ofullständig som systematisk litteraturgranskning
Vakil, 2004 [87]	Översiktsartikel
Van Hout, 2003 [88]	Avser både ulcus och GERD, dåligt redovisad litteratursökning, tillämpning som budgetkalkyl för Nederländerna
Verma, 2002, [89]	Kostnader endast i Diskussion, observationsstudie
Yamaguchi, 2005 [90]	Inga uppgifter om kostnader i metod eller resultat, endast i slutsatser
Yamasaki, 2002 [91]	Randomisering efter patientens önskemål
You, 2001 [92]	Bismut i ett av läkemedlen

GERD = Gastroesofageal refluxsjukdom
HMO = Health Maintenance Organization
NHS = National Health Services
RCT = Randomiserad kontrollerad undersökning

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Bilaga 5. **Läkemedelslista**

A02 - medel vid syrarelaterade symtom

A02A - antacida

A02AD01 - Aluminium-, kalcium- och magnesium
A02AD01 - Camalox
A02AD01 - Link
A02AD01 - Link Jordgubb
A02AD01 - Novalucol
A02AD01 - Novaluzid
A02AD01 - Novaluzid Mint
A02AD01 - Rennie
A02AD01 - Rennie Lakrits
A02AD04 - Hydrotalcit
A02AD04 - Altacet
A02AHÖÖ - Antacida och natriumbikarbonat
A02AHÖÖ - Natriumbikarbonat
A02AÖÖÖ - Antacida
A02AÖÖÖ - Natriumcitrat

A02B - medel vid magsår och gastroeso

A02BA01 - Cimetidin
A02BA01 - Aciloc
A02BA01 - Acinil
A02BA01 - Tagamet
A02BA02 - Ranitidin
A02BA02 - Artonil
A02BA02 - Inside
A02BA02 - Inside Brus
A02BA02 - Rani-Q
A02BA02 - Ranitidin Alpharma
A02BA02 - Ranitidin Hexal
A02BA02 - Ranitidin Medartuum
A02BA02 - Ranitidin Nm Pharma
A02BA02 - Ranitidin Pliva
A02BA02 - Ranitidin Ratiopharm
A02BA02 - Ranitidin Recip
A02BA02 - Ranitidin Sandoz
A02BA02 - Ranitidin Stada
A02BA02 - Ranitidine Ranbaxy
A02BA02 - Zantac
A02BA02 - Zantac Brus

Fortsätter på nästa sida

Bilaga 5. Läkemedelslista, fortsättning

A02BA03 - Famotidin
A02BA03 - Famotidin Hexal
A02BA03 - Famotidin Stada
A02BA03 - Pepcid
A02BA03 - Pepcidin
A02BA03 - Pepcidin Rapitab
A02BA04 - Nizatidin
A02BA04 - Nizax
A02BA53 - Famotidin, kombinationer
A02BA53 - Pepcid Duo
A02BB01 - Misoprostol
A02BB01 - Cytotec
A02BC01 - Omeprazol
A02BC01 - Losec
A02BC01 - Losec Mups
A02BC01 - Omeprazol Arrow
A02BC01 - Omeprazol Bmm Pharma
A02BC01 - Omeprazol Merck Nm
A02BC01 - Omeprazol Ratiopharm
A02BC01 - Omeprazol Sandoz
A02BC02 - Pantoprazol
A02BC02 - Pantoloc
A02BC03 - Lansoprazol
A02BC03 - Lanzo
A02BC03 - Lanzo P
A02BC04 - Rabeprazol
A02BC04 - Pariet
A02BC05 - Esomeprazol
A02BC05 - Inexium
A02BC05 - Nexium
A02BD05 - Omeprazol, amoxicillin och klaritromycin
A02BD05 - Losec Mups Hp
A02BD06 - Esomeprazol, amoxicillin och klaritromycin
A02BD06 - Nexium Hp
A02BX02 - Sukralfat
A02BX02 - Andapsin
A02BX02 - Succosa
A02BX03 - Pirenzepin
A02BX03 - Gastrozepin
A02BX05 - Vismutsubcitrat

Fortsätter på nästa sida

A02BX05 - De-Nol
A02BX13 - Alginsyra
A02BX13 - Gaviscon

A02Ö - Medel vid syrarelaterade symtom
A02ÖÖÖÖ - Medel vid syrarelaterade symtom
A02ÖÖÖÖ - Extempore

J01CA - Penicilliner med utvidgat spektrum
J01CA01 - Ampicillin
J01CA02 - Pivampicillin
J01CA04 - Amoxicillin
J01CA04 - Amimox
J01CA04 - Amoxicillin Sandoz
J01CA04 - Amoxicillin Scand Pharm
J01CA04 - Imacillin
J01CA06 - Bakampicillin
J01CA08 - Pivmecillinam
J01CA11 - Mecillinam
J01CA12 - Piperacillin

J01FA - Makrolider
J01FA01 - Erytromycin
J01FA06 - Roxitromycin