Enhancing the reporting and utility of systematic reviews of interventions in paediatrics: PRISMA-Children and Adolescents (PRISMA-C) 2026 extension checklist and explanation

Seven eAppendices

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eTable 1. Characteristics of survey panellists (n = 82)

Characteristics	N (%)
Panellist identification	
Invited directly by the Core Project Team	66 (80)
Referral from panellists	16 (20)
Primary perspective	
Academia	79 (96)
Non-profit	2 (2)
Other (Clinician)	1 (1)
Highest level of education	
MD/PhD	36 (44)
Medical degree (e.g., MD, MBBS, MBChB)	13 (16)
PhD	24 (29)
Master's degree	8 (10)
Bachelor's degree	1 (1)
Location	
Europe	27 (33)
North America	25 (30)
Oceania	11 (13)
Asia	11 (13)
South America	6 (7)
Middle East	1 (1)
Africa	1 (1)
Interest-holder group[a]	
Paediatric systematic review author	61 (74)
Paediatric trial protocol author	36 (44)
Paediatric trial report author	36 (44)
Paediatric clinician-scientist	34 (41)
Child health researcher	50 (61)
Paediatrician	25 (30)
Reporting guideline developer	15 (18)
Core outcome set developer	12 (15)
Methodologist	21 (26)
Biostatistician	7 (9)
Epidemiologist	21 (26)
Journal editor	24 (29)
Funder	0 (0)
Other	6 (7)
Paediatrics/child health research discipline[b]	
Allergy/Immunology	2 (3)
Child Health	1 (1)
Critical Care	3 (4)
Dentistry/Oral Health	3 (4)
Emergency Medicine	1 (1)
Infectious Diseases	2 (3)

Methodology	5 (7)
Neonatology	9 (12)
Nephrology	1 (1)
Neurology	4 (5)
Nutrition	5 (7)
Oncology	1 (1)
Ophthalmology	3 (4)
Paediatric Pain	1 (1)
Perinatology	1 (1)
Pharmacology	1 (1)
Physical Rehabilitation	1 (1)
Psychiatry	6 (8)
Public Health	2 (3)
Pulmonology	1 (1)
Quality, Safety, and Risk Management	1 (1)
Rare Disease	1 (1)
Surgery	2 (3)
Vaccinology	2 (3)
Other[c]	17 (22)
Level of expertise in systematic reviews of paediatric intervention research[d]	
High	54 (66)
Average	26 (32)
Low	2 (2)
Level of expertise using PRISMA[e]	
High	46 (56)
Average	35 (43)
Low	1 (1)
Self-reported experience[a]	
Have experience as an author, peer reviewer, or editor of systematic reviews of paediatric intervention research	81 (99)
Have expertise and experience working on a paediatric systematic review with other interest-holders (e.g., healthcare providers, regulatory bodies, policy makers) with sufficient knowledge on the content and material needed in a systematic review)	47 (57)
Are an editor of a journal that publishes paediatric systematic reviews	23 (28)
None of the above	1 (1)
Self-reported area of expertise for paediatric systematic reviews[a]	
Registration/protocols	64 (78)
Question formulation	66 (80)
Searching for studies	65 (79)
Study selection	73 (89)
Data collection	70 (85)
Risk of bias assessment	70 (85)
Certainty assessment	47 (57)
Meta-analysis	62 (76)
Alternative statistical synthesis methods	22 (27)
Automation of systematic review processes	18 (22)

Knowledge translation	40 (49)
None of the above	2 (2)
Author of at least 2 systematic reviews of interventions in paediatrics in the last 5 years (between 2020-2025)	
Yes	64 (78)
No	18 (22)
Number of systematic reviews of interventions in paediatrics you were an author on in 2020-2025 (of those who indicated "Yes" above)	
None	0 (0)
1	4 (6)
2-5	40 (63)
6-10	11 (17)
>10	9 (14)
Number of systematic reviews of interventions in paediatrics written/co-authored during entire career (all panellists)	
None	3 (4)
1	8 (10)
2-5	40 (49)
6-10	11 (13)
>10	20 (24)
Number of paediatric systematic reviews (of any kind) written/co-authored during entire career (all panellists)	
None	3 (4)
1	7 (9)
2-5	32 (39)
6-10	10 (12)
>10	30 (37)
Number of paediatric randomized controlled trials (RCTs) you have been part of the design, planning, and conduct during career (all panellists)	
None	24 (29)
1	8 (10)
2-5	29 (35)
6-10	6 (7)
>10	15 (18)

[a] Panellists can select more than one option.

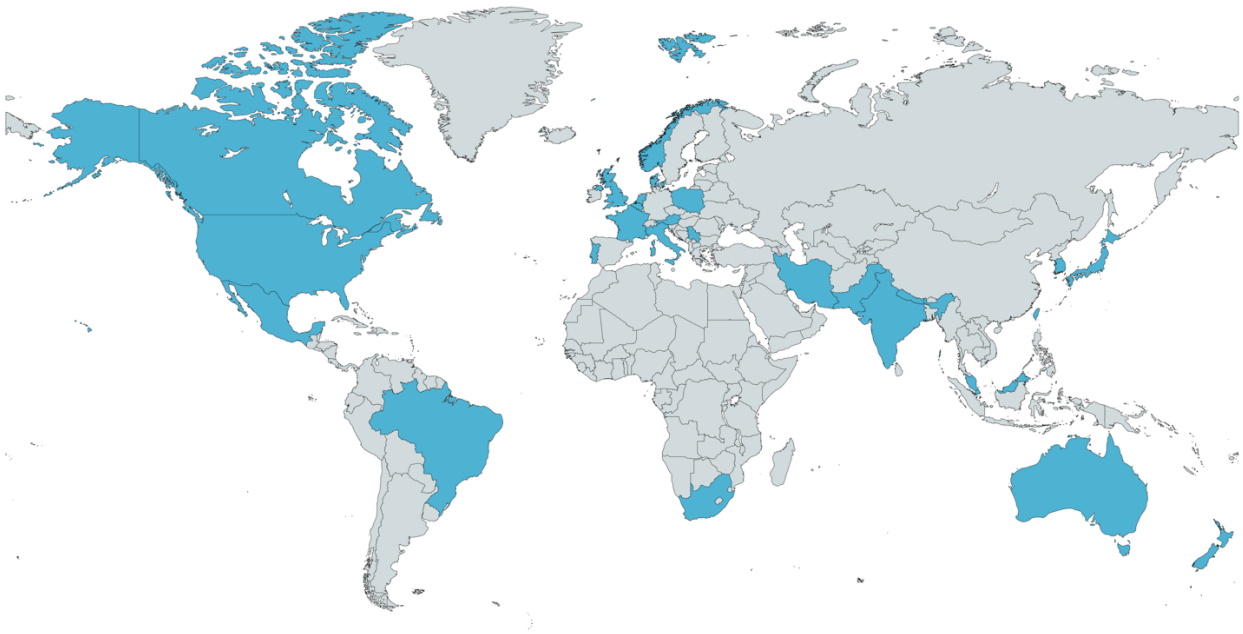
[b] Limited to those who identified as a paediatric systematic review author, paediatric trial protocol author, paediatric trial report author, clinician-scientist, child health researcher, and/or paediatrician.

[c] Other consisted of a mix of specialties: Perinatal and neonatal clinical research (n = 1); hepatology, gastroenterology, obesity, metabolic diseases, genetics, cell biology (n = 1); rare disease, trials, pain, disability (n = 1); IBD and liver disease (n = 1); neonatal/prematurity (n = 1); neonatology, endocrinology, growth and nutrition (n = 1); newborn survival and growth, paediatric infectious diseases (n = 1); technologies for paediatric patient safety (n = 1); all areas (n = 1); nutrition, infectious diseases, non-communicable diseases, neonatal (n = 1); asthma, tuberculosis, allergy (n = 1); diabetes and/or Integrated Care (n = 1); infant feeding, allergy, long covid (n = 1); pulmonology and epidemiology (n = 1); paediatric ICU delirium, Paediatric Intensive Care Unit (PICU) sleep, paediatric emergence delirium (n = 1); antiemetics, allergic rhinitis, antipyretics (n = 1); metabolic health (n = 1).

[d] Panellists' self-rated expertise (e.g., designing, conducting, reporting, understanding, and using) systematic reviews of paediatric intervention research

[e] Panellists' self-rated expertise on using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines

eFigure 1. Geographic distribution of survey panellists (in blue) (n = 82 panellists)



Map created with mapchart.net
Note: The 82 panellists were located in the following 27 countries: Canada (n = 15), United Kingdom (n = 9), United States of America (n = 9), Australia (n = 8), Brazil (n = 6), Italy (n = 4), India (n = 3), The Netherlands (n = 3), New Zealand (n = 3), Denmark (n = 2), France (n = 2), Malaysia (n = 2), Portugal (n = 2), Austria (n = 1), Belgium (n = 1), Iran (n = 1), Japan (n = 1), Mexico (n = 1), Nepal (n = 1), Norway (n = 1), Pakistan (n = 1), Poland (n = 1), Serbia (n = 1), Singapore (n = 1), South Africa (n = 1), South Korea (n = 1), and Taiwan (n = 1)

eAppendix 2. Detailed methods

1. Identification of candidate reporting items

We identified candidate reporting items for PRISMA-C through two sources. The first source was the "base" PRISMA-C items that were developed during the initial PRISMA-C development efforts.[1] These items were developed to serve as an extension to the PRISMA 2009 guideline.[2] Informed by two systematic reviews published in 2017,[3] a Delphi survey, and in-person consensus meeting, these base PRISMA-C items comprise 7 new candidate PRISMA-C items, and suggested modifications to 11 PRISMA 2009 items.[1 2] The second source for candidate reporting items was the CONSORT-C 2026 items, providing 13 new paediatric specific items for randomized controlled trial (RCT) reports.[4]

All candidate items from these two sources were reviewed alongside the PRISMA 2020 guideline, allocated in its relevant sections, and reworded or split as needed to make them relevant to systematic reviews (e.g., CONSORT-C Item 1a.1 was reworded from "Identify that it is a paediatric **trial**" to "Identify that it is a paediatric **systematic review**").

Based on recommendations from the PRISMA Executive, we included only candidate reporting items **specific** to paediatrics in the preliminary candidate list. To facilitate integration of PRISMA-C with the PRISMATIC (PRISMA, Technology, and Implementation to enhance reporting Completeness) web applications,[5] no modifications to existing PRISMA 2020 items were considered. Instead, due to the importance of reporting based on targeted pediatric age subgroup(s), Core Project Team members (AB, LH, MO) selected nine PRISMA 2020 items that might be relevant for the "ontogeny statement" (see main text, **Results, Section 3.6.2**).

Each candidate reporting item was reviewed by the Core Project Team to ensure its paediatric specificity and was finalized for inclusion in the survey (see below, **eAppendix 4**). We included a total of 9 items for the main checklist, 8 items for the abstract, and 9 PRISMA 2020 items for the ontogeny statement in the survey.

2. Survey

2.1 Identification of survey panellists

We adopted the following eligibility criteria from PRISMA 2020,[6] and tailored it for PRISMA-C. Individuals with the following expertise were eligible to respond to the survey: 1) authors, peer reviewers, or editors of systematic reviews of interventions in paediatrics; 2) those with expertise and experience working on a paediatric systematic review with other interest-holders (e.g., healthcare providers, regulatory bodies, policy makers), with sufficient knowledge on the content and material needed in a systematic review; 3) editors of journals that publish paediatric systematic reviews; or 4) those with methodological background and expertise with regards to paediatric systematic reviews in at least one of the following: registration/protocols, question formulation, searching for studies, study selection, data collection, risk of bias assessment, certainty assessment, meta-analysis, alternative statistical synthesis methods, automation of systematic review processes, and knowledge translation.

In an effort to assemble a group with both content and methods expertise in systematic reviews of interventions in paediatrics, we directly invited: A) corresponding authors who published a systematic review(s) of interventions in paediatrics from January 1, 2024 to May 27, 2025; B) Editors in chief (or similar role) at top paediatric journals (i.e., Pediatrics, Journal of Pediatrics, Archives of Disease in Childhood, JAMA, JAMA Pediatrics, and The Lancet Child and Adolescent Health), or journals that published at least six systematic reviews of interventions in paediatrics from January 1, 2024 to May 27,

2025; C) SPIRIT-C 2026 and CONSORT-C 2026 Delphi panellists that completed all three rounds, and self-identified as a systematic reviewer (n = 56); and D) members of the Core Outcomes Reporting in Neonatal Trials (CORINT) writing team members, who self-identified as a systematic reviewer (n = 17), including one CORINT study group member who is also part of Group C but did not self-identify as a systematic reviewer during the time of the CORINT project. For individuals in groups A, C, and D to be eligible to complete the survey, they had to have published at least two systematic reviews of interventions in paediatrics in the last 5 years (2020-2025). If they had not published at least two systematic reviews of interventions in paediatrics in the last 5 years, they were still considered eligible if they self-reported to fit criteria 2, 3, or 4 listed above. Two Core Project Team members (MFK, LHa) with expertise in systematic reviews of interventions in paediatrics were also invited (Group E), as were four other past collaborators; however, all were required to fit the criteria 2, 3, or 4.

To identify potential panellists that fit the Group A criteria, an experienced research librarian conducted a search to identify systematic reviews of interventions in paediatrics published from January 1, 2024, to May 27, 2025. The search strategy is reported in the Supplementary Materials (**eAppendix 3**). We screened the first 1000 records of this search to identify systematic reviews of interventions in paediatrics and excluded records that were not within a paediatric age range, studies on pregnancy and labour, and records that were not systematic reviews or meta-analysis of interventions in paediatrics. We also excluded protocols of systematic reviews. After this initial screen, we screened out records published in journals or by publishers known to be controversial or predatory. To identify individuals in Group B, the search used to identify Group A panellists was run in PubMed PubReMiner.[7] In addition, editors in chief (or similar) of the top paediatric journals were partially informed by the journals used to identify trials included in the CORINT study.[8] All identified individuals were sent an invitation to contribute, asking them to complete an online registration form, self-report their background and expertise, and confirm that they met the eligibility criteria. Those who met the criteria were given access to the survey. We also implemented “snowball sampling” by encouraging registrants to share the names and e-mail addresses of colleagues they thought would be interested or qualified to complete the survey. Those referred were directly invited by the Core Project Team and sent the link to the survey. If referents were also corresponding authors or editors in chief (Groups A, B), the eligible dates were extended to the survey end date (August 22, 2025, instead of May 27, 2025). Otherwise, referents had to meet the eligibility criteria, as detailed above.

2.2 Structure and content

Once the Core Project Team had agreed on a preliminary list of candidate reporting items, we built a survey on the Research Electronic Data Capture (REDCap) platform,[9] where panellists would vote on and provide feedback on the candidate reporting items. Consistent with the development of PRISMA 2020,[10] we conducted a one-time survey. Prior to launch, the survey was piloted by Core Project Team members (n = 3; MFK, LHa, MO), Cochrane Netherlands research staff (n = 2), and a PhD research associate (n = 1). We reviewed all feedback on survey functionality, leading to several improvements prior to launch, and improved the wording for some of the candidate reporting items based on feedback from pilot testers. The PRISMA-C survey comprised three parts: Sections A, B, and C.

2.2.1 Section A: Main checklist and abstract items

Survey panellists voted on 17 candidate reporting items (9 main checklist items, 8 abstract items) to determine which candidate items should be included in the minimum set to support comprehensive reporting in a systematic review of interventions in paediatrics. Candidate items are listed in **eAppendix 4** (Section A, **eTable 2** and **eTable 3**). For the 9 candidate reporting items for the main checklist,

panellists were provided with four options to "This item should be included in PRISMA-C": "No, exclude", "Unsure", "Yes, keep", and "I'm opting out". The "I'm opting out" option was provided in case a panellist did not want to vote for a particular item, whether it be the item being out of their expertise or for any other reason. For 8 candidate abstract reporting items, panellists were provided the same four voting options to "This item should be included in PRISMA-C for abstracts". We provided a free-text box for all 17 candidate reporting items to give panellists an option to provide feedback on the item, such as wording.

2.2.2 Section B: PRISMA 2020 items for the ontogeny statement

Section B invited panellists to review and provide feedback on the "ontogeny statement" and its rationale (see main text, **Box 1,** for finalized version). We introduced the "ontogeny statement" concept as part of PRISMA-C 2026, as PRISMA 2020 items would not be modified to facilitate a smooth integration of PRISMA-C 2026 as part of the PRISMATIC project initiatives.[5] The ontogeny statement is intended to provide authors explicit guidance and transparency on which PRISMA 2020 items should be reported by the various age groups and ranges that may be included in the systematic review.

For both the ontogeny statement and rationale, voting options were: "Clear, no modifications needed", "Minor modifications needed", and "Major modifications needed", with a free text box for any modification suggestions. Section B also included voting on nine candidate PRISMA 2020 items that this statement would apply to. For each of the nine items, panellists were provided the same voting options as with Section A for "This PRISMA 2020 item should be included under the ontogeny statement ("for all included paediatric age subgroups")".

2.2.3 Section C: Barriers, facilitators, and interventions for reporting guideline implementation and adherence

In Section C, we invited panellists to share their thoughts on implementation barriers and facilitators, and interventions to enhance implementation and adherence of reporting guidelines (**eAppendix 5**, **eTables 5-7**). Known barriers, facilitators, and solutions/interventions were identified from four publications focused on these topics.[11-14] Panellists were asked to select which of the suggested 8 barriers and 4 facilitators in using reporting guidelines they personally experienced. They were also asked to indicate which of the suggested 12 solutions/interventions would be most effective in increasing implementation and adherence to PRISMA-C 2026. They also had the opportunity to elaborate in a free-text box on any other barriers, facilitators, or solutions/interventions that they personally experienced but were not available in the choices presented.

2.2.4 Survey conduct

We launched the survey on July 29, 2025, and gave panellists until August 22, 2025, to complete it. To identify any referrals, we checked participants' responses daily; if referrals were provided, they were sent an invitation to contribute to the survey. Every week, we sent a reminder to all those who had registered but not yet completed the survey, and those that had not yet registered; in total, three follow-up reminder e-mails were sent. After the deadline, the survey remained open for an additional six days to allow those who had registered but not yet completed the survey to finish it; no additional invitations or follow-up reminders were sent during this six-day period.

2.2.4 Analysis

Once the survey was closed, voting frequencies and percentages were calculated. We only included responses from those who completed the entire survey. Comments from free-text boxes were reviewed

and summarized by one author (AB). To meet pre-set consensus criteria to be included as an item, ≥70% of panellists had to vote the item as "Yes, keep"; the reverse was true for consensus criteria to be excluded. However, meeting the threshold did not necessarily guarantee inclusion in the checklist, as we selected items for discussion at the Core Project Team Consensus Meeting based on the voting frequencies and percentage, but also on the free-text box comments received for the item. For example, if panellists commented that a particular item was redundant, or should be merged with another item, this warranted discussion at the Consensus Meeting.

3. Core Project Team Consensus Meeting

A survey summary report was prepared with all findings and proposed modifications and was shared with the Core Project Team. Members were asked to review the material specifically for topics that were to be discussed during the meeting. A one-hour virtual meeting was held over Zoom on September 10, 2025, to discuss and make decisions on items that warranted further discussion, finalization of the wording of the ontogeny statement, rationale, and part of the scope statement. Five Core Project Team members (AB, LHa, MFK, LH, MO) attended the meeting. One Core Project Team member could not attend, but a separate meeting was scheduled with them the following week and attended by three members (DM, AB, MO).

During the Core Project Team Consensus Meeting, we discussed two main checklist items, three abstract items, the ontogeny statement and rationale, part of the scope statement, four PRISMA 2020 items for the ontogeny statement, and four additional PRISMA 2020 items suggested by survey panellists. Discussions revolved around the inclusion/exclusion of items, placement of items, and wording. Each item was first presented with survey results and a summary of comments, and then any revised wording adjustments and decisions to be made for the item based on survey results and comments. The meeting was recorded and all decisions made were noted down. The survey summary report, slide deck, meeting minutes with decisions, and the meeting recording was shared with the Core Project Team member (DM) who was unable to attend the Consensus Meeting, and a separate meeting with a smaller group was held a week later (AB, DM, MO). During this meeting, we confirmed consensus on all decisions from the previous meeting, made final decisions on wording of concepts (e.g., "ontogeny statement"), and reviewed the content and format of the checklist and item explanations.

4. Family caregiver workshop

The engagement of family caregivers was co-designed by the Patient Engagement Expert (MS), the project lead (AB), and the principal investigator (MO). The stepwise method of involving family caregivers was informed by past projects where patient and public partners had successfully been involved in reporting guideline development.[15 16]

To facilitate meaningful contributions, we sought to involve family caregivers with sufficient background experience and expertise on both reporting guideline development and evidence synthesis. Given the complexity of systematic review methods and concepts, and to avoid tokenistic involvement, we elected to not involve young people. The level of background knowledge needed would require substantial training for young people to be able to contribute meaningfully, which was not feasible with the available resources for this project. However, candidate PRISMA-C items were identified from CONSORT-C 2026, and, thus, generating PRISMA-C 2026 candidate reporting items partially integrated the perspectives of young people (ages 10-24 years) and family caregivers.[4] In developing SPIRIT-C 2026 and CONSORT-C 2026,[4 17] robust methods had been implemented to involve young people and family caregivers throughout the project and obtain their perspectives on what should be reported in a paediatric RCT protocol and report; their involvement is described in detail in a separate publication.[15]

We invited family caregiver advisors (n = 5) from the SPIRIT-C 2026 and CONSORT-C 2026 project, and family caregivers of children with rare diseases who had undergone training in evidence synthesis with the Patient Engagement Lead (MS) previously (n = 4) to join a 1.5-hour virtual workshop. They would be given the opportunity to provide their perspectives on items that were voted in to PRISMA-C 2026. A week prior to the workshop, family caregivers were sent an e-mail with the workshop slide deck, pre-final PRISMA-C 2026 checklist, and a truncated survey summary report featuring only the reporting items that would be discussed during the workshop. We asked family caregivers to review the slide deck and checklist prior to the meeting noting that reviewing the survey summary report was optional and not mandatory.

The 1.5-hour workshop comprised a training component and a workshop component and was led by three members of the Core Project Team (MS, AB, MO). The training component provided background knowledge on what a systematic review is, the difference between primary research and evidence synthesis, and reporting guidelines. The current project's aims, how the PRISMA-C 2026 extension is developed, and the importance of their perspective were highlighted. As invited family caregivers had already received training on reporting guidelines and evidence synthesis through other projects in the past, the training component was an opportunity for them to refresh their knowledge and ensure they understood the purpose of the PRISMA-C project. The interactive workshop component followed and was dedicated to discussing the 9 main checklist items that had preliminarily been included after the survey and Core Project Team Consensus Meeting. Family caregivers had the opportunity to review the item, review elements that were already considered for the item and ratify them, and suggest any additional elements and information that they thought should be reported from their perspective. At the end of the workshop, we asked all attendees to complete an anonymous evaluation survey to indicate their experience and provide feedback on the training component and workshop component.

5. Finalizing the extension

After the family caregiver workshop, Core Project Team Members (AB, MO) reviewed all materials in the context of the PRISMA 2020 guideline and paediatric specific reporting items that had been preliminarily included. The PRISMA-C 2026 checklist was finalized, and the statement paper was drafted. Examples of good reporting were identified from published systematic reviews of paediatric intervention research. All materials were reviewed and approved by all authors.

eAppendix 3. Literature search strategy to identify corresponding authors of systematic reviews of paediatric randomized controlled trials

Ovid MEDLINE(R) ALL <1946 to May 27, 2025>			
#	**Searches**	**Results**	
1	(MEDLINE or systematic-review or (literature adj2 review)).tw. or (search* adj12 (literature or database?)).ti,ab. or intervention$.ti.	954841	Search filter SR Health Canada[18]
2	Adult Children/ or Adolescent/ or Child/ or Child, preschool/ or Infant/ or Infant, newborn/ or Infant, low birth weight/ or Infant, small for gestational age/ or Infant, very low birth weight/ or Infant, postmature/ or Infant, premature/ or Child of impaired parents/ or Child, abandoned/ or Child, exceptional/ or Child, gifted/ or Child, unwanted/ or Minors/ or Adolescent hospitalized/ or Adolescent institutionalized/ or Child hospitalized/ or Child institutionalized/ or Homeless youth/ or Disabled children/ or Pediatrics/ or child*.tw. or paediatric*.tw. or pediatric*.tw. or perinat*.tw. or neonat*.tw. or newborn*.tw. or infan*.tw. or bab*.tw. or toddler*.tw. or boy*.tw. or girl*.tw. or kid*1.tw. or schoolage.tw. or juvenil*.tw. or underage*.tw. or teen*.tw. or offspring.tw. or youth*.tw. or pubescen*.tw. or adolescen*.tw. or infan*.jw. or child*.jw. or pediatric*.jw.	5349487	Child filter (in-house)*
3	1 and 2	179637	
4	((randomized controlled trial or controlled clinical trial).pt. or drug therapy.fs. or (randomized or randomised or placebo or randomly or trial or groups).ab.) not (exp animals/ not humans/)	5549443	Cochrane RCT filter[19]
5	3 and 4	63004	
6	limit 5 to yr="2024 -Current"	8038	2024-curent

*AmsterdamUMC in-house developed filter; this child filter is a fine-tuned version of several published search filters developed in-house to be as sensitive as possible, hence the inclusion of details such as journal titles etc.

eAppendix 4. Voting results: Candidate reporting items

Section A

eTable 2. Candidate reporting items for PRISMA-C 2026

Survey item #	Candidate item wording	Voting results (Yes, keep)	Final decision	Final item numbering and wording
1 C, §	Identify that it is a pediatric systematic review and specify the age group(s) and interventions studied	98%	Included	1a. Identify that it is a paediatric systematic review
2 P, ‡	Describe the rationale for the review in terms of each element of the PICO for the targeted pediatric age group(s). If the systematic review includes both adults and children/adolescents, describe the rationale in terms of PICO for the targeted pediatric age group	91%	Excluded	N/A
3 C, †	Provide a justification for including data from multiple pediatric age groups or children/adolescents at different developmental stages, and discuss potential differences in treatment effects related to age or development	79%	Included	Item split into two: 3a. Provide justification for included age groups, ranges, or developmental stages* 3b. Discuss potential differences and similarities in treatment effects related to age or development*
4 P, §	If eligible intervention(s), comparator(s), and/or outcome(s) differ across included pediatric age groups, describe for each. If the systematic review includes both adult and children, describe each element of the PICO for the targeted pediatric age group	89%	Included	5a. If multiple age groups or ranges are eligible and require variable delivery of interventions, comparators, or the choice of outcomes or measurement methods differ, detail these*
5 C, †	Address the relevance, validity and reliability of selected outcomes and outcome measurement instruments in various included age subgroup(s)	80%	Excluded	N/A
6 P, §	Synthesise data separately by relevant age subgroups whenever possible. If synthesis by subgroups is not feasible, or if data from adults and children/adolescents are combined, provide justification	85%	Included	13d.a. Describe how data was synthesized separately by relevant age groups or ranges. If not feasible, provide an explanation
7 P, ‡	Report what was extracted for each pediatric age subgroup, if different data was extracted for each subgroup	85%	Excluded	N/A
8 C, §	Report number of children/adolescents in each primary study by age group(s)	91%	Included	17a. Report number of children/adolescents by age groups or ranges*

9 [P, §]	Comment on the appropriateness of how outcomes were measured (addressing e.g., validity, feasibility, reliability, responsiveness) for each targeted pediatric age subgroup	85%	Included	23b.a. Comment on the appropriateness of outcome measurement, including aspects such as validity, feasibility, reliability, and responsiveness of measurement instruments, for each age groups or ranges*

*****Report item if applicable/done, or state explicitly that it is not applicable/done
[P] Item identified from initial development efforts of PRISMA-C
[C] Item identified from CONSORT-C 2026 checklist
[§] Item included after survey voting
[†] Item discussed at the Core Project Team Consensus Meeting
[‡] Item was preliminarily included after survey voting, but was revisited after the Family Caregiver Workshop prior to extension finalization and excluded due to redundancy with existing items

eTable 3. Candidate reporting items for PRISMA-C 2026 Abstract

Survey item #	Candidate item wording	Voting results (Yes, keep)	Final decision	Final item numbering and wording
A1 [C, §]	Identify the age group(s) and interventions and the main outcomes (e.g., function, morbidity, mortality)	98%	Include	2.2-C. Identify the age groups and ranges, interventions, and main outcomes
A2 [P, §]	If applicable, if the systematic review includes both adults and children/adolescents, describe a subgroup analysis for the targeted pediatric age group(s) in the methods and results of the abstract	76%	Include	2.6-C. Describe a planned subgroup analysis for the paediatric age groups or ranges when both adults and children/adolescents are included*
A3 [C, †]	Indicate eligible age range(s) and/or developmental stage(s) for study inclusion	91%	Exclude	N/A
A4 [C, †]	Provide a justification for pediatric subgroup analyses	41%	Exclude	N/A
A5 [C, §]	Indicate the number of children/adolescents analysed, specifying totals for each defined age range	83%	Include	2.8.1-C. Indicate the total number of children/adolescents analysed, and specify subtotals for each age group or range if deemed important
A6 [C, §]	Present results for each of the pre-specified eligible age range(s) or developmental stage(s) studied	79%	Include	2.8.2-C. Present results for each of the pre-specified eligible age groups or ranges studied*
A7 [C, †]	Present results for important harms by pre-specified eligible age range(s) or developmental stage(s)	69%	Merged / to be included as detail for 2.8.2-C	N/A
A8 [C, ‡]	Specify the age range(s) to which the results are applicable	78%	Exclude	N/A

*****Report item if applicable/done, or state explicitly that it is not applicable/done
[P] Item identified from initial development efforts of PRISMA-C
[C] Item identified from CONSORT-C 2026 checklist
[§] Item included after survey voting
[†] Item discussed at the Core Project Team Consensus Meeting
[‡] Item was preliminarily included after survey voting, but was revisited after the Family Caregiver Workshop prior to extension finalization and excluded due to redundancy with existing items

Section B

eTable 4. Candidate PRISMA 2020 reporting items for the ontogeny statement

Survey item #	PRISMA 2020 Item	Voting results (Yes, keep)	Final decision
B1†	PRISMA Item 4: Provide an explicit statement of the objective(s) or question(s) the review addresses	78%	Include
B2§	PRISMA Item 13e: Describe any methods used to explore possible causes of heterogeneity among study results (e.g., subgroup analysis, meta-regression)	84%	Include
B3§	PRISMA Item 19: For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots	84%	Include
B4§	PRISMA Item 20b: Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	85%	Include
B5†	PRISMA Item 20c: Present results of all investigations of possible causes of heterogeneity among study results	70%	Include
B6†	PRISMA Item 21: Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed	71%	Exclude
B7†	PRISMA Item 22: Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed	78%	Include
B8§	PRISMA Item 23a: Provide a general interpretation of the results in the context of other evidence	87%	Include
B9§	PRISMA Item 23d: Discuss implications of the results for practice, policy, and future research	88%	Include
Additional items suggested by survey panellists and discussed at the Core Project Team consensus meeting:			
N/A	PRISMA Item 5†: Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses	N/A	Include
N/A	PRISMA Item 6†: Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	N/A	Exclude
N/A	PRISMA Item 7†: Present the full search strategies for all databases, registers and websites, including any filters and limits used	N/A	Exclude
N/A	PRISMA Item 10a†: List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	N/A	Include

§ Item included after survey voting

† Item discussed at the Core Project Team Consensus Meeting

eAppendix 5. Voting results: Barriers, facilitators, and enablers for PRISMA-C implementation

Section C

eTable 5. Barriers experienced or observed in using reporting guidelines

Barrier	N (%)*
Constraints (e.g., word count limits) imposed by the journal	54 (66)
Lack of enforcement and verification of use and adherence from journals and funders	41 (50)
Lack of clarity on who is responsible for checking the completeness and accuracy of submitted reporting guideline checklists	34 (41)
Increased workload and burden on researchers	31 (38)
Lack of explicit oversight, leading to assumption that adherence is optional	30 (37)
Difficulty identifying most appropriate guideline due to the number of available guidelines	29 (35)
Lack of awareness of reporting guidelines	26 (32)
Unclear benefits	10 (12)
None of the above	2 (2)

*Note: Panellists can select more than 1 option

eTable 6. Facilitators experienced or observed in using reporting guidelines

Facilitator	N (%)*
Desire to accurately describe interventions, design, conduct, and analysis	64 (78)
Journal endorsement and mandates of reporting guideline use	63 (77)
Associated implications to the work being of “quality” when reporting guidelines are used	52 (63)
Recommendations for use by other researchers	31 (38)
None of the above	0 (0)

*Note: Panellists can select more than 1 option

eTable 7. Solutions/interventions thought to be the most effective to increase adherence and implementation to PRISMA-C

Solution/intervention	N (%)*
Mandate of reporting guideline use by journals, preprint servers, funders, and regulatory bodies for publication, funding, and approval of research	70 (85)
Use of generative artificial intelligence (AI) and large language models (LLMs) to automate checks for adherence to reporting guidelines and consistency across paper, registries, and protocols to reduce burden of reporting guideline use	49 (60)
Verification of author compliance to reporting guidelines	40 (49)
Framework of use that is unified and user-friendly (e.g., item bank with items, examples of good reporting) with the availability of structured templates for different study types	39 (48)
Reporting guideline consolidation, streamlining, and harmonization	38 (46)
Introducing staff training, peer review, and editorial checks dedicated to assessing completeness of reporting	38 (46)
Audit and monitoring of journals done independently to assess reporting completeness	34 (41)
Increased investment and emphasis in education and research integrity training programs, workshops, online courses, and mentorship initiatives	35 (43)
Use of subheadings to offer guidance to authors in preparing their manuscript	35 (43)
Various training to facilitate practical use of reporting guidelines	33 (40)
Encouraging, checking, and providing feedback on adherence	31 (38)
Selection and assistance of authors, peer reviewers, and editors in selecting relevant reporting guideline through software solutions	29 (35)
None of the above	1 (1)

*Note: Panellists can select more than 1 option

eAppendix 6. Tables and figures for the Explanation and Elaboration

Item 5a (*Example 2*)

Table 1. Trial Eligibility Criteria (Treadwell et al., 2025)[20]

(Note: This table has been truncated for conciseness)

Aspect	Inclusion	Exclusion
Patients	• **Children (aged 6–11 years), adolescents (aged 12–17 years), and adults (18 years or older) with migraine headache (episodic or chronic)** • We did not require trials to include only individuals with an International Classification of Headache Disorders diagnosis of migraine headache • ≥80% of trial participants had migraine headache, or the trial reports a subgroup analysis composed of at least 80% patients with migraine • For trials with participants with other headache types (e.g., medication-overuse headache, tension-type headache, cluster headache) in addition to migraine, we included the trial if at least 80% of participants had migraine	Trials conducted exclusively: • Among individuals in institutions (e.g., psychiatric inpatients, long-term care facilities, incarcerated populations) • Parents, for trials with interventions targeting children and adolescents • Individuals with psychotic disorders
Interventions	Migraine-focused behavioral interventions used for prevention, administered either alone or with pharmacotherapy, delivered in-person, via telehealth, or with e- or mHealth 1. CBT • CBT • Cognitive therapy • MBCT[a] • Behavioral therapy • SMT • Coping skills training • LCT • **Parent/caregiver operant training (parent or caregiver reinforces coping behaviors)** • Problem-solving training 2. Biofeedback • Thermal/temperature biofeedback (hand warming/thermal biofeedback; often feedback of skin temperature from finger) • Electromyographic biofeedback (feedback of electrical activity from muscles of scalp, neck, or upper body) • Heart rate variability biofeedback • Electrocardiographic biofeedback • Pulse • Blood volume pulse • Respiratory • Electroencephalography/neurofeedback 3. Relaxation training • Diaphragmatic breathing • Progressive muscle relaxation (alternatively tensing/relaxing selected muscles) • Autogenic feedback (use of calm, self-soothing statements to promote a state of deep relaxation)	Trials focused solely on: • Physical therapy • Exercise • Catharsis therapy (e.g., written emotional disclosure) • Occupational therapy • Creative arts therapy (art therapy, music therapy, dance therapy) • Massage

Aspect	Inclusion	Exclusion
	• Autogenic training • **Guided imagery/guided visual imagery (children/adolescents)** 4. Mindfulness-based stress reduction • Meditation (use of silently repeated word or sound to promote mental calm and relaxation) • MBCT[a] • Transcendental meditation • **Guided imagery/guided visual imagery (adults)** 5. Acceptance and commitment therapy 6. Education • Education (skills, lifestyle, exercise, nutrition, hydration, stress management, sleep hygiene) • Neuroscience education therapy • Healthy lifestyle counseling • Sleep counseling • Trigger avoidance • Weight management (informational) • Diary/tracking 7. Hypnotherapy 8. Trauma-informed therapy • EMDR • Trauma-focused therapy 9. DBT 10. Motivational interviewing and stages of change 11. Professionally led support groups/peer support 12. Combination therapies Non-headache-focused behavioral interventions • CBT for insomnia or depression/anxiety • Sleep hygiene counseling • **Parent/caregiver operant training (parent or caregiver reinforces adaptive sleep behaviors)** • • Healthy lifestyle counseling	
Outcomes	Trial must have reported one or more of three primary outcomes Migraine/headache attack frequency • Migraine/headache count: migraine days per month, migraine attacks per month, headache days per month, or headaches per month • Responder rate: 50% or more reduction in one of the above quantities Functional status/disability • MIDAS, PedMIDAS, HIT-6, HANA, MIBS, FIS, FDI (parent form), **FDI (child and adolescent),** IMPAC, PDI QoL • Migraine-specific: MSQ	Some other outcomes were included in the full report, but are not discussed in this article

Abbreviations: CBT, cognitive behavioral therapy; DBT, dialectical behavioral therapy; EMDR, eye movement desensitization and reprocessing; FDI, Functional Disability Inventory; FIS, Fatigue Impact Scale; HANA, Headache Needs Assessment; HIT-6, Headache Impact Test-6; LCT, learning to cope with triggers; MBCT, mindfulness-based cognitive therapy; MIBS, Migraine Interictal Burden Scale; MIDAS, Migraine Disability Assessment; MSQ, Migraine-Specific Quality of Life Questionnaire v2.1; PDI, Pain Disability Inventory; PedMIDAS, Pediatric Migraine-Specific Disability Assessment; QoL, quality of life; RCT, randomized controlled trial; SMT, stress management training; SR, systematic review.

[a] MBCT was categorized as a combination of cognitive therapy and MBSR, so it appears under two categories.

Item 17a (*Example 1*)

Table 1. Characteristics of included studies (Guerrero-Magaña et al., 2024)[21]

Study ID; country and references[a]	Study design; follow-up from baseline	Participants—sample size; age range; sex (% male); race/ethnicity; income status	Intervention—description; interventionist; setting; use of theory	Outcomes measured
Children, Holiday—Summer break				
Baranowski, 2003; USA[reference]	Two-armed RCT12-weeks	N = 35 girls and their parents or caregivers; 8-year-olds (mean 8.3 years); 0% male; African-American; 46% had a household income <$40,000	Intervention group: GEMS-FFFP special summer day camp, followed by a special home Internet intervention for the girls and their parents. Control group: summer day camp, followed by a monthly home Internet intervention without GEMS-FFFP enhancements. Interventionist: N/R. Setting: Day camp. Use of theory: Social cognitive theory	Height, BW, BMI (kg/m2), FM%, WC
Evans, 2018; USA[reference]	Two-armed non-RCT8 weeks	N = 81; 6–12 years; 57.4% male; 18.25% non-Hispanic White, 19.25% non-Hispanic Black, 31.25% non-Hispanic Other, 31.25% Hispanic (all races); Low income	Intervention group: Physical activity programming SPARK-AS and lunch offered through the SFSP. Comparison group: SFSP open-side at their housing community but no access to the intervention programming. Interventionist: College-age summer staff. Setting: Community public park. Use of theory: Social cognitive theory	BMIz
Evans, 2020; USA[reference]	Two-armed RCT7 or 8 weeks (2017, 2018)	N = 94; 6–12 years; 8.7% non-Hispanic White, 15.25% non-Hispanic Black, 13.5% non-Hispanic other, 63% Hispanic (all races); Low income	Intervention group: Daily day camp offering physical activities including sports, arts and crafts. Free breakfast and lunch meals provided via the SFSP. Comparison group: Experienced summer vacation as planned by their parent/guardian without enrolling in summer day camp or other daily structured summer programming for more than 1 week. Interventionist: N/R. Setting: Day camp. Use of theory: N/R.	BMIz
Hopkins, 2019; USA[reference]	Three-armed cluster-RCT8 weeks	N = 87; Kindergarten through 5th grade, Age range not reported (mean 7.56 years); 43.02% males, 89.53% Black, 10.47 non-Black; Low income	Enhanced Care: Nutrition, physical activity, and mental health programming with access to free meals and safe play. Standard Care: Nutrition and physical activity programming with access to free meals and safe play. Active Control: access to free meals and safe play, (no nutrition, physical activity or mental health programming). Interventionist: N/R. Setting: Public	BMIz

			schools. Use of theory: Social cognitive theory	
Kilanowski, 2015; USA[reference]	Two-armed non-RCT12 weeks	N = 171; 55% males; 6–13 years; Race/Ethnicity: N/R; Income status: N/R	Intervention group: Nutrition and physical activity through calisthenics and sport lessons to migrant children. Control group: Received bilingual healthy eating, low-literacy, publicly available CDC flyers on healthy eating. Interventionist: Part-time media teacher, pediatric nurse practitioner. Setting: Midwest Migrant Education Program locations. Use of theory: N/R	BMI (kg/m2), BMIp
Meucci, 2013; USA[reference]	Three-armed RCT4- week or 8-week	N = 22 adolescents; 55% males; 8–12 years; Race/Ethnicity: N/R; Income status: N/R	Intervention group: 4-week or 8-week group play-based activity, nutrition classes and healthy snacks and lunches. Control group: Followed their usual summer break without any intervention from the study coordinators; however, they were asked to maintain their current level of physical activity for the duration of the study. Interventionist: Expert instructors. Setting: Day camp. Use of theory: Social cognitive theory	Height, BW, BMI (kg/m2), FM
von Klinggraeff, 2022; USA[reference]	Three-armed non-RCT12-weeks	N = 180; 7–9 years (mean 7.9 years); 40% males; 94% non-Hispanic Black; Low-income	HSL intervention: Alternated academic classes with physical activity, with 15-min nutrition education session during lunch, plus healthy breakfast, lunch, and snack. 21C intervention: Academic sessions plus physical activity before lunch. Healthy breakfast and lunch. Control group: No program. Interventionist: N/R. Setting: School. Use of theory: Social cognitive theory	BMI (kg/m2)
Adults—Winter holiday (or Chilean National Holidays—Hernandez-Jana 2010)				
Hernandez-Jaña, 2020; Chile[reference]	Two-armed RCT3 weeks	N = 36; Age range not reported, (mean 20.91 years); Race/Ethnicity: N/R; Income status: N/R	Intervention group: Traditional nutritional session (lasted 20 min) that included a body composition measurement, nutritional assessment, and a brief educational talk about healthy eating. This group received healthy recommendations focused on the Chilean National Holidays. Control group: Were asked to continue their normal activities. Interventionist: N/R. Setting: University laboratory. Use of theory: N/R	BW, BMI (kg/m2), FM%.

Hirsh, 2019; USA[reference]	Two-armed pilot RCT6-weeks	N = 22; 21–45 years; 21.87% males; Race/Ethnicity: N/R; Income status: N/R	Intervention group: 52 days of intermittent energy restriction during 2 days per week (730 kcal/d; 3050 kJ/d) and 5 days of eating their habitual diet, with daily consumption of a set of dietary supplements. Control group: Followed their habitual diet without any restriction and daily intake of multivitamin for 52 days. Interventionist: N/R. Setting: Clinical setting. Use of theory: N/R	BW, AE
Kaviani, 2019; USA[reference]	Two-armed RCT7 weeks	N = 111; 18–65 years; 26.12% males; Race/Ethnicity: N/R; Income status: N/R	Intervention group: Performed DSW. Participants were instructed to try not to gain weight, and no additional instructions on how to achieve that goal were provided. Control group: Did not receive any intervention. They completed the same study visits as the intervention group. Interventionist: N/R. Setting: Clinical setting. Use of theory: Social cognitive theory	BW, BMI (kg/m2), FM%, WC.
Mason, 2018; UK[reference]	Two-armed RCT4–8 weeks	N = 272; 22% males; >18 years; white (78%); Income status: N/R	Intervention group: DSW, weight record and weight trajectory feedback; information of weight management strategies over the Christmas period; and PACE information for regularly consumed festive foods and drinks. The goal was to gain no more than 0.5 kg of baseline weight. Comparison group: received a leaflet on healthy living. Interventionist: N/R. Setting: home or convenient location. Use of theory: Self-regulation theory and habit formation model	BW, FM%.
Watras, 2007; USA[reference]	Two-armed RCT6 months	N = 48 randomized, N = 40 completers; 18–44 years; 20% males; Race/Ethnicity: N/R; Income status: N/R	Intervention group: 4 g/day of 78% active CLA isomers of safflower oil (3.2 g/day CLA). Comparison group: 4 g/day of placebo (safflower oil). Interventionist: N/R. Setting: Clinical setting. Use of theory: None reported	BW, FM%, AE

Abbreviations: 21C, 21st Century Summer Learning Program; AE, Adverse Events; BMI, Body Mass Index; BMIz, Body Mass Index z-score; BMIp, Body Mass Index percentiles; BW, body weight; CDC, Centers for Disease Control and Prevention; CLA, conjugated linoleic acid; DSW, daily self-weighing; FM, fat mass kilograms; FM%, fat mass percentage; GEMS-FFFP, girls health enrichment multisite studies-fun, food, and fitness project; HSL, healthy summer learners; N/R, information not reported; PACE, physical activity calorie equivalents; RCT, randomized controlled trial; SFSP, summer food service program; SPARK-AS, Sports, Play Active Recreation for Kids After School; UK, United Kingdom; USA, United States of America; WC, waist circumference.

[a] For studies with more than one reference listed, the first is the primary reference.

Item 17a (*Example 2*)

Table 1. Baseline characteristics of participants in the included studies (Pascual-Morena et al., 2023)[22]

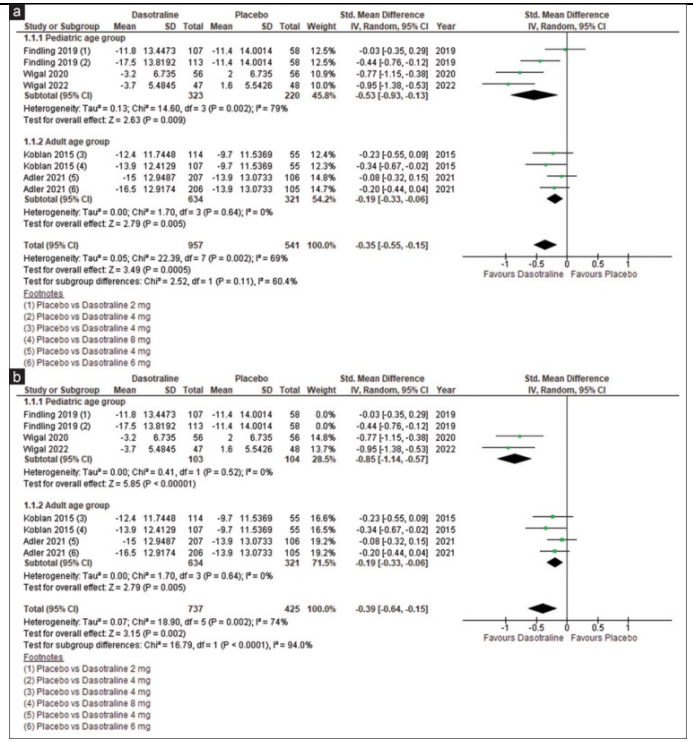
Reference	Region	Trial	Participants			Pre-intervention	Intervention		Included outcomes		
			Type SMA	Sample	Age at infusion [a]		Dose	Length	MF	RF	SF
Baranello et al. (2021) [reference]	America Europe	NCT02913482 (FIREFISH 1)	SMA1	21	6.7 m (3.3–6.9)	Native	0.08 mg/kg 0.20 mg/kg	12 months	✓	–	–
Chiriboga et al. (2023) [reference]	America Europe	NCT03032172 (JEWELFISH)	SMA 1, 2, and 3	174	14.0 y (1–60)	Oxesoxime: 71 RO6885247: 13 Nusinersen: 76 Onasemnogene abeparvovec: 14	0.20 mg/kg (<2 years) 0.25 mg/kg (>2 years and <20 kg) 5 mg (>20 kg)	12 months	–	–	✓
Darras et al. (2021) [reference]	America Asia Europe	NCT02913482 (FIREFISH 2)	SMA1	41	5.3 m (2.2–6.9)	Native	0.20 mg/kg	12 months	✓	✓	–
Finkel et al. (2022) [reference]	NS	NCT03779334 (RAINBOWFISH)	Presym. SMA[b]	7	26.5 d	Native	NS	12 months	✓	–	–
Kwon et al. (2022) [reference]	America	Trial	SMA1 and 2	155	13.0 ± 10.0 y	Native: 26 Nusinersen: 101 Onasemnogene abeparvovec: 9 Both: 11 Unknown: 8	0.20 mg/kg (<2 years) 0.25 mg/kg (>2 years and <20 kg) 5 mg (>20 kg)	4.8 months	–	–	✓
Masson et al. (2022) [reference]	America Asia Europe	NCT02913482 (FIREFISH 2)	SMA1	41	5.3 m (4.2–6.8)	Native	0.20–0.25 mg/kg	24 months	✓	–	✓
McCluskey et al. (2023) [reference]	Europe	Trial	SMA2	6	34.5 ± 7.2 y	Native	NS	9 months	✓	✓	–
Mercuri et al. (2022) [reference]	Europe	NCT02908685 (SUNFISH 1)	SMA2 and 3	51	7.0 y (2.0–24.0)	Native	0.25 mg/kg (2–11 y) 5 mg (12–25 y)	24 months	✓	✓	✓
Mercuri et al. (2022)[34]	America Asia Europe	NCT02908685 (SUNFISH 2)	SMA2 and 3	180	10.0 y (2.0–25.0)	Native	0.25 mg/kg (<20 kg) 5 mg (>20 kg)	12 months	✓	✓	✓
Ñungo Garzón et al. (2023) [reference]	Europe	NCT04256265	SMA2	6	33.0 ± 12.2 y	Native: 4 Nusinersen: 2	0.25 mg/kg (<20 kg) 5 mg (>20 kg)	12 months	✓	✓	–
Oskoui et al. (2023) [reference]	America Asia Europe	NCT02908685 (SUNFISH 2)	SMA 2 and 3	180	10.0 y (2.0–25.0)	Native	0.25 mg/kg (<20 kg) 5 mg (>20 kg)	24 months	✓	✓	✓

Abbreviations: MF, motor function; NS, not specified; RF, respiratory function; SF, safety profile; SMA, spinal muscular atrophy.
[a] Age at infusion described as years (y), months (m) or days (d).
[b] Presymptomatic participants. Four participants with two copies of the *SMN2* gene (probable SMA1) and three participants with more than two copies of the *SMN2* gene (probable SMA2 or 3) were included.

eTable 8. Examples of good reporting for the PRISMA 2020 items applicable under the ontogeny statement

PRISMA 2020 Item	Example
Item 4. Objectives: Provide an explicit statement of the objective(s) or question(s) the review addresses	**Example 1:** "A recent systematic review and network meta-analysis (SRNMA) compared the efficacy of different inhaler therapies in preventing exacerbations in both mild and moderate adult asthma [reference], subject to different treatments. As such, an unmet need exists for an updated SRNMA focusing on mild asthmatic patients stratified by age group (i.e., children [defined as ages 6-11 years] and adolescents/adults). The optimal treatments for mild asthma across the various options require clarification to inform clinical practice. This study sought to identify variation across the treatment options and rank these based on short- to intermediate-term and long-term outcomes."(Pornsuriyasak et al., 2025)[23]; example adapted to include age ranges as defined in the paper **Example 2:** Currently, approved treatments for children and adolescents [defined as ages 10-17 years] encompass daily oral metformin, subcutaneous insulin, subcutaneous [glucagon-like peptide 1] GLP-1 receptor agonists (once-daily liraglutide and once-weekly exenatide), daily oral dapagliflozin, and daily oral empagliflozin. Canagliflozin, in turn, is limited to individuals aged 18 or older.[reference] However, the restricted number of clinical trials requires a thorough data synthesis to comprehensively evaluate the safety and efficacy of [sodium-glucose cotransporter 2 inhibitors] SGLT2i treatment. In light of these considerations, this study aimed to conduct a systematic review and meta-analysis to assess the potential benefits and risks associated with SGLT2i treatment in pediatric and young adult patients with [type 2 diabetes mellitus] T2DM." (dos Santos Borges et al., 2024)[24]; example adapted to include age ranges as defined in the paper
Item 5. Eligibility criteria: Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses	**Example 1:** *See Example 2 for PRISMA-C Item 5a:* Table 1. Trial Eligibility Criteria (Treadwell et al., 2025)[20] **Example 2:** "We included [randomized controlled trials] RCTs with a placebo or usual care group comparator that included 0 to 18 year-olds with obesity who participated in any (i) physical activity, (ii) nutrition, (iii) psychological, (iv) technology-based interventions or (v) multicomponent interventions (i.e., ≥2 of the aforementioned intervention types) with outcome data reported ≥3 months post-baseline. Outcomes of interest were selected and ranked by importance by stakeholders (i.e., caregivers, clinicians and researchers) who were surveyed as part of our protocol to update the *Canadian Clinical Practice Guideline for Managing Paediatric Obesity.*[reference] Prioritized outcomes included [patient-reported outcome measures] PROMs ([health-related quality of life] HRQoL, anxiety, depression), cardiometabolic risk factors (blood pressure, lipids, insulin resistance and liver enzymes), anthropometry ([body mass index] BMI *z*-score [BMIz], BMI and weight) and adverse events (AEs). Along with analyses that combined children and adolescents of all ages, we performed subgroup analyses across age groups, including: 0 to 5 year-olds, 6 to 12 year-olds and 13 to 18 year-olds, inclusively. We used aggregate-level data, with studies classified in our pre-determined age groups according to the mean age of participants within each study. We examined outcomes at follow-up times of 3–6 months post-baseline (inclusive), 7–12 months post-baseline (inclusive) and >12 months post-baseline, if reported, and examined intervention duration of 0–6 months and 7–12 months inclusively. In the Results section, data are presented by the outcome rather than the intervention type, in the order that outcomes were prioritized by stakeholders.[reference]" (Henderson et al., 2025)[25]
Item 10a. Data items: List and define all outcomes for which data were sought. Specify whether all	**Example:** "The primary outcome of this systematic review was medication adherence posttreatment. Trials were included if they reported on at least one measure of medication adherence (i.e., self-report, electronic adherence monitoring devices, pill counts, pharmacy refill data), regardless of whether adherence was conceptualized as a primary or secondary outcome within the manuscript. One primary measure of adherence was selected for inclusion from each trial. If trials included more than one measure of adherence, the more objective measure was selected to minimize the potential impact of social desirability, recall bias, and "white coat

PRISMA 2020 Item	Example
results that were compatible with each outcome domain in each study were sought (for example, for all measures, time points, analyses), and, if not, the methods used to decide which results to collect	adherence" on treatment outcomes [reference] using the following hierarchy: (1) electronic adherence monitoring devices; (2) pharmacy refill data; (3) pill counts; and (4) self-report measures. If self-report measures were completed by multiple informants (e.g., parent/caregiver and child), parent/caregiver reports were included for trials including children (under 13 years of age) and child reports were included for trials including adolescents and young adults (13 years of age and older). If multiple measures of adherence were obtained via the same measurement strategy (e.g., medication initiation, medication persistence, and medication discontinuation from pharmacy refill data), the measure most closely approximating daily medication-taking behavior was included (e.g., medication persistence over initiation or discontinuation)." (McGrady et al., 2024)[26]
Item 13e. Synthesis methods: Describe any methods used to explore possible causes of heterogeneity among study results (such as subgroup analysis, meta-regression)	**Example:** "Heterogeneity among the effect sizes in the included studies was assessed using *I*-squared (I^2) statistic, with values of 50% or higher indicating significant heterogeneity.[reference] To address variability in participant characteristics, intervention types, and instruments used to measure mental health outcomes, the random-effects model (DerSimonian and Laird) was applied to obtain more conservative estimates.[reference] … Subgroup analyses, stratified by age group (children or adolescents [defined as ages 7-19 years]), BMI category (overweight or obesity), intervention type (e.g., physical activity, emotion regulation, health education), intervention theory (e.g., behavioural, cognitive, behavioural and cognitive), intervention duration, and World Bank income levels (high-income countries [HICs], or low- and middle-income countries [LMICs]) were further conducted to identify potential sources of heterogeneity." (Zhou et al., 2025)[27]; example adapted to include age ranges as defined in the paper

<table>
<tr><th>PRISMA 2020 Item</th><th>Example</th></tr>
<tr><td>Item 19. Results of individual studies: For all outcomes, present for each study (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (such as confidence/credible interval), ideally using structured tables or plots</td><td> 

Example: “Figure 2: The forest plot for included studies pooled together using random effects model for assessing difference in [attention-deficit hyperactive disorder] ADHD total symptom score… The subgroup analysis has been done to show the changes in pediatric [defined as ages 6-12 years] and adult [defined as ages 18-55 years] age group (a). Sensitivity analysis has been done by removing the data of the study by Findling et al. (b)” (Maiti et al., 2024)[28]; example adapted to include age ranges as defined in the paper
Figure obtained from an open access article, distributed under the Creative Commons Attribution-NonCommerical-ShareAlike 4.0 License</td></tr>
<tr><td>Item 20b. Results of syntheses: Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate</td><td>Example: Table 2. Physical activity intervention: SMD to MD conversion in standard/SI units (Henderson et al., 2025)[25]
(Note: This table has been truncated to remove repetitive examples)
<table>
<tr><th>Outcome</th><th># of studies</th><th>Pooled SMD (95% CIs)</th><th>Mean difference, MD (95% CIs)</th><th>p-value: subgroup difference</th><th>Units</th></tr>
<tr><td>SBP</td><td></td><td></td><td></td><td></td><td></td></tr>
</table></td></tr>
</table>

PRISMA 2020 Item	Example					
and its precision (such as confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect	Intervention versus usual care	11	−1.05 (−1.57 to −0.52)	−9.389 (−14.039 to −4.650)	NA	mmHg
	Subgroups (Intervention vs. usual care)					
	Age 6–12 years	3	−0.88 (−1.86 to 0.10)	−7.869 (−16.633 to 0.894)	0.70	mmHg
	Age 13–18 years	8	−1.11 (−1.72 to −0.49)	−9.926 (−15.381 to −4.382)		
	DBP					
	Intervention versus usual care	11	−0.47 (−0.77 to −0.16)	−3.784 (−6.200 to −1.288)	NA	mmHg
	Subgroups (Intervention vs. usual care)					
	Age 6–12 years	3	−0.56 (−1.13 to 0.01)	−4.509 (−9.099 to 0.081)	0.70	mmHg
	Age 13–18 years	8	−0.43 (−0.78 to −0.08)	−3.462 (−6.280 to −0.644)		
	Total cholesterol					
	Intervention versus usual care	5	−0.79 (−1.13 to −0.45)	−0.457 (−0.654 to −0.261)	NA	mmol/L
	Subgroups (Intervention vs. usual care)					
	Age 6–12 years	2	−0.92 (−1.39 to −0.46)	−0.533 (−0.805 to −0.266)	0.08	mmol/L

PRISMA 2020 Item	Example					
	Age 13–18 years	2	−1.04 (−1.56 to −0.52)	−0.602 (−0.903 to −0.301)		
	Age—Mixed	1	−0.34 (−0.78 to 0.11)	−0.197 (−0.452 to 0.064)		
	HDL					
	Intervention versus usual care	6	0.30 (−0.21 to 0.81)	0.056 (−0.039 to 0.152)	NA	mmol/L
	Subgroups (Intervention vs. usual care)					
	Age 6–12 years	2	−0.09 (−0.53 to 0.35)	−0.017 (−0.099 to 0.066)	<0.01	mmol/L
	Age 13–18 years	3	0.99 (0.52 to 1.46)	0.186 (0.097 to 0.274)		
	Age—Mixed	1	−0.38 (−0.83 to 0.06)	−0.071 (−0.156 to 0.011)		
	LDL					
	Intervention versus Usual care	5	−0.96 (−1.50 to −0.41)	−0.435 (−0.680 to −0.186)	NA	mmol/L
	Subgroups (Intervention vs. usual care)					
	Age 6–12 years	2	−1.36 (−1.86 to −0.86)	−0.616 (−0.843 to −0.390)	<0.01	mmol/L
	Age 13–18 years	2	−1.02 (−1.54 to −0.51)	−0.462 (−0.698 to −0.231)		

PRISMA 2020 Item	Example

Age—Mixed	1	−0.10 (−0.54 to 0.35)	−0.045 (−0.245 to 0.159)		
Triglycerides					
Intervention versus usual care	6	−0.86 (−1.23 to −0.48)	−0.370 (−0.529 to −0.207)	NA	mmol/L
Subgroups (Intervention vs. usual care)					
Age 6–12 years	2	−1.26 (−1.75 to −0.78)	−0.542 (−0.753 to −0.336)	0.03	mmol/L
Age 13–18 years	3	−0.76 (−1.22 to −0.29)	−0.327 (−0.525 to −0.125)		
Age—Mixed	1	−0.35 (−0.80 to 0.09)	−0.151 (−0.344 to 0.039)		
Fasting insulin					
Intervention versus usual care	10	−1.39 (−2.08 to −0.70)	−83.677 (−125.215 to −42.140)	NA	pmol/L
Subgroups (Intervention vs. usual care)					
Age 6–12 years	1	−1.13 (−3.32 to 1.07)	−68.025 (−199.862 to 64.413)	0.81	pmol/L
Age 13–18 years	9	−1.42 (−2.15 to −0.69)	−85.483 (−129.428 to −41.538)		
BMI					

PRISMA 2020 Item	Example
	Intervention versus usual care | 18 | −0.38 (−0.69 to −0.07) | −1.123 (−2.039 to −0.207) | NA | kg/m^2 *Subgroups (Intervention vs. usual care)* Age 6–12 years | 7 | −0.32 (−0.80 to 0.17) | −0.946 (−2.365 to 0.502) | 0.76 | kg/m^2 Age 13–18 years | 10 | −0.46 (−0.87 to −0.05) | −1.360 (−2.571 to −0.148) Age—Mixed | 1 | −0.03 (−1.22 to 1.16) | −0.089 (−3.606 to 3.429) *Note*: Bolded estimates and 95% confidence intervals are statistically significant at the 0.05 level. Abbreviations: ALT: Alanine Transaminase; BMI: Body Mass Index; BMIz: Body Mass Index *z*-score; DBP: Diastolic Blood Pressure; HDL-C: High Density Lipoprotein-Cholesterol; HOMA-IR: Homeostatic Model Assessment of Insulin Resistance; LDL-C: Low Density Lipoprotein-Cholesterol; SBP: Systolic Blood Pressure. [a] Depression Scale in Children (CDS). [b] Manifest Anxiety Scale in Children-Revised (CMAS-R). [c] Index ((fasting insulin µU/mL × fasting glucose mmol/L)/22.5). *Table obtained from open-access article distributed under the terms of the Creative Commons CC BY-NC-ND 4.0 license*
Item 20c. Results of Syntheses: Present results of all investigations of possible causes of heterogeneity among study results	**Example:** "For the subgroup of children and adolescents (aged 10–17 years old), the mean change in [hemoglobin A1c] HbA1c (%) from baseline had statistical significance with the use of SGLT2i compared to placebo in both the short follow-up period (MD = −0.97; 95% CI = −1.33 to −0.62; p < 0.00001; I^2 = 0%; Figure S1) and the long follow-up (MD = −0.98; 95% CI = −1.48 to −0.49; p = 0.0001; I^2 = 0%; Figure 2). Besides, the rate of any adverse effect was comparable between the SGLT2i and placebo groups in both the short-term (RR = 1.03; 95% CI = 0.76–1.40; p = 0.85; I^2 = 65%; Figure S11) and long-term (RR = 1.09; 95% CI = 0.93–1.27; p = 0.28; I^2 = 0%; Figure 9)." (dos Santos Borges et al., 2024)[24]
Item 22. Certainty of evidence: Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed	**Example:** "In 1 RCT conducted in children aged 2 to 6 years, there was no difference in medically significant wheezing after [live attenuated influenza vaccine] LAIV vs [inactivated influenza vaccine] IIV administration, defined as rate of wheezing illness, or as medically significant wheezing (P = [not reported] NR; "very low" certainty). [reference] Evidence was downgraded for [risk of bias] ROB, indirectness, and imprecision (Table 4). Similarly, there was no difference in medically significant wheezing after LAIV vs IIV in a different observational study conducted in children aged 2 to 17 years with a recent history of asthma/wheeze/respiratory airway disease (P = NR; "very low" certainty). [reference] Evidence was downgraded in the ROB and indirectness domains (Table 4)."

PRISMA 2020 Item	Example

TABLE 4. Summary of Findings in Children and Adolescents Aged 2 to 17 Years With Asthma and/or Recurrent Wheeze

Quality Assessment							Summary of Findings
Outcome Study	**Risk of Bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication Bias**	**Certainty of Evidence**	**Effect Size for LAIV vs IIV**
Children aged 2–6 y with asthma and/or recurrent wheeze							
Critical outcome: Asthma-/wheeze-associated hospitalization, assessed by:							
Hospitalization due to lower respiratory tract illness (Ambrose et al. 2012: Ashkenazi et al., N = 795; and Belshe et al., N = 1145)[reference] Randomized studies	−1 (full methodology NR)	0	−2 (unclear if outcome was asthma-/wheeze-related; follow-up was 90 d)	−1 (sample size calculations NR)	–	⨁⊖⊖⊖ Very low	Hospitalization rates within 90 d after vaccination were similar for each treatment group in each study (*P* = NR[a]).
Rate of ED visits or hospitalizations for asthma N = 47 715[reference] N = 42 424[reference] Observational studies	−1 (methods for controlling confounding factors NR)	0	−1 (possible disparity in the definition of wheeze between the vaccine provider and study)	−1 (sample size calculations NR)	–	⨁⊖⊖⊖ Very low	Rates of ED visits or hospitalization for asthma were similar or lower after LAIV than IIV (*P* = NR[b]).
ED visits or hospitalizations for LRTIs N = 47 715[reference] Observational study	−1 (methods for controlling confounding factors NR)	0	−1 (unclear if LRTIs were asthma-/wheeze-related)	−1 (small sample size)	–	⨁⊖⊖⊖ Very low	No difference in the number of ED visits or hospitalizations for LRTIs after LAIV vs IIV[c]
Critical outcome: Medically attended asthma-/wheeze-associated incident, assessed by:							
Medically attended or medically documented wheezing (Ambrose et al. 2012: Ashkenazi et al., N = 795; and Belshe et al., N = 1145)[reference] Randomized studies	−1 (full methodology NR)	0	0	−1 (sample size calculations NR)	–	⨁⨁⊖⊖ Low	No significant differences in the rates of medically attended or medically documented wheezing between LAIV vs IIV (*P* = NR[d])

PRISMA 2020 Item	Example							
	Rate of medically attended LREs (including asthma and wheeze) N = 4771[reference] Observational study	0	0	−2 (confounding of the study group outcomes[e]; included events other than asthma or wheeze[f])	0	–	⊕⊕⊖⊖ Low	Rates of medically attended LREs did not increase when LAIV use was extended to a wider population with asthma or wheeze compared with participants who received IIV (*P* = NR[a])
	Important outcome: medically significant wheezing, assessed by:							
	Rate of wheezing illness (Ambrose et al. 2012: Ashkenazi et al., N = 795; and Belshe et al., N = 1145)[reference] Randomized studies	−1 (full methodology NR)	0	−1 (follow-up was 28 d)	−1 (unclear if wheezing was medically significant)	–	⊕⊖⊖⊖ Very low	No difference in rates of wheezing illness for LAIV vs IIV (*P* = NR[a])
	Medically significant wheezing (Ambrose et al. 2012: Belshe et al., N = 1145)[reference] Randomized study	−1 (full methodology NR)	0	0	−1 (sample size calculations NR)	–	⊕⊕⊖⊖ Low	No significant difference in the rates of medically significant wheezing among children receiving LAIV vs IIV (*P* = NR[a])
	Children aged 2–17 y with asthma or recurrent wheeze							
	Critical outcome: Medically attended asthma-/wheeze-associated incident, assessed by:							
	Medically attended asthma/wheeze incident N = 4771[reference] Observational study	0	0	−2 (confounding of the study group[e]; outcomes included events other than asthma or wheeze)	0	–	⊕⊕⊖⊖ Low	Incidents of medically attended asthma/wheeze did not increase when LAIV use was extended to a wider population with asthma or wheeze when compared with those who received IIV (*P* = NR[g]).
	Important outcome: medically significant wheezing, assessed by:							

PRISMA 2020 Item	Example
	Medically significant wheezing N = 268[reference] Observational study	−1 (methods for controlling confounding factors NR)	0	−2 (unclear if wheezing was medically significant; end point also included chest tightness; misalignment of population age[g])	0	–	⊕⊖⊖⊖ Very low	The proportions of participants experiencing medically significant wheezing were similar after LAIV vs IIV (*P* = NR[h]). Abbreviations: d, days; ED, emergency department; IIV, inactivated influenza vaccine; LAIV, live attenuated influenza vaccine; LRE, lower respiratory event; LRTI, lower respiratory tract infection; NR, not reported; y, years. Evidence downgrading shown in quality-assessment domains: 0, not serious; −1, serious; −2, very serious concerns; –, none. The quality rating of evidence from randomized controlled trials was initially rated as "high" and could be subject to downgrading, whereas the quality of evidence from observational studies was initially rated as "low" and could be either downgraded or upgraded accordingly. Certainty rating: ⊕⊕⊕⊕, high certainty of evidence (no evidence was considered high certainty); ⊕⊕⊕⊖, moderate certainty of evidence (no evidence was considered moderate certainty); ⊕⊕⊖⊖, low certainty of evidence; ⊕⊖⊖⊖ very low certainty of evidence. [a]As reported by authors with no statistical comparison. [b]No statistical comparison was reported. [c]Authors state that "hospitalization or emergency department visits for each lower respiratory tract infection evaluated was not more frequent among LAIV-vaccinated compared with IIV-vaccinated children." No statistical analysis was reported. [d]No P value reported; only a narrative summary of statistical outcomes was given. [e]The authors indicate that 7%–11% of the IIV group received LAIV, while 68% of the LAIV group received LAIV. [f]LREs included acute bronchiolitis, bronchitis, acute respiratory failure, and acute bronchospasm in addition to asthma and wheezing. [g]Population aged 2–11 years. [h]As reported by the authors. (Bandell et al., 2025)[29] *Table obtained from open-access article distributed under the terms of the Creative Commons CC-BY-ND-NC license*
Item 23a. Discussion: Provide a general interpretation of the results in the context of other evidence	**Example:** "In children [defined as ages 6-11 years], we confirmed the superiority of [inhaled corticosteroids] ICS over [leukotriene receptor antagonists] LTRA in lowering the risk of exacerbations; this was consistent with a previous [systematic review and meta-analyses] SRMA on ICS vs. LTRA [reference], and similar to another previous SRMA, where LTRA were reported to be non-inferior to ICS in terms of [forced expiratory volume in 1 s] FEV_1 and asthma symptoms [reference]… In adolescents/adults, the highest- to lowest-ranked interventions for preventing non-severe exacerbations were regular ICS/LABA, tiotropium, AN-ICS/FABA, regular ICS, and LTRA. Although regular ICS/[long-acting β2-agonists] LABA were ranked highest, the upper limits of the RR 95% CI for the three ICS-containing regimens were not different. Therefore, regular ICS monotherapy could be considered non-inferior to ICS/FABA or

PRISMA 2020 Item	Example
	ICS/LABA in preventing non-severe exacerbations with all providing at least a 25% lowered risk relative to AN-SABA." (Pornsuriyasak et al., 2025)[23]; example adapted to include age ranges as defined in the paper
Item 23d. Discussion: Discuss implications of the results for practice, policy, and future research	**Example: "4.1 Implications for policy and practice** Evidence in this systematic review shows that a promising strategy, with no reported harms or adverse effects, that could be implemented in children [and adolescents] [defined as 6-13 years] is an intervention composed of a daily day camp during the summer holiday period, offering a diverse range of physical activities such as sports and arts and crafts, complemented by nutritious, free breakfast and lunch. The intervention should have a duration between 6 to 8 weeks for 7 to 8 h daily from Monday to Friday. Ideally, this intervention would be an extension of similar activities conducted in school time to ensure success. In countries outside of the United States, especially, it is recommended that this program be delivered as part of a rigorous, high-quality [randomized controlled trial] RCT or cluster-RCT. Such an approach will further contribute to the evidence base and enhance our understanding of its effects for children. For adults, a promising intervention involves daily self-weighing combined with nutrition counselling.[reference] In these two RCTs with a low risk of bias, the interventions applied were based on social cognitive theory with a focus on self-efficacy and applied using a personal feedback cycle and establishment of logical and achievable goals for the individual for physical activity and healthy eating behaviors. Participants were recommended to weigh themselves at least twice a week, but preferably daily, to allow self-monitoring of their weight. The intervention by Mason et al.[reference] also used brochures of energy equivalents in calories to minutes of physical activity using the energy contained in common foods during festive periods in adults as well as simple healthy eating tips (e.g., do not consume food in a hurry, keep the consumption of ultra-processed foods to a minimum). The duration of the intervention should be at least 4 to 8 weeks and should include the period from mid- to late-November to early January. To build on the evidence base, it is crucial to test these interventions as part of high-quality RCTs in countries outside of the United States and United Kingdom. This will provide valuable insights into their effectiveness and applicability across diverse populations. **4.2 Implications for research** An important finding of this systematic review is that there is a need for better quality studies in both children and adults. For studies in children and adolescents, authors should report the reasons for participants being lost to follow-up, clearly state whether the outcome assessor is blinded to the intervention group, use a multiple regression model to control for confounders in the analysis (for studies that do not use randomization), and report the randomization process for RCTs. For the studies in adults, authors should clearly report whether the participants and outcome assessors were blinded to the intervention group, detail the allocation concealment process, and report their pre-specified statistical analysis plan. Interventions of higher intensity and longer duration (see suggestions in the previous section) are needed to improve results in children and adults, and with larger sample sizes. Research gaps include the adolescent age group and, for all age groups, studies outside of the United States and the United Kingdom, including in low- and middle-income countries and in other cultural groups." (Guerrero-Magaña et al., 2024)[21]; example adapted to include age ranges as defined in the paper

eAppendix 7. PRISMA-C 2026 Expanded Checklist

Section and Topic	#	PRISMA 2020 items	#	PRISMA-C 2026 extension items	Elements
TITLE					
TITLE	1	Identify the report as a systematic review.	1a	Identify that it is a paediatric systematic review	• "Paediatric" in the title and/or the age group (e.g., newborn, infant, children, adolescents) • Age range (e.g., ages 10-17 years) • If relevant, mention contextual factors e.g., biological sex, geographical location
ABSTRACT					
ABSTRACT	2	See the PRISMA 2020 for Abstracts checklist. (**Table 2**)	2a	See Abstract items for PRISMA-C 2026 (**Table 2**)	• See Table 2 for PRISMA-C 2026 Abstract items
INTRODUCTION					
RATIONALE	3	Describe the rationale for the review in the context of existing knowledge.	3a*	Provide justification for included age groups, ranges, or developmental stages	• Reasons for including certain age groups, providing age ranges; developmental stages; disease stage, subtype, or severity • Expected differences and/or similarities across multiple included age groups/ranges, or if relevant/supported by evidence, in the context of critical contextual factors (e.g., demographic factors (e.g., race, ethnicity), biological sex, geographical location)
			3b*	Describe potential differences and similarities in treatment effects related to age or development	• If applicable, discuss specific knowledge gaps for specific age groups, and how treatment effect may be different or similar based on age or developmental stage, or disease subtype, stage, and/or severity
OBJECTIVES	4§	Provide an explicit statement of the objective(s) or question(s) the review addresses.			

Section and Topic	#	PRISMA 2020 items	#	PRISMA-C 2026 extension items	Elements
METHODS					
ELIGIBILITY CRITERIA	5§	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	5a*	If multiple age groups or ranges are eligible and require variable delivery of interventions, comparators, or the choice of outcomes or measurement methods differ, detail these	• Any differences in the interventions, comparators, and/or outcomes across multiple included age groups or ranges • When involving both adults and children/adolescents, describe PICO element details separately
INFORMATION SOURCES	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.			
SEARCH STRATEGY	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.			
SELECTION PROCESS	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.			
DATA COLLECTION PROCESS	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.			
DATA ITEMS (outcomes)	10a§	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.			
DATA ITEMS (other variables)	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.			
STUDY RISK OF BIAS ASSESSMENT	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.			
EFFECT MEASURES	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.			
SYNTHESIS METHODS (eligibility for synthesis)	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).			
SYNTHESIS METHODS (preparing for synthesis)	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.			

Section and Topic	#	PRISMA 2020 items	#	PRISMA-C 2026 extension items	Elements
SYNTHESIS METHODS (tabulation and graphical methods)	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.			
SYNTHESIS METHODS (statistical synthesis methods)	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	13d.a	Describe how data was synthesized separately by relevant age groups or ranges. If not feasible, provide an explanation	• Report pre-specified analyses based on pre-defined age groups/ranges, disease stage, subtype, or severity • Report pre-specified subgroup analyses to explore differences between subgroups • If data is combined for analyses, provide a justification of why this was done and how
SYNTHESIS METHODS (methods to explore heterogeneity)	13e[§]	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).			
SYNTHESIS METHODS (sensitivity analyses)	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.			
REPORTING BIAS ASSESSMENT	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).			
CERTAINTY ASSESSMENT	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.			
RESULTS					
STUDY SELECTION (flow of studies)	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.			
STUDY SELECTION (excluded studies)	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.			
STUDY CHARACTERISTICS	17	Cite each included study and present its characteristics.	17a	Report number of children/adolescents by age groups or ranges	• Number of children/adolescents based on pre-specified age groups or ranges, disease stage, subtype, or severity, or any other accepted

Section and Topic	#	PRISMA 2020 items	#	PRISMA-C 2026 extension items	Elements
					staging/types (e.g., developmental stages)
RISK OF BIAS IN STUDIES	18	Present assessments of risk of bias for each included study.			
RESULTS OF INDIVIDUAL STUDIES	19§	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.			
RESULTS OF SYNTHESES (characteristics of contributing studies)	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.			
RESULTS OF SYNTHESES (results of statistical syntheses)	20b§	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.			
RESULTS OF SYNTHESES (results of investigations of heterogeneity)	20c§	Present results of all investigations of possible causes of heterogeneity among study results.			
RESULTS OF SYNTHESES (results of sensitivity analyses)	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.			
REPORTING BIASES	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.			
CERTAINTY OF EVIDENCE	22§	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.			
DISCUSSION					
DISCUSSION (interpretation)	23a§	Provide a general interpretation of the results in the context of other evidence.			
DISCUSSION (limitations of evidence)	23b	Discuss any limitations of the evidence included in the review.	23b.a*	Comment on the appropriateness of outcome measurement, including aspects such as validity, feasibility, reliability, and responsiveness of measurement instruments, for each age groups or ranges	• Whether the outcomes and OMIs used were appropriate for included age groups/ranges, disease stage, subtype, or severity, in terms of their validity, reliability, responsiveness, and feasibility

Section and Topic	#	PRISMA 2020 items	#	PRISMA-C 2026 extension items	Elements
					• If applicable, whether patient-reported outcomes were considered • If applicable, whether there were any translations or modifications to the OMIs used, and how this impacted data synthesis
DISCUSSION (limitations of review processes)	23c	Discuss any limitations of the review processes used.			
DISCUSSION (implications)	23d[§]	Discuss implications of the results for practice, policy, and future research.			
OTHER INFORMATION					
REGISTRATION AND PROTOCOL (registration)	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.			
REGISTRATION AND PROTOCOL (protocol)	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.			
REGISTRATION AND PROTOCOL (amendments)	24c	Describe and explain any amendments to information provided at registration or in the protocol.			
SUPPORT	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.			
COMPETING INTERESTS	26	Declare any competing interests of review authors.			
AVAILABILITY OF DATA, CODE, AND OTHER MATERIALS	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.			

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