**Suppl 2.** CASP Checklist

Effect of Discontinuation of tamsulosin in Korean men with Benign Prostatic Hyperplasia taking tamsulosin and dutasteride: An open-label, prospective, randomised pilot study

(Lee et al., 2012)

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| **1**. | **Did the study address a clearly focused research question?**   * *Intervention – Combination therapy of Tamsulosin 0.2 mg + Dutasteride 0.5 mg* * *Control – Dutasteride 0.5 mg monotherapy* * *Population studied – Korean men with BPH* * *Intervention given – Combination therapy* * *Comparator chosen – IPSS, PV, QOL, Qmax, adverse events (AEs)* * *Outcomes measured – IPSS changes, Qmax, QOL, AEs* | Yes No Can’t tell   |
| **2**. | **Was the assignment of participants to interventions randomised?**   * *After 48 week combination treatment, all participant were randomised 1:1 to the second period of study, once daily treatment and follow up in a 12 weeks interval* * *Open-label, prospective, pilot randomised control trail* | Yes No Can’t tell     |
| **3**. | **Were all participants who entered the study accounted for at its conclusion?**   * *High drop-out rate 20.4%* * *Participants were analysed in the study groups by intention-to-treat analysis* * *72 weeks long-term treatment with every 12 weeks visit* | Yes No Can’t tell   |
| **4.** | * **Were the participants ‘blind’ to intervention they were given?** * **Were the investigators ‘blind’ to the intervention they were giving to participants?** * **Were the people assessing/analysing outcome/s ‘blinded’?** | Yes No Can’t tell       |
| **5**. | **Were the study groups similar at the start of the randomised controlled trial?**   * *43 in combination & 43 in monotherapy group* * *Patients*≥*60 with IPSS of 8-19, PV*≥*25 ml* | Yes No Can’t tell   |
| **6**. | **Apart from the experimental intervention, did each study group receive the same level of care (that is, were they treated equally)?**   * *Compared combination therapy vs tamsulosin monotherapy* * *Same measurements were conducted in each 12 weeks intervals visit in both groups* | Yes No Can’t tell   |
| **7**. | **Were the effects of intervention reported comprehensively?**   * *IPSS changes between baseline and 72 weeks: Mean baseline and endpoint IPSS of all participants were 15.25±4.80 and 10.97±5.46 respectively (P<0.001)* * *Qmax changes: Mean baseline and endpoint were 8.14±1.42 and 10.55±3.11 ml/s, respectively (P<0.001)* * *PV changes from baseline to 72 weeks: PV mean baseline and endpoint were 40.45±12.81 and 26.82±14.91 respectively (P<0.001)* * *In BPH progression such as decreased Qmax, increased IPSS and PVR, there were no significant difference in both groups* | Yes No Can’t tell   |
| **8.** | **Was the precision of the estimate of the intervention or treatment effect reported?**   * *Confidence intervals were not mentioned* | Yes No Can’t tell   |
| **9**. | **Do the benefits of the experimental intervention outweigh the harms and costs?**   * *Drug-related AEs and sexual AEs were reported; but there was lack of a cost-effectiveness analysis* | Yes No Can’t tell   |
| **10**. | **Can the results be applied to your local population/in your context?**   * *Tamsulosin 0.2 mg plus dutasteride 0.5 mg combined therapy is applicable to Asian men with moderate-to-severe BPH as present study recommend* * *Uncertainty presented and small size, huge number of participants dropped out* | Yes No Can’t tell   |
| **11.** | **Would the experimental intervention provide greater value to the people in your care than any of the existing interventions?**   * *Further study needs to be done in terms of current study involved a small sample size* | Yes No Can’t tell   |

**Suppl 2.** CASP Checklist – *(continued)*

Comparison of the response to treatment between Asian and Caucasian men with Benign Prostatic Hyperplasia: Long-term results from the combination of dutasteride and tamsulosin study (Chuang et al., 2012)

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| **1**. | **Did the study address a clearly focused research question?**   * *Intervention – Combination therapy of Tamsulosin 0.4 mg + Dutasteride 0.5 mg* * *Control – Tamsulosin 0.4 mg with placebo & Dutasteride 0.5 mg with placebo* * *Population studied – Asian and Caucasian men with BPH* * *Intervention given – Combination drugs;* * *Comparator chosen – IPSS, PV, BPH progression, QOL, Qmax* * *Outcomes measured – AUR or BPH-related surgery, BPH clinical progression, IPSS, Qmax, PV* | Yes No Can’t tell   |
| **2**. | **Was the assignment of participants to interventions randomised?**   * *Randomised in a 1:1 ratio to 4 years of daily treatment and follow up* * *Multinational, multicentre, double-blind, parallel-group, randomised control trail* | Yes No Can’t tell   |
| **3**. | **Were all participants who entered the study accounted for at its conclusion?**   * *Literally most of overall patient completed 48 months visit* * *Participants were analysed in the study groups by intention-to-treat analysis* * *4 years long-term follow up study* | Yes No Can’t tell   |
| **4.** | * **Were the participants ‘blind’ to intervention they were given?** * **Were the investigators ‘blind’ to the intervention they were giving to participants?** * **Were the people assessing/analysing outcome/s ‘blinded’?** | Yes No Can’t tell       |
| **5**. | **Were the study groups similar at the start of the randomised controlled trial?**   * *325 Asian & 4259 Caucasian men with moderate-to-severe BPH* * *Patients≥ 50 with IPSS≥12, PV≥30 ml Smaller Asian population (n=325) vs Huge number of Caucasian participants (n=4259)* | Yes No Can’t tell   |
| **6**. | **Apart from the experimental intervention, did each study group receive the same level of care (that is, were they treated equally)?**   * *Compared combination therapy vs each monotherapy group within Asian and Caucasian subgroup* * *Same measurements were conducted follow-up intervals were the same for Asian and Caucasian group* | Yes No Can’t tell   |
| **7**. | **Were the effects of intervention reported comprehensively?**   * *Primary outcomes – AUR or BPH-related surgery:*   *- were not statistically significant for combination therapy vs either monotherapy in Asian group(Combination: 17.7±7.21; Dutasteride: 17.8±6.60; Tamsulosin: 17.8±6.53)*  *- Was significantly lower with combination therapy compared with tamsulosin monotherapy (P<0.001), was not significant difference for combination vs dutasteride (Combination: 3.6±1.24; Dutasteride: 3.6±1.24)*   * *Secondary outcomes – BPH clinical progression, IPSS, Qmax, PV and IPSS question 8:*   *- were significantly lower in the combination group vs tamsulosin group in both the Asian and Caucasian (P<0.05)*  *- was also significantly lower in combination group vs dutasteride group in the Caucasian subpopulation ( combination: 12.1%; Dutasteride: 17.7%; Tamsulosin: 20.4%)*  *- Was not significant different between combination and dutasteride group in the Asian subpopulation (Combination: 18.7%; Dutasteride: 17.9%; Tamsulosin: 33.0%)* | Yes No Can’t tell   |
| **8.** | **Was the precision of the estimate of the intervention or treatment effect reported?**   * *Confidence intervals were not mentioned* | Yes No Can’t tell   |
| **9**. | **Do the benefits of the experimental intervention outweigh the harms and costs?**   * *Adverse events and serious adverse events were included and reported; There were lack of a cost-effectiveness analysis* | Yes No Can’t tell   |
| **10**. | **Can the results be applied to your local population/in your context?**   * *Predominantly are Caucasian in overall participants, but different from this literature review care allocation which mass majority are Asian national* * *Asian men have lower PV and PSA level than western and Caucasian men, varied tolerance to dutasteride doses;* * *Further comparison need to be done in terms of sample size; Small size of Asian population* | Yes No Can’t tell   |
| **11.** | **Would the experimental intervention provide greater value to the people in your care than any of the existing interventions?**   * *Singapore multi-racial environment may needed a strong clinical considering when prescribing combination therapy for various racial populations* | Yes No Can’t tell   |

**Suppl 2.** CASP Checklist – *(continued)*

Influence of baseline variables on changes in International Prostate Symptom Score after combined therapy with dutasteride plus tamsulosin or either monotherapy in patients with Benign Prostatic Hyperplasia and lower urinary tract symptoms: 4-year results of the CombAT study (Roehrborn et al., 2014)

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| **1**. | **Did the study address a clearly focused research question?**   * *Intervention – Combination of Tamsulosin 0.4 mg + Dutasteride 0.5 mg* * *Control – Tamsulosin 0.4 mg with placebo & Dutasteride 0.5 mg with placebo* * *Population studied – Men aged >60 years with LUTS/BPH* * *Intervention given – Combination therapy* * *Comparator chosen – IPSS, PV, QOL, Qmax, PSA level* * *Outcomes measured – IPSS changes, PV Qmax, QOL* | Yes No Can’t tell   |
| **2**. | **Was the assignment of participants to interventions randomised?**   * *4844 participants were randomised 1:1:1 to the 3 groups and further divided into 8 subgroups with every 3 months visit* * *Multinational, multicentre, double-blind, parallel-group, randomised control trial* | Yes No Can’t tell   |
| **3**. | **Were all participants who entered the study accounted for at its conclusion?**   * *More than 90% patients completed entire study* * *Participants were analysed in the study groups by intention-to-treat analysis 4 years long-term follow up study* | Yes No Can’t tell   |
| **4.** | * **Were the participants ‘blind’ to intervention they were given?** * **Were the investigators ‘blind’ to the intervention they were giving to participants?** * **Were the people assessing/analysing outcome/s ‘blinded’?** | Yes No Can’t tell       |
| **5**. | **Were the study groups similar at the start of the randomised controlled trial?**   * *In the base of intervention and control group, 4844 patients≥50 years old divided into 8 subgroups* | Yes No Can’t tell   |
| **6**. | **Apart from the experimental intervention, did each study group receive the same level of care (that is, were they treated equally)?**   * *Same measurements were conducted in each 3 months visit in all 3 groups and relevant 8 subgroups based on difference in IPSS, PSA, PV, BMI, age and BII scores* | Yes No Can’t tell   |
| **7**. | **Were the effects of intervention reported comprehensively?**   * *In every subgroups, combination therapy resulted in a significantly greater improvement from baseline IPSS at 48 moths vs tamsulosin monotherapy* * *However, compared to dutasteride monotherapy, the superiority of combination therapy observed in subgroups with lower baseline PV<60 ml & PSA<4 ng/ml* * *In subgroups with PV≥60 ml & PSA≥4 ng/ml, dutasteride and combination group has a similar improvement in LUTS* * *Combination group showed a significant improvement in Qmax than tamsulosin monotherapy but not to dutasteride group;* * *Furthermore, Qmax improvement appeared to increase with PV & PSA level in combination group* * *In QOL assessment, QOL≤2 at 4 years was significant greater with combined therapy than patients with PV 40-60 ml & PSA level < 4 ng/ml in dutasteride group and all subgroups patients with various PSA & subgroup patients with PV≥40 ml in tamsulosin monotherapy* | Yes No Can’t tell     |
| **8.** | **Was the precision of the estimate of the intervention or treatment effect reported?**   * *Confidence intervals were reported* | Yes No Can’t tell   |
| **9**. | **Do the benefits of the experimental intervention outweigh the harms and costs?**   * *Comparison was made among groups but nil AEs were reported as well as there was no cost-effectiveness analysis conducted* | Yes No Can’t tell   |
| **10**. | **Can the results be applied to your local population/in your context?**   * *Long-term combined therapy is applicable to Asian men with high PV≥60 ml & high PSA level≥4 ng/ml* | Yes No Can’t tell   |
| **11.** | **Would the experimental intervention provide greater value to the people in your care than any of the existing interventions?**   * *May be further study on Asian men with moderate-to-severe BPH could be conduct* | Yes No Can’t tell   |

**Suppl 2.** CASP Checklist – *(continued)*

Efficacy and Safety of a fixed-dose combination of Dutasteride and Tamsulosin treatment (Duodart) compared with watchful waiting with initiation of tamsulosin therapy if symptoms do not improve, both provided with lifestyle advice, in the management of treatment-naïve men with moderately symptomatic Benign Prostatic Hyperplasia: 2-year CONDUCT study results (Roehrborn et al., 2015)

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| **1**. | **Did the study address a clearly focused research question?**   * *Intervention – Fixed-dose combination (FDC) of Dutasteride and Tamsulosin* * *Control – Watchful waiting (WW) with initiation of single tamsulosin if symptoms not improved plus same lifestyle advices* * *Population studied – Moderate BPH with IPSS of 8-19, PV≥30 ml and PSA level≥1.5 ng/ml* * *Intervention given – Combination drugs of Dutasteride 0.5 mg+Tamsulosin 0.4 mg plus lifestyle advices* * *Comparator chosen – IPSS, QOL* * *Outcomes measured – Symptomatic improvement, BPH clinical progression, safety* | Yes No Can’t tell   |
| **2**. | **Was the assignment of participants to interventions randomised?**   * *Randomised 1:1 in a 2 years daily treatment and follow up* * *International, multicentre, open-label, parallel-group, randomised phase 3 study* | Yes No Can’t tell   |
| **3**. | **Were all participants who entered the study accounted for at its conclusion?**   * *There were 7 losses to follow-up and 70 exclusions in FDC group & 9 losses to follow up and 64 exclusions in watchful waiting (WW) group* * *Intention-to-treat population used for efficacy analyses* * *2 years long-term follow up study* | Yes No Can’t tell   |
| **4.** | * **Were the participants ‘blind’ to intervention they were given?** * **Were the investigators ‘blind’ to the intervention they were giving to participants?** * **Were the people assessing/analysing outcome/s ‘blinded’?** | Yes No Can’t tell       |
| **5**. | **Were the study groups similar at the start of the randomised controlled trial?**   * *369 men in FDC & 373 in WW group with moderate BPH, IPSS of 8-19, PV≥30mls, PSA level*≥*1.5 ng/ml* | Yes No Can’t tell   |
| **6**. | **Apart from the experimental intervention, did each study group receive the same level of care (that is, were they treated equally)?**   * *Study protocol was clearly defined* * *FDC & WW with initiation of single tamsulosin therapy groups with lifestyle advices provided* * *Same measurements were conducted follow-up intervals were the same for FDC and WW group* | Yes No Can’t tell   |
| **7**. | **Were the effects of intervention reported comprehensively?**   * *Primary endpoint was symptomatic improvement:*   *- Measured by IPSS; was significantly greater for FDC than WW group (-5.4 vs -3.6 points, P<0.001);*   * *Secondary outcomes included BPH clinical progression, impact of QOL and safety:*   *-With FDC, the risk of BPH progression was reduced by 43.1% (P<0.001);*  *- 29% and 8% of men in the watchful waiting and FDC groups had clinical progression, respectively;*  *- Improvement in QOL were seen in both groups but were significantly greater with FDC group (P<0.001); and safety profile of FDC was consistent with established profiles of Tamsulosin and Dutasteride.* | Yes No Can’t tell   |
| **8.** | **Was the precision of the estimate of the intervention or treatment effect reported?**   * *Confidence intervals were reported – combined therapy significantly reduced the relative risk of clinical progression by 43.1% (95% CI 22.5, 58.2)* | Yes No Can’t tell   |
| **9**. | **Do the benefits of the experimental intervention outweigh the harms and costs?**   * *Adverse events and serious adverse events were included and reported, however had no analysing on cost-effectiveness* * *Lack of placebo control group* | Yes No Can’t tell   |
| **10**. | **Can the results be applied to your local population/in your context?**   * *Participants are all international, ensure what races they are* * *Does the clinical effect is as effective as Western men when it apply to Asian men?* * *Free combination formulate vs Fixed-dose, which is better or are they the similar?* | Yes No Can’t tell   |
| **11.** | **Would the experimental intervention provide greater value to the people in your care than any of the existing interventions?**   * *Various formulation of FDC (Dutasteride 0.5 mg + Tamsulosin 0.4 mg) in Singapore* | Yes No Can’t tell   |

**Suppl 2.** CASP Checklist – *(continued)*

Efficacy and safety of Tamsulosin 0.4 mg single pills for treatment of Asian patients with symptomatic Benign Prostatic Hyperplasia with lower urinary tract symptoms: A randomised, double-blind, phase 3 trial (Chuang et al., 2018)

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| **1**. | **Did the study address a clearly focused research question?**   * *Intervention – Tamsulosin 0.4 mg and Tamsulosin 0.2 mg monotherapy respective* * *Control – placebo group* * *Population studied – 45 years olde men with BPH, IPSS*≥13 * *Intervention given – Tamsulosin 0.4 and 0.2 mg* * *Comparator chosen –IPSS, PV, QOL, Qmax, laboratory test, vital signs and ECG, safety* * *Outcomes measured – Total IPSS changes; Changes in a sub score of IPSS, voided volume, PVR, Qmax and QOL, safety of administration* | Yes No Can’t tell   |
| **2**. | **Was the assignment of participants to interventions randomised?**   * *Randomised in a 1:1:1 ratio to 12 weeks daily treatment* * *Multicentre, double-blind, randomised control trail* | Yes No Can’t tell   |
| **3**. | **Were all participants who entered the study accounted for at its conclusion?**   * *Withdrawals were done due to adverse events, subjective decision, lost to follow up, taking other medication* * *Participants were analysed in the study groups by intention-to-treat analysis* | Yes No Can’t tell   |
| **4.** | * **Were the participants ‘blind’ to intervention they were given?** * **Were the investigators ‘blind’ to the intervention they were giving to participants?** * **Were the people assessing/analysing outcome/s ‘blinded’?** | Yes No Can’t tell       |
| **5**. | **Were the study groups similar at the start of the randomised controlled trial?**   * *The baseline characteristics no significant difference among the 3 groups* * *Men aged 45 years old and older with diagnosed BPH, IPSS*≥*13, Qmax 4-15 ml/s with a voided urine volumes*≥*100 ml, PVRU<300 ml* | Yes No Can’t tell   |
| **6**. | **Apart from the experimental intervention, did each study group receive the same level of care (that is, were they treated equally)?**   * *Tamsulosin 0.4 mg and 0.2 mg monotherapy vs placebo treatment respectively* * *Same measurements were conducted follow-up intervals were the same 3 groups* | Yes No Can’t tell   |
| **7**. | **Were the effects of intervention reported comprehensively?**   * *Primary efficacy outcome was the change in total IPSS:*   *- Total IPSS was improved in the Tamsulosin 0.4 mg and 0.2 mg group, however, the extent of improvement was greater in Tamsulosin 0.4 mg than 0.2 mg (P<0.0001)*   * *Secondary efficacy outcome were changes in a sub score of IPSS, voided volume, PVR, Qmax and QOL:*   *- IPSS voiding and storage symptoms sub score were improved more in Tamsulosin 0.4 mg and 0.2 mg group than placebo*  *- Qmax and PVR were improved in both Tamsulosin 0.4 mg and 0.2 mg groups*   * *Safety assessment:*   *- TEAEs were 20.65% in Tamsulosin 0.4 mg, 15.245 in Tamsulosin 0.2 mg and 10.43% in placebo group respectively*  *- AEs were 7.10% in Tamsulosin 0.4 mg, 2.44% in Tamsulosin 0.2 mg and 1.23% in placebo group* | Yes No Can’t tell   |
| **8.** | **Was the precision of the estimate of the intervention or treatment effect reported?**   * *Confidence intervals 95% was reported* | Yes No Can’t tell   |
| **9**. | **Do the benefits of the experimental intervention outweigh the harms and costs?**   * *Adverse events and treatment emergency adverse events were explained and reported; lack of a cost-effectiveness analysis, however* | Yes No Can’t tell   |
| **10**. | **Can the results be applied to your local population/in your context?**   * *Study was conducted in Asian region, results is applicable to Singapore* * *Small size of overall participants (494 in total), selection bias was presented as average age of patients enrolled was 63.5 years old* | Yes No Can’t tell   |
| **11.** | **Would the experimental intervention provide greater value to the people in your care than any of the existing interventions?**   * *Targeted population is safe to prescribe and administer tamsulosin 0.4 mg in view of LUTS/BPH* | Yes No Can’t tell   |

**Suppl 2.** CASP Checklist – *(continued)*

Superiority of dutasteride 0.5 mg and tamsulosin 0.2 mg for the treatment of moderate-to-severe Benign Prostatic Hyperplasia in Asian men (Haque et al., 2018)

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| **1**. | **Did the study address a clearly focused research question?**   * *Intervention – Combination therapy of Tamsulosin 0.2 mg + Dutasteride 0.5 mg* * *Control – Tamsulosin 0.2 mg monotherapy & Dutasteride matched placebo* * *Population studied – Asian men with moderate-to-sever BPH* * *Intervention given – Combination therapy* * *Comparator chosen – IPSS, PV, QOL, Qmax, AEs* * *Outcomes measured – IPSS reduction, Qmax, time to first AUR or BPH-related surgery, PAS-SFI score, QOL, safety and tolerability* | Yes No Can’t tell   |
| **2**. | **Was the assignment of participants to interventions randomised?**   * *Eligible participant were randomised 1:1 to 2 years of once daily treatment and follow up in a 3 month interval* * *Multicentre, double-blind, parallel-group, randomised control trail* | Yes No Can’t tell   |
| **3**. | **Were all participants who entered the study accounted for at its conclusion?**   * *3 deaths reported but unrelated to present treatment* * *Participants were analysed in the study groups by intention-to-treat analysis* * *2 years long-term treatment with each 3 moths visit* | Yes No Can’t tell   |
| **4.** | * **Were the participants ‘blind’ to intervention they were given?** * **Were the investigators ‘blind’ to the intervention they were giving to participants?** * **Were the people assessing/analysing outcome/s ‘blinded’?** | Yes No Can’t tell       |
| **5**. | **Were the study groups similar at the start of the randomised controlled trial?**   * *305 in combination & 302 in monotherapy group* * *Patients*≥*50 with IPSS*≥*12, PV*≥*30 ml, total PSA*≥*1.5, Total serum PSA*≥*1.5 and* ≤*10 ng/ml, Qmax>5 and* ≤*15 ml/s, Minimum voided volume*≥*125 ml* | Yes No Can’t tell   |
| **6**. | **Apart from the experimental intervention, did each study group receive the same level of care (that is, were they treated equally)?**   * *Compared combination therapy vs tamsulosin monotherapy + placebo* * *Same measurements were conducted in each 3 months intervals visit in both groups* | Yes No Can’t tell   |
| **7**. | **Were the effects of intervention reported comprehensively?**   * *Primary end-point was the comparative change in IPSS from baseline to 2 years study in combination therapy vs tamsulosin monotherapy:*   *- Statistically significant improvement in the IPSS from baseline in the combination therapy group compared with tamsulosin monotherapy at year 2 but not at earlier time-point (P=0.004)*   * *Secondary end-point:*   *- IPSS responders (≥25%, ≥2 points, ≥3 points improvement) were greater in combination group than tamsulosin monotherapy (P<0.05)*  *- From baseline in Qmax was significant higher in combination therapy*  *- Safety and tolerability in terms of relevant overall adverse events (AEs) was similar between two groups, but drug-related AEs were more frequent in combination therapy and primarily were sexual dysfunction related* | Yes No Can’t tell   |
| **8.** | **Was the precision of the estimate of the intervention or treatment effect reported?**   * *Confidence intervals were not mentioned* | Yes No Can’t tell   |
| **9**. | **Do the benefits of the experimental intervention outweigh the harms and costs?**   * *Drug-related AEs and sexual AEs were reported; but there was lack of a cost-effectiveness analysis* | Yes No Can’t tell   |
| **10**. | **Can the results be applied to your local population/in your context?**   * *Tamsulosin 0.2 mg plus dutasteride 0.5 m g combined therapy is applicable to Asian men with moderate-to-severe BPH as present study recommend* * *Further comparison need to be done in terms of Tamsulosin 0.2 mg + Dutasteride 0.5 mg vs Tamsulosin 0.4 mg + Dutasteride 0.5 mg* | Yes No Can’t tell   |
| **11.** | **Would the experimental intervention provide greater value to the people in your care than any of the existing interventions?**   * *Mass majority people in Singapore are Asian population* | Yes No Can’t tell   |

**Suppl 2.** CASP Checklist – *(continued)*

Making shared decision with older men selecting treatment for lower urinary tract symptoms secondary to Benign Prostatic Hyperplasia (LUTS/BPH): A pilot randomised trial

(Ngu, Neo, Koh, Ho, & Tan, 2022)

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| **1**. | **Did the study address a clearly focused research question?**   * *Intervention – Trained physician on SDM and with use of pictorial score in urine flow assessment during consultation process* * *Control – Untrained physician on SDM and without use of score* * *Population studied – Singaporean men with BPH* * *Intervention given – Trained physician on SDM with use of pictorial score on LUTS assessment* * *Comparator chosen - Quality of decisions made* * *Outcomes measured – Composite score 0f decision-making* | Yes No Can’t tell   |
| **2**. | **Was the assignment of participants to interventions randomised?**   * *After initial assessment for participants, all participants and physicians were randomised 1:1 into two groups and follow up in every 2 months* * *Open-label, prospective, pilot randomised control trail* | Yes No Can’t tell   |
| **3**. | **Were all participants who entered the study accounted for at its conclusion?**   * *There were no drop outs or missing data* * *Participants were analysed in the study groups by intention-to-treat analysis* | Yes No Can’t tell   |
| **4.** | * **Were the participants ‘blind’ to intervention they were given?** * **Were the investigators ‘blind’ to the intervention they were giving to participants?** * **Were the people assessing/analysing outcome/s ‘blinded’?** | Yes No Can’t tell       |
| **5**. | **Were the study groups similar at the start of the randomised controlled trial?**   * *30 patients with 11trained physicians vs 30 patients with untrained 11 physicians* * *Patients*≥*50 with IPSS*≥*8, QOL*≥*3* | Yes No Can’t tell   |
| **6**. | **Apart from the experimental intervention, did each study group receive the same level of care (that is, were they treated equally)?**   * *Trained physician on SDM with use of urine flow assessment tool pictorial score vs untrained physician on SDM without use of pictorial score* * *Same measurements were conducted in both groups* | Yes No Can’t tell   |
| **7**. | **Were the effects of intervention reported comprehensively?**   * *Comparison of SDM score among two group:*   *- Patients form intervention group reported a greater composite scores compared to the control group, while it was unsignificant in statistic stand point (70.8 vs 59.6 with SD 20.3 vs SD 22.4 respectively)*  *- Physician from both group reported a similar composite score which is not statistical significant as well (78.1 vs 73.2 & SD 14.1 vs SD 19.8)* | Yes No Can’t tell   |
| **8.** | **Was the precision of the estimate of the intervention or treatment effect reported?**   * *Confidence intervals were not reported* | Yes No Can’t tell   |
| **9**. | **Do the benefits of the experimental intervention outweigh the harms and costs?**   * *Nil harms were reported; but there was lack of a cost-effectiveness analysis* | Yes No Can’t tell   |
| **10**. | **Can the results be applied to your local population/in your context?**   * *Uncertainty presented and small size* * *SDM is suggested to physician in the consultation for BPH treatment* | Yes No Can’t tell   |
| **11.** | **Would the experimental intervention provide greater value to the people in your care than any of the existing interventions?**   * *Further study needs to be done in terms of current study involved a small sample size* * *In order to optimising the personalised care , patient-related barriers needs to be addressed throughout the entire consultation* | Yes No Can’t tell   |