

# Outcomes of comprehensive fixed appliance orthodontic treatment: A systematic review with meta-analysis and methodological overview

Spyridon N. Papageorgiou  
Damian Höchli  
Theodore Eliades

Clinic of Orthodontics and Pediatric  
Dentistry, Center of Dental Medicine,  
University of Zurich, Zurich, Switzerland

**Objective:** The aim of this systematic review was to assess the occlusal outcome and duration of fixed orthodontic therapy from clinical trials in humans with the Objective Grading System (OGS) proposed by the American Board of Orthodontics.

**Methods:** Nine databases were searched up to October 2016 for prospective/retrospective clinical trials assessing the outcomes of orthodontic therapy with fixed appliances. After duplicate study selection, data extraction, and risk of bias assessment according to the Cochrane guidelines, random-effects meta-analyses of the mean OGS score and treatment duration were performed and 95% confidence intervals (CIs) were calculated. **Results:** A total of 34 relevant clinical trials including 6,207 patients (40% male, 60% female; average age, 18.4 years) were identified. The average OGS score after treatment was 27.9 points (95% CI, 25.3–30.6 points), while the average treatment duration was 24.9 months (95% CI, 24.6–25.1 months). There was no significant association between occlusal outcome and treatment duration, while considerable heterogeneity was identified. In addition, orthodontic treatment involving extraction of four premolars appeared to have an important effect on both outcomes and duration of treatment. Finally, only 10 (39%) of the identified studies matched compared groups by initial malocclusion severity, although meta-epidemiological evidence suggested that matching may have significantly influenced their results.

**Conclusions:** The findings from this systematic review suggest that the occlusal outcomes of fixed appliance treatment vary considerably, with no significant association between treatment outcomes and duration. Prospective matched clinical studies that use the OGS tool are needed to compare the effectiveness of orthodontic appliances.

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**Corresponding author:** Spyridon N. Papageorgiou.  
Senior Teaching and Research Assistant, Clinic of Orthodontics and Pediatric Dentistry,  
Center of Dental Medicine, University of Zurich, Plattenstrasse 11, Zurich 8032, Switzerland.  
Tel +41-44-634-32-87 e-mail [snpapage@gmail.com](mailto:snpapage@gmail.com)

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## INTRODUCTION

Fixed appliances have become an integral part of comprehensive orthodontic treatment as versatile tools that enable three-dimensional control of tooth movement. Through the years, considerable effort has been invested in the optimization of orthodontic appliances to increase their treatment efficiency,<sup>1-5</sup> with the primary goals of developing interventions that aim to enhance the therapeutic effects of fixed appliances or interventions that aim to reduce the duration of orthodontic treatment.

Assessment of the success of orthodontic treatment generally involves evaluations of the patient's post-treatment records. However, without a valid and reliable evaluation method, treatment outcome assessments are difficult and often subjective. The American Board of Orthodontics (ABO) developed the Objective Grading System (OGS) for the precise evaluation of orthodontic treatment outcomes using the final dental casts and panoramic radiographs of patients.<sup>6</sup> The OGS rates eight criteria that contribute to ideal intercuspation and function. Best occlusion and alignment receive a score of 0 points, while deviations from ideal are given penalty points. Consequently, a high percentage of accordance can be achieved in both interexaminer and intraexaminer assessments, as reported in the orthodontic literature.<sup>7</sup> In addition to functioning as an objective clinical examination tool, the OGS is also used for the assessment of treatment progress and final outcomes with increased reliability, validity, and precision.<sup>8</sup> The ABO also developed the discrepancy index (DI) as a pretreatment scoring system, which has become an accepted and reliable index for the quantification of treatment complexity on the basis of orthodontic diagnostic records.<sup>9</sup>

A systematic evaluation of the range of typical treatment outcomes is crucial for the development of a standard of care<sup>10</sup> that can be used to judge the quality of orthodontic treatment.<sup>11</sup> To the best of our knowledge, no objective quality assessment using the ABO OGS has been performed in the field of orthodontics. Although previous systematic reviews have investigated the typical duration of orthodontic treatment,<sup>12,13</sup> they have not assessed the possible association between treatment duration and outcome, nor between treatment duration and initial discrepancy.

Therefore, the aim of this systematic review was to assess the occlusal outcomes and duration of fixed appliance orthodontic therapy from clinical trials in humans with the OGS of the ABO.

## MATERIALS AND METHODS

### Protocol and registration

The protocol for this systematic review was prepared *a priori* and registered in PROSPERO (CRD42016049203), and all *post hoc* changes were appropriately noted. This systematic review was conducted and reported in accordance with the Cochrane Handbook<sup>14</sup> and PRISMA statement,<sup>15</sup> respectively.

### Eligibility criteria

We initially aimed to assess the comparative effectiveness of various orthodontic fixed appliances in terms of occlusal outcomes using parallel randomized and prospective nonrandomized trials in human patients. However, the pilot search indicated that very limited material was available (only two prospective trials); therefore, the review protocol was based on the inclusion of prospective or retrospective cohort studies assessing fixed appliance orthodontic treatment to provide an explorative overview of treatment outcomes (Appendix A). Studies where the OGS was not used or improperly used, nonclinical studies, and animal studies were excluded. Studies regarding novel orthodontic appliances with an unclear evidence base were excluded from the clinical part of the review but included in the explorative methodological overview.

### Information sources and literature search

Nine electronic databases were systematically searched, without any limitations, from inception up to October 7, 2016 (Appendix B). Two additional sources, namely Google Scholar and the ISRCTN registry, and the reference/citation lists of included studies and relevant reviews were manually searched for additional studies or protocols. There were no limitations concerning language, publication year, or publication status.

### Study selection and data collection

Titles identified from the search were screened by one author (SNP), and the corresponding abstracts/full texts were subjected to subsequent duplicate, independent checking using the eligibility criteria by a second author (DH), while conflicts were resolved by a third author (TE).

The characteristics of included studies and numerical data were extracted in duplicate by two authors (SNP, DH) using predetermined and piloted extraction forms. Missing or unclear information was requested from the authors of the studies.

### Risk of bias in individual studies

The risk of bias in the included nonrandomized studies was assessed using the Downs and Black checklist<sup>16</sup> after initial calibration. Because the primary aim of this review

was to provide an overview of possible OGS scores after orthodontic treatment, a main risk of bias assessment was included using the Downs and Black checklist for cohort studies. In a separate methodological overview of comparative cohort studies with two or more experimental groups, we also assessed whether confounding due to baseline differences in malocclusion severity measured using the DI between compared groups was appropriately addressed by matching or covariate adjustment.

### Data synthesis: cohort studies

The outcome of fixed appliance treatment is bound to be affected by patient- and appliance-related characteristics.<sup>3-5</sup> Accordingly, a random-effects model proposed by Paule-Mandel<sup>17</sup> was deemed appropriate to incorporate this variability<sup>18</sup> because it outperforms the older DerSimonian and Laird estimator.<sup>17</sup> A weighted mean with the corresponding 95% confidence interval (CI) was calculated across studies for the primary and secondary outcome as a primary analysis. The produced forest plots were augmented with contours denoting the magnitude of the observed effects.<sup>19</sup>

### Data synthesis: comparative cohort studies with at least two groups

The mean difference (MD) was used to pool the influence of reported treatment-related characteristics across included case-control studies. The effect of matching by initial discrepancy on the results of the meta-analyses was assessed by calculating the difference in MDs ( $\Delta$ MD) between matched and nonmatched groups through random-effects meta-regression. Then, the absolute  $\Delta$ MDs were pooled across comparisons using random-effects meta-analysis.

### Heterogeneity

Absolute and relative between study heterogeneity were quantified using  $\tau^2$  and  $I^2$  statistics, respectively. Relative heterogeneity was defined as the proportion of total variability in the results as explained by heterogeneity, not by chance. To quantify our uncertainty, 95% CIs were calculated for the heterogeneity statistics. Furthermore, 95% predictive intervals (95% PrI), which incorporate existing heterogeneity and provide a range of possible effects for a future clinical setting, were calculated for the meta-analyses of three or more studies.<sup>20</sup>

### Risk of bias across studies and additional analyses

Indications for reporting biases (including small-study effects) were assessed using Egger's linear regression tests in meta-analyses of at least 10 studies. In cases of bias, robustness of the results was checked using

subgroup sensitivity analyses according to precision.

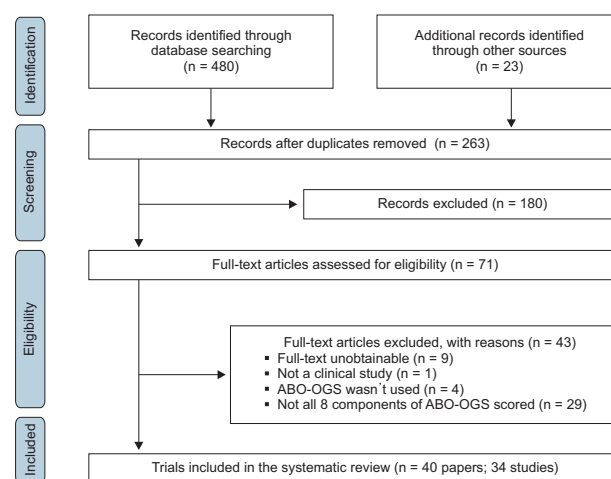
We planned to seek possible sources of heterogeneity through prespecified random-effects meta-regressions with the Knapp and Hartung adjustment at the study level. These were based on the patient age, sex (% male patients), extraction rate, and mean baseline DI. In addition, a possible interrelation between the mean OGS score and treatment duration was investigated.

Sensitivity analyses were performed by dividing included cohort studies into (a) those that explicitly reported the use of only one-phase fixed-appliance treatment and (b) those that reported the use of two-phase treatment or those that did not provide clear reports. If considerable differences were identified between these subsamples, the subsample with clear reporting of one-phase fixed appliance treatment was used, because direct comparison between one- and two-phase treatment was neither possible nor within the scope of this study. All statistical analyses were performed using Stata SE 14.2 (Stata Corp, College Station, TX, USA) by one author (SNP). A two-tailed  $p$ -value of 0.05 was considered significant for hypothesis testing, although for heterogeneity testing and reporting bias testing, a value of 0.10 was considered significant because of low power.<sup>21</sup>

## RESULTS

### Study selection

A total of 480 and 23 papers were identified through electronic (Appendix B) and manual searches, respectively (Figure 1). After the removal of duplicates and



**Figure 1.** Study flowchart showing the identification and selection of eligible studies.

ABO-OGS, Objective Grading System (OGS) proposed by the American Board of Orthodontics.

**Table 1.** Characteristics of the studies included in our systematic review assessing the occlusal outcomes and duration of orthodontic fixed appliance treatment

No.	Study	Setting	Patient (n)	Sex, male (%)	Mean age (yr)	Extraction (%)	Malocclusion	DI	OGS	Tx time	Only FA	Factors
1	Junqueira, 2012; Mendes, 2012	BRA; uni Sao Paulo	68	56	NR	71	Cl. II/divI	No	Yes	No	No	Ex
2	Marques, 2012	BRA; various practices	60	37	17.4	NR	NR	No	Yes	Yes	No	Clinician
3	Li, 2015*	CHI; uni	76	36	32.2	Ex	Cl. I	Yes	Yes	Yes	Yes	Int*
4	Carvajal-Florez, 2016	COL; uni Antioquia 10-11	34	44	20.9	NR	NR	No	Yes	Yes	No	Finishing <sup>†</sup>
5	Barbosa Lis, 2014	COL; uni Antioquia 11-12	39	48	NR	Ex/nonEx	NR	No	Yes	Yes	No	-
6	Rodríguez, 2014	COL; uni Manizales 11-12	31	NR	NR	NR	NR	No	Yes	No	Yes	-
7	Anthopoulou, 2014; Mislík, 2016	GRE; uni & 5 practices	55	35	14.9	45	Cl. I Ex/nonEx	No	Yes	No	Yes	Clinician; Ex
8	Jain, 2013	IND; college Manipal	40	NR	16.6	Ex	NR	Yes	Yes	Yes	Yes	Prescription <sup>†</sup>
9	Soltani, 2012	IRA; 2 practices	60	23	NR	NonEx	Cl. I	No	Yes	No	Yes	Prescription <sup>†</sup>
10	Fathadian, 2005	IRA; uni	60	23	17.9	Ex/nonEx	Cl. I	No	Yes	Yes	Yes	Ex
11	Deguchi, 2011	JAP; uni 02-05	30	0	24.3	Ex	Open bite	Yes	Yes	No	Yes	Anchorage <sup>†</sup>
12	Deguchi, 2015	JAP; uni Okayama	25	20	24.2	Ex	Cl. II	Yes	Yes	Yes	Yes	Int*
13	Vivattanatipa, 2016	THA; TBO	200	NR	NR	NR	NR	Yes	Yes	No	Yes	-
14	Akinci Cansunar, 2014; Cansunar, 2014; Cansunar, 2016*	TUR; 9 unis	1,098	40	16.3	49	Cl. II	Yes	Yes	Yes	Yes	1- or 2-phase; Ex
15	Brown, 2015	USA; practice Bandeen	64	50	13.8	NonEx	NR	Yes	Yes	Yes	Yes	Int*
16	Kuncio, 2007*	USA; practice Kuncio	11	9	26.8	NonEx	NR	No	Yes	Yes	Yes	-
17	Djeu, 2005*	USA; practice Shelton	48	NR	23.7	NonEx	NR	Yes	Yes	Yes	Yes	-
18	Alford, 2011*	USA; practice Snyder	63	51	17.8	NonEx	NR	Yes	Yes	Yes	No	-
19	Aszkler, 2014	USA; practice Wick	30	NR	NR	Ex/NonEx	NR	No	Yes	No	Yes	-
20	Chalabi, 2015	USA; uni Buffalo	50	38	NR	NR	Various	No	Yes	No	No	Gender
21	Brown, 2011	USA; uni Detroit Mercy 03-07	714	NR	NR	NR	NR	Yes	Yes	No	No	-
22	Yang-Powers, 2002	USA; uni Illinois	124	44	14.5	37	Various	No	Yes	Yes	No	Clinician
23	Knierim, 2006	USA; uni Indiana 01-03	437	42	17.8	28	Various	No	Yes	Yes	No	Early debond; Ex; malocclusion

Table 1. Continued

No.	Study	Setting	Patient (n)	Sex, male (%)	Mean age (yr)	Extraction (%)	Malocclusion	DI	OGS	Tx time	Only FA	Factors
24	Vu, 2008	USA; uni Indiana 04-06	455	39	16.3	28	Various	Yes	Yes	Yes	No	Canine impaction; compliance; DI; early debond; Ex; FEA; gender; HG; malocclusion; missed appointments; oral hygiene; orthognathic surgery; RME
25	Detterline, 2010	USA; uni Indiana 05-08	828	38	16.3	NonEx	NR	Yes	Yes	Yes	Yes	Slot size <sup>†</sup>
26	Park, 2008	USA; uni Indiana 97-07	200	31	15.2	25	Various	Yes	Yes	Yes	Yes	Finishing <sup>†</sup>
27	Pinskaya, 2004; Hsieh, 2005	USA; uni Indiana 98-00	521	42	16.0	31	Various	No	Yes	Yes	No	Ex
28	Campbell, 2007	USA; uni Indiana 98-03	382	45	15.3	NR	Various	Yes	Yes	Yes	No	Early debond; malocclusion
29	Deguchi, 2005	JAP; uni Okayama 02	72	26	18.7	58	Various	Yes	Yes	Yes	No	-
30	Schabel, 2008	USA; uni Michigan	48	NR	NR	NR	NR	No	Yes	No	No	-
31	Hoybjerg, 2013	USA; uni Oklahoma 02-10	90	46	15.2	50	Various	No	Yes	Yes	Yes	Ex
32	Santiago, 2012	USA; uni Puerto Rico 07-08	64	42	14.1	NR	NR	Yes	Yes	Yes	No	Compliance; gender
33	Ferguson, 2016*	USA; uni Saint Louis	28	NR	NR	NonEx	Cl. I	No	Yes	No	Yes	-
34	Sohrabi, 2016	USA; uni Washington 12-13	102	NR	16.4	17	Cl. I/II/III	No	Yes	Yes	No	-

Data modifications according to the eligibility of the included reports was as follows.

- (i) Pulfer 2009 was excluded from the descriptives because it drew upon the data of Hsieh 2005 and Knierim 2006 to pool them together.
- (ii) Junqueira 2012 and Mendes 2012 were judged to have mostly overlapping patients; only data from Mendes 2012 are reported, which were the more extensive of the two.
- (iii) Anthopoulou 2014 and Mislik 2016 had overlapping patient populations where different factors were assessed. The demographics of Anthopoulou 2014 are reported here.
- (iv) Akinci Cansunar 2014, Cansunar 2016, and Cansunar 2016 were judged to have mostly overlapping patients in their report. Data from Akinci Cansunar 2014 are reported here.
- (v) Pinskaya 2004 and Hsieh 2005 were omitted as they included both labial and lingual appliances.
- (vi) Only a subgroup of patients originating from the Okayama University was included from the Deguchi 2005 study, because the cohort from Indiana University was described in multiple other reports.

\*Patient groups pertaining to treatment alternatives noneligible for this review (aligners, lingual appliances, computer- or corticotomy-assisted orthodontics) were excluded.

<sup>†</sup>Intervention groups were pooled and not separately assessed because of the retrospective nature of the included studies.

<sup>‡</sup>Some reported in different reports on the same cohort.

Ex, Extraction; DI, discrepancy index; OGS, Objective Grading System; Tx, treatment; FA, fixed appliances; uni, University; NR, not reported; Cl., class; div, division; Int, intervention; Ex, extraction treatment; Non-Ex, nonextraction treatment; FFA, fixed functional appliance; TBO, Thai Board of Orthodontics; HG, headgear; RME, rapid maxillary expansion.

initial screening, 71 papers were assessed using the eligibility criteria and 40 were included in our systematic review (Figure 1; Appendix C). In four instances, multiple publications pertaining to the same or overlapping patient cohorts were grouped together. Thus, a total of 34 studies were finally included in our systematic review.

**Study characteristics**

The characteristics of the included studies can be seen in Table 1. The 34 included studies originated from private practices or educational institutions from 10 different countries and included a total of 6,207 patients (median, 64 patients/study). There were 1966 (39.6%) male patients and 3,000 (60.4%) female patients with an average age of 18.4 years. Among the 34 included studies, 25 (73.5%) reported information about the inclusion or exclusion of tooth extractions; four included extraction patients, seven included non-extraction patients, and the remaining eleven studies had reported an average extraction rate of 40%, and three did not report the percentage of extractions. The treated malocclusions were often unspecified, and the DI was used to gauge the severity of the initial malocclusion in only 16 (47.1%) studies. In 18 (52.9%) studies, the authors explicitly stated that only one-phase treatment with fixed appliances was performed, while in the remaining 16 (47.1%) studies, two-phase treatment was performed for some of the included patients. All of the included studies measured the post-treatment OGS score, which was the primary outcome, while 23 (67.6%) studies also measured the treatment duration, which was the secondary outcome.

**Risk of bias within studies**

The risk of bias assessment for the 34 included studies is shown in Figure 2 and Appendix D–E. A high risk of bias for at least one domain was found in 31 studies (91.2%). The most problematic domains included the study design (where 85% studies were retrospective) and blinding (79% studies did not use blinding).

**Data synthesis and additional analyses: cohort studies**

A total of 29 (85.3%) of the 34 included studies could be used in the meta-analyses for the primary outcome (ABO OGS); the remaining either reported on overlapping patient populations or had missing data. The results of the random-effects meta-analysis indicated that the overall OGS score after treatment was 27.9 points (95% CI, 25.3–30.6 points) with high heterogeneity and no considerable differences between the subsample of studies that included strictly one-phase fixed appliance treatment (27.5 points; 95% CI, 24.5–30.5 points) and the subsample of studies reporting two-phase/unclear treatment (28.3 points; 95% CI 24.5–32.1 points; *p* for difference between subsamples > 0.1) (Table 2, Figure 3).

The meta-analysis of the 18 included studies reporting the secondary outcome of treatment duration indicated that the mean treatment duration among all studies was 24.9 months (95% CI, 24.6–25.1 months) with high heterogeneity (Figure 4). The average treatment duration differed significantly (*p* = 0.004) between the subsample of studies reporting one-phase fixed appliance treatment (24.8 months; 95% CI, 21.4–28.3 months) and the subsample of studies reporting two-phase/unclear treatment (31.6 months; 95% CI, 30.8–32.3 months). The difference in the mean duration between the

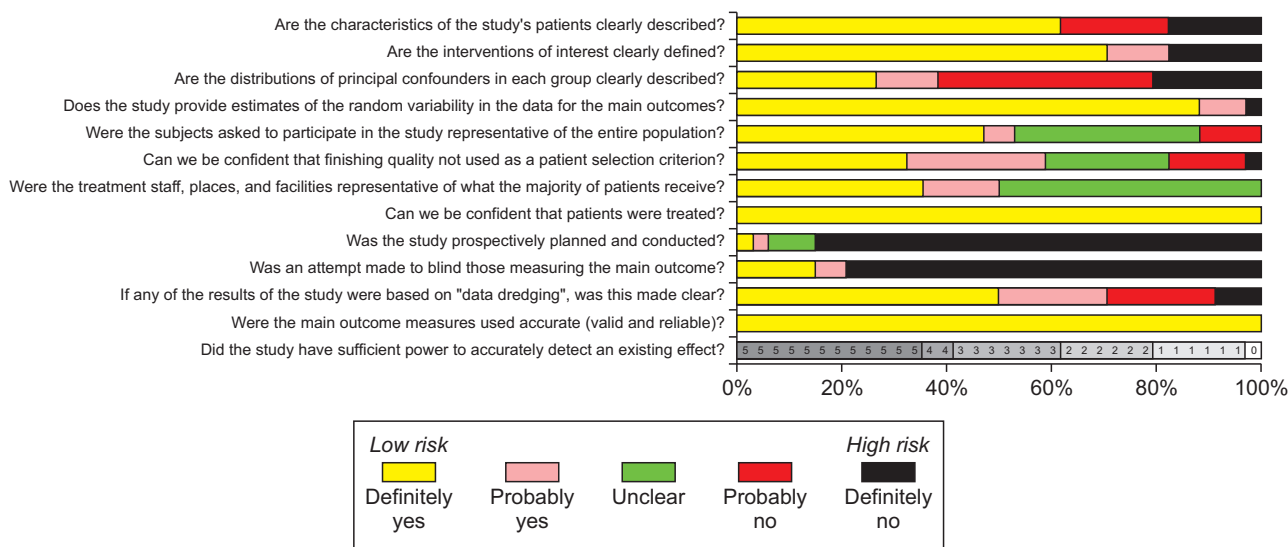


Figure 2. Summary of the risk of bias in the included studies.

**Table 2.** Results of the meta-analyses for the primary (OGS score) and secondary (treatment duration) outcomes of orthodontic fixed appliance (FA) treatment

Outcome	Subgroup	Studies, n	Mean	95% CI	Tau <sup>2</sup> (95% CI)	I <sup>2</sup> (95% CI), %	95% PrI	Difference (95% CI)	p-value
ABO-OGS score	Overall	29	27.93	25.31–30.55	50.00 (34.11–50.00)	99.1 (98.7–99.1)	13.17–42.70		
	Only FA No	14	28.29	24.53–32.06	50.00 (41.39–50.00)	99.1 (98.9–99.1)	12.33–44.26	–0.70 (–6.28 to 4.88)	0.800
	Yes	15	27.51	24.47–30.54	33.91 (17.90–50.00)	98.2 (96.7–98.8)	14.49–40.53		
Tx duration (mo)	Overall	16	24.86	24.60–25.12	0.00 (50.00–50.00)	0.0 (99.3–99.3)	24.58–25.14		
	Only FA No	8	31.56	30.79–32.33	0.00 (49.03–50.00)	0.0 (96.7–96.7)	30.60–32.52	–13.22 (–21.60 to –4.84)	0.004
	Yes	8	24.84	21.41–28.27	23.36 (10.81–50.00)	99.2 (98.3–99.6)	12.26–37.42		

OGS, Objective Grading System; CI, confidence interval; PrI, predictive interval; ABO, American Board of Orthodontics; Tx, treatment.

two treatment subsamples was 13.2 months (95% CI, 4.8–21.6 months), although considerable heterogeneity remained even after the separate analysis.

Meta-regressions failed to identify a significant influence of any study-level characteristics on the primary outcome of OGS score or the secondary outcome of treatment duration (Appendix F). However, significant signs of reporting bias (Appendix G) were identified for the secondary outcome of treatment duration through Egger's test ( $p = 0.031$ ), where small/imprecise studies tended to report longer treatment durations compared with the remaining studies (Appendix G). Stratified subgroup analyses according to study precision indicated that bias was mainly concentrated in the subgroup of studies reporting two-phase or unclear treatment (Appendix G), while the subgroup of studies reporting one-phase fixed appliance treatment was relatively robust (Egger's test,  $p > 0.05$ ). Finally, we could not perform sensitivity analyses on the basis of risk of bias in the included studies, because most of them (91%) had a high risk of bias.

#### Data synthesis and additional analyses: comparative cohort studies with at least two groups

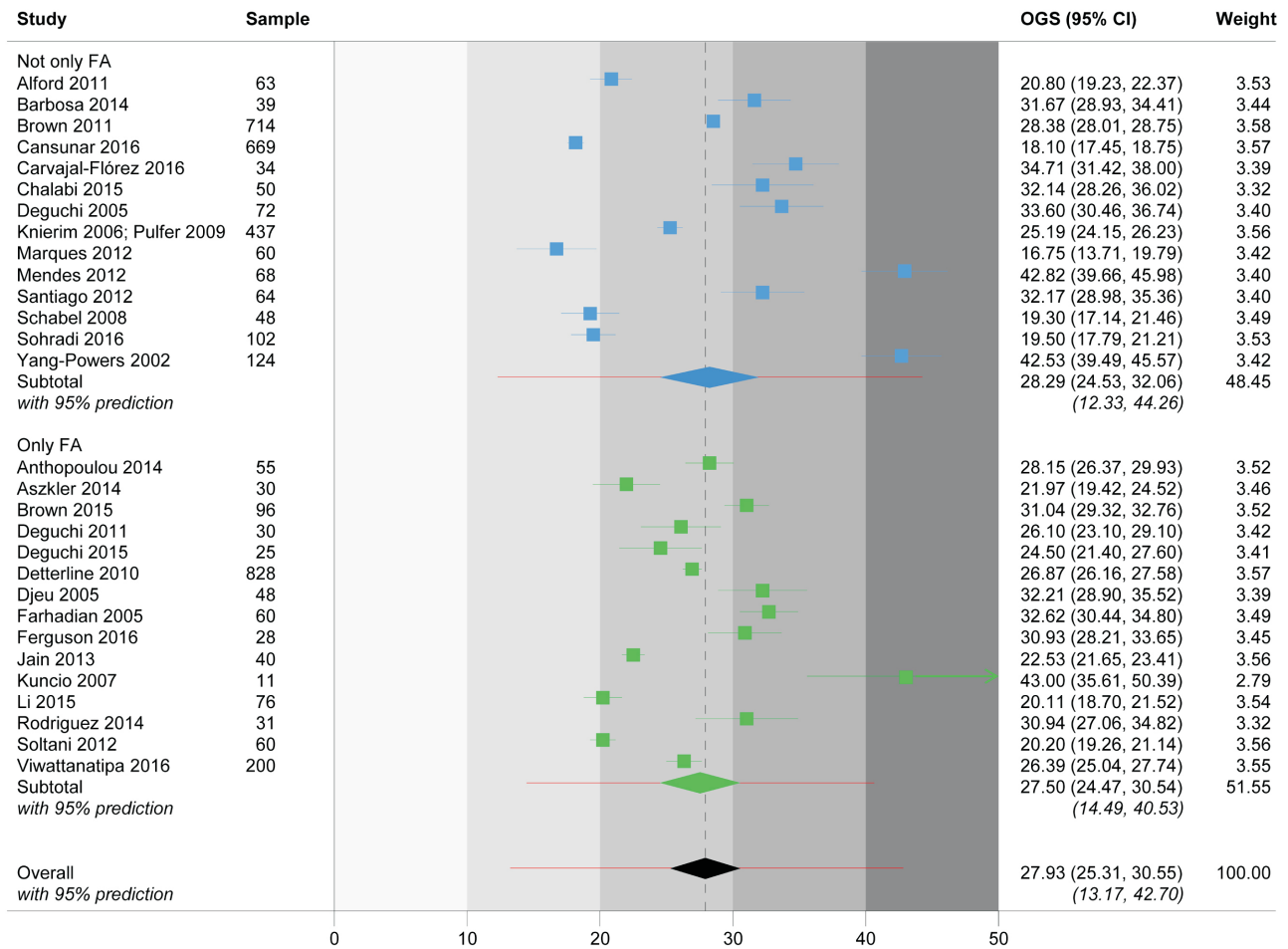
Signs of discordant results (i.e., significant differences between subgroups; Table 2) and reporting bias (Appendix G) were found for the subgroup of studies with two-phase/unclear treatment. Therefore, factors from comparative two-group cohort studies were assessed only for those studies that strictly reported one-phase fixed appliance treatment, which were free from bias (Table 3). Orthodontic treatment with extraction of four premolars was associated with a slight improvement in

occlusal outcomes, as indicated by the OGS score (MD, –4.9 points; 95% CI, –11.8 to 1.9 points;  $p = 0.159$ ), and a moderate increase in the treatment duration (MD, 6.4 months; 95% CI, 1.4 to 11.5 months;  $p = 0.013$ ). However, only the increase in treatment duration was statistically significant at the 5% level. Finally, no considerable differences in occlusal outcomes could be found between patients treated in the orthodontic department at a university and those treated in a private orthodontic clinic.

#### Methodological overview

Additionally, the methodological status of all available comparisons included in the studies identified from this systematic review was assessed, regardless of whether they were eligible for the clinical part of the systematic review (Table 4). From the 26 comparisons regarding various treatment factors reported in the included studies, 10 (38.5%) used matching to form patient groups that were comparable in terms of the severity of the baseline malocclusion. However, in one case, the pre-treatment ABO OGS score was used to match the severity of the baseline pre-treatment malocclusion, and this was identified as problematic. In four (15.4%) of the 26 identified comparisons, the severity of the baseline malocclusion in the compared groups was considered by using it as a covariate in the statistical analyses. Overall, baseline confounding was adequately assessed, in one way or the other, in only 10 (38.5%) of the included comparisons.

Among the available comparisons, two included both matched and nonmatched studies and enabled an assessment of the influence of matching on the



**Figure 3.** Overall pooling for occlusal outcomes of fixed appliance (FA) treatment assessed using the Orthodontic Grading System proposed by the American Board of Orthodontics Mean Orthodontic Grading System scores and their corresponding 95% confidence intervals (CIs) for each included study are given as boxes with horizontal lines, respectively. The weighted pooled summary estimates with and their corresponding 95% CIs for the two subgroups or overall are given as diamonds. Horizontal lines at the diamonds represent the 95% prediction that gives a range of possible values to be clinically seen, while incorporating existing heterogeneity.

results (Appendix H). In the comparison of aligner versus fixed appliance treatment, studies with matched patient samples tended to find considerably greater differences in occlusal outcomes. Moreover, studies with baseline matching tended to find considerably smaller differences in occlusal outcomes between extraction and nonextraction treatment groups compared with studies without matching. Finally, the absolute pooled difference in the OGS score between matched and nonmatched patient samples across studies was calculated as  $\Delta MD = 7.20$  OGS points (95% CI,  $-2.16$  to  $16.57$  points;  $p = 0.132$ ; Appendix I). This could possibly have clinical implications, although evidence was very limited.

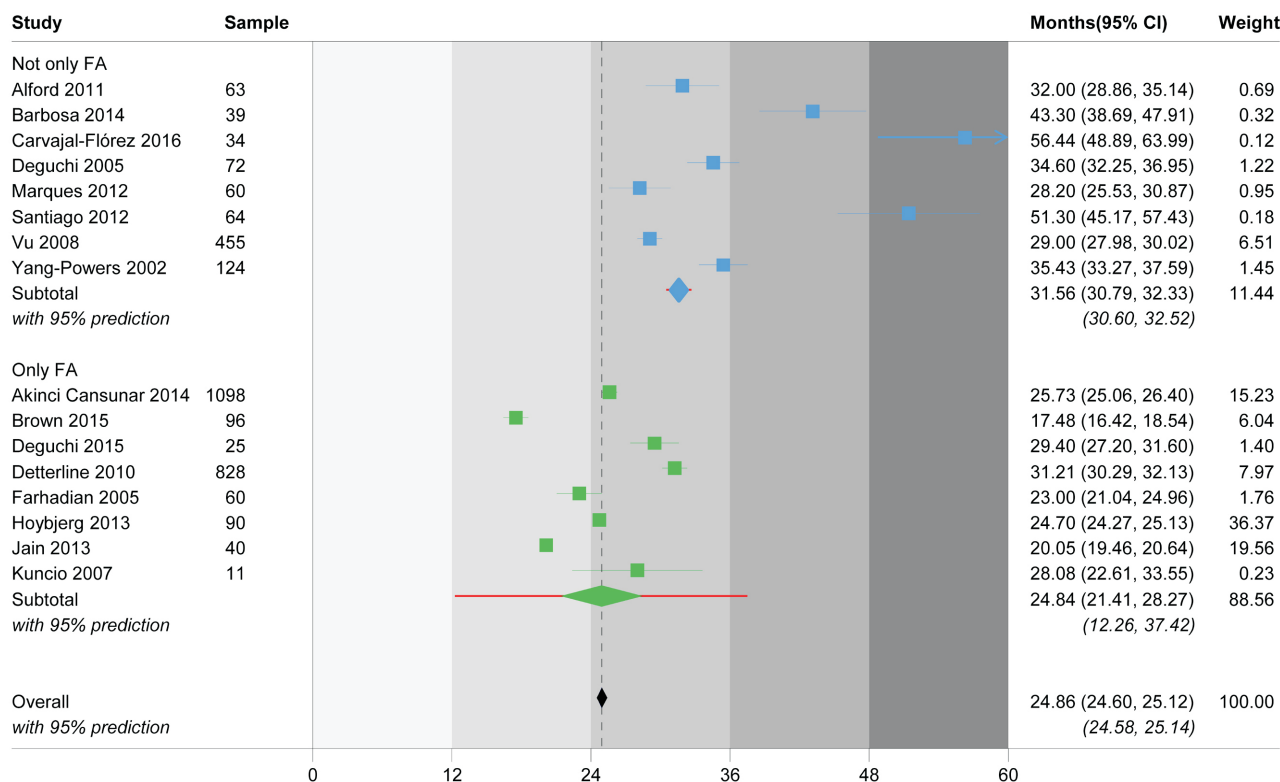
## DISCUSSION

### Summary of evidence

This systematic review summarizes evidence from 34 clinical cohort studies including a total of 6,207 patients who received comprehensive orthodontic fixed appliance treatment. The pooled analysis for the primary outcome, which was occlusal outcomes as measured using the OGS score, indicated an average OGS score of 27.9 OGS points (95% CI, 25.3–30.6 points), which was relatively consistent regardless of one-phase or two-phase treatment ( $p = 0.800$ ; Table 2).

Analysis of the secondary outcome, which was the treatment duration, revealed an average treatment duration of 24.9 months (95% CI, 24.6–25.1 months). However, a considerable difference of 13.2 months





**Figure 4.** Overall pooling for the fixed appliance (FA) treatment duration in months. Mean treatment durations and their corresponding 95% confidence intervals (CIs) for each included study are given as boxes with horizontal lines, respectively. The weighted pooled summary estimates with and their corresponding 95% CIs for the two subgroups or overall are given as diamonds. Horizontal lines at the diamonds represent the 95% prediction that gives a range of possible values to be clinically seen, while incorporating existing heterogeneity.

(4.8–21.6 months;  $p = 0.004$ ; Table 2) in treatment duration was found between studies that strictly reported one-phase fixed appliance treatment and those that reported two-phase or unclear treatment. Therefore, this systematic review focuses on the clearly defined subsample of studies on one-phase fixed appliance treatment with an average treatment duration of 24.8 months (95% CI, 21.4–28.3 months). This is slightly higher than the average treatment duration of 19.9 months reported by Tsihaki et al.<sup>22</sup> However, a fixed-effect model was used by the authors of that study, which cannot be easily justified in such a broad clinical scenario<sup>18</sup> and could, in combination with the reported statistical inconsistency, have had a profound impact on the meta-analysis results.<sup>19</sup> In addition, contrary to the studies included in the previous systematic review of Tsihaki et al.,<sup>22</sup> the studies assessed in the present review included the assessment of final occlusal outcomes using the ABO OGS in their scope and could possibly have paid extra attention to the finishing stage of orthodontic treatment. Finally, the number of studies included was considerably higher in the previous

systematic review than in the present review (22 and 8 studies, respectively), because the use of the ABO OGS was not an inclusion criterion in the former.

Interestingly, we found no association of the average outcome of orthodontic treatment with the mean treatment duration, mean severity of the initial malocclusion as assessed using the DI, and various patient- or treatment-related characteristics (Appendix F). Although this is in agreement with the findings of two included studies<sup>23,24</sup> that found nonsignificant correlation coefficients of  $-0.18$  to  $-0.30$  for the association between the ABO OGS and DI, this does not mean that the DI is not a crucial component of the ABO OGS framework in clinical investigations of treatment effects.

The only factor that appeared to considerably influence the outcomes of orthodontic treatment was the inclusion of tooth extractions. First, on a study level, the mean OGS score was significantly associated with the extraction rate in each study (Appendix F). On an average, every 10% increase in the extraction rate was significantly associated with a decrease in the OGS

**Table 3.** Results of the meta-analyses regarding the effect of characteristics from included comparative case-control studies reporting one-phase fixed appliance treatment on the primary (OGS score) and secondary outcome (treatment duration)

Factor	ABO OGS score					Treatment duration								
	n	MD	95% CI	Tau <sup>2</sup> (95% CI)	I <sup>2</sup> (95% CI), %	95% PrI	%	95% PrI	I <sup>2</sup> (95% CI)	Tau <sup>2</sup> (95% CI)	95% CI	95% PrI	p	
Extraction of four premolars	2	-4.94	-11.82 to 1.94	21.02 (NA)	85.3 (NA)	NA	0.159	2	6.41	1.38-11.45	11.21 (NA)	83.6 (NA)	NA	0.013
Private practice vs. university clinic	1	0.5	-3.77 to 4.77	-	NA	NA	0.818	-	-	-	-	-	-	-

ABO, American Board of Orthodontics; OGS, Objective Grading System; n, number of studies; MD, mean difference; CI, confidence interval; PrI, predictive interval; NA, not applicable.

score by 0.7 point, which indicated better occlusal outcomes. In addition, analysis of within-study data from case-control studies indicated that comprehensive treatment involving extraction of the four premolars was associated with improved treatment outcomes, as indicated by a decrease in the OGS score (MD, -4.9 OGS points; 95% CI, -11.8 to 1.9 OGS points;  $p = 0.159$ ), and a prolonged treatment duration (MD, 6.4 months; 95% CI, 1.4 to 11.5 months;  $p = 0.013$ ). Although only the increase in the treatment duration was statistically significant at the 5% level, this was most probably due to imprecision caused by a small sample size; the addition of future studies may rectify this.

Finally, a methodological overview was conducted of all identified clinical case-control studies that assessed occlusal outcomes according to various treatment-related factors (Table 4). This also included study arms that assessed novel interventions (aligners and individualized or lingual appliances) that were excluded from the clinical part of the systematic review because of their basic design.<sup>25,26</sup> The results indicated that the majority of studies neither matched the compared patient groups according to their baseline malocclusion severity nor used the baseline malocclusion severity as a covariate in the statistical analyses (Table 4). As a result, only 10 (38.5%) of the available comparisons were free from baseline confounding. This might be important, as meta-epidemiological analysis indicated that matching of experimental groups according to the baseline malocclusion severity may considerably influence the observed results (Appendixes H and I).

Some additional methodological flaws were found among the included studies. First, a large number ( $n = 29$ ) of possibly relevant clinical studies identified from the literature search did not assess all eight components of the ABO OGS and were consequently excluded from the present review because of pooling incompatibility. Second, an included study used the ABO OGS to measure the baseline malocclusion severity and match the compared groups,<sup>27</sup> and this contradicts the rationale behind this index which might be problematic<sup>28,29</sup> and does not justify substitution of the DI.<sup>9</sup> Finally, some included studies measured the baseline severity with the DI and performed statistical tests to determine baseline differences in DI among the compared groups. This practice is inherently wrong<sup>30</sup> because the results can be easily distorted by increasing the sample size; furthermore, it cannot substitute proper matching or covariate adjustment.

The strengths of this systematic review include the *a priori* registration in PROSPERO, the extensive unrestricted literature search, which included studies in languages other than English, the use of robust methodology pertaining to the qualitative and

**Table 4.** Methodological overview of comparison-specific characteristics obtained from of identified case-control studies

No	Study*	Intervention	Comparison	Initial malocclusion severity			Selection bias addressed?
				Matching	How	Used as covariate	
1	Detterline, 2010	18"-slot CB	22"-slot CB	Yes	DI	Yes	Yes
2	Ferguson, 2016	Corticotomy & CB	CB	No	-	No	
3	Anthopoulou, 2014	Ex	Non-Ex	Yes	Discriminant analysis	No	Yes
4	Farhadian, 2005	Ex	Non-Ex	No	-	No	No
5	Hoybjerg, 2013	Ex	Non-Ex	No	-	No	No
6	Knierim, 2006	Ex	Non-Ex	No	-	No	No
7	Pinskaya, 2004	Ex	Non-Ex	No	-	No	No
8	Sohradi, 2016	Ex	Non-Ex	No	-	No	No
9	Vu, 2008	Ex	Non-Ex	No	-	No	No
10	Akinci Cansunar, 2014	Ex	Non-Ex	No	-	No	No
11	Carvajal-Flórez, 2016	Finishing protocol	Conventional finishing	No	-	No	No
12	Park, 2008	Finishing protocol	Conventional finishing	Yes	DI	Yes	Yes
13	Deguchi, 2011	Skeletal anchorage	No skeletal anchorage	No	-( $\Delta$ DI = 14.5)	No	No
14	Brown, 2015	Indirect bracket placement	Direct bracket placement	Yes	DI	No	Yes
15	Brown, 2015	Insignia appliance	CB	Yes	DI	No	Yes
16	Djeu, 2005	Invisalign aligners	CB	Yes	DI	No	Yes
17	Kuncio, 2007	Invisalign aligners	CB	No	-	No	No
18	Li, 2015	Invisalign aligners	CB	Yes	DI + RCT	No	Yes
19	Deguchi, 2015	Lingual appliance	CB	Yes	DI	No	Yes
20	Jain, 2013	MBT prescription CB	Roth prescription CB	No	-( $\Delta$ DI = 3.8)	Yes	Yes
21	Soltani, 2012	MBT prescription CB	SE prescription CB	No	-	No	No
22	Marques, 2012	Orthodontist	General dentist	Yes	ABO OGS	No	No
23	Hoybjerg, 2013	3 Retention protocols	-	No	-	No	No
24	Alford, 2011	SureSmile appliance	CB	No	$\Delta$ DI = 2.6	Yes	Yes
25	Mislik, 2016	University clinic	Private practice	Yes	Discriminant analysis	No	Yes
26	Yang-Powers, 2002	University clinic	ABO-submitted cases	No	-	No	No

\*Mendes et al. (2012) was excluded because patients were matched in terms of the final ABO OGS score.

CB, Conventional brackets; DI, discrepancy index; Ex, extraction treatment; Non-Ex, nonextraction treatment; RCT, randomized clinical trial; MBT, McLaughlin-Bennett-Trevisi; SE, standard edgewise; ABO, American Board of Orthodontics; OGS, Objective Grading System.

quantitative synthesis of data,<sup>31</sup> transparent reporting of quantitative data for all outcomes from the included studies, the use of the new robust Paule-Mandel random-effects estimator,<sup>17</sup> and the use of subgroup, meta-regression, and sensitivity analyses to check the robustness of the results. However, some limitations cannot be overlooked. First and foremost, this systematic review included mostly observational, nonrandomized,

retrospective clinical studies, and this is bound to have influenced the results of the meta-analyses.<sup>25</sup> Therefore, we planned *a priori* not to focus on the comparative effectiveness of various interventions, considering it would require experimental prospective controlled studies. Instead, we provided an overview of expected treatment outcomes and possible influencing factors and assessed methodological issues in existing studies.

Finally, as considerable heterogeneity was found in both the primary and secondary outcomes, which remained unexplained even after the investigation of possible sources through subgroup, meta-regression, and sensitivity analyses, readers should be cautioned that the pooled estimates of the meta-analyses may be imprecise. Clinicians are instead advised to base their conclusions on the range of possible values indicated by the 95% CIs and 95% PrIs to identify cases that deviate from these ranges.

## CONCLUSION

### Recommendations for clinical practice

With regard to clinical relevance, this systematic review cannot provide robust evidence on the comparative effectiveness of various interventions. The range of expected occlusal outcomes and treatment duration are provided on the basis of the identified studies, and clinicians are advised to consider these two in conjunction and take care to identify cases with extreme deviations from this range. Comprehensive treatment with extraction of the four premolars may be associated with possibly improved occlusal outcomes and a longer treatment duration than non-extraction treatment. However, the available evidence is limited and not free from bias.

### Recommendations for future research

The use of the ABO OGS can be very helpful for objective evaluation and comparison of the occlusal outcomes of orthodontic treatment with different fixed appliances, as well as several surgical and nonsurgical treatment outcomes through randomized controlled trials. Furthermore, researchers should consider both occlusal outcomes and the treatment duration in their trials to draw robust conclusions regarding the treatment efficiency. Researchers comparing various interventions should match compared patients according to the severity of the baseline malocclusion using the DI or any other robust method. Finally, covariate adjustment according to the severity of the baseline malocclusion can aid in achieving the most reliable statistical estimates<sup>30</sup> and improving their statistical power.<sup>32</sup> However, it must be stressed that *post hoc* matching of compared patients does not substitute proper prospective trial planning and cannot alleviate the inherent biases that can be found in nonrandomized and, particularly, retrospective study designs.<sup>25,26,33</sup>

## SUPPLEMENTARY MATERIALS

Appendices A–I is available at <https://doi.org/10.4041/kjod.2017.47.6.401>.

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## Appendix

### Outcome of comprehensive fixed appliance orthodontic treatment: a systematic review with meta-analysis and methodological overview

**Appendix A.** A priori eligibility criteria used in the review.

Domain	Inclusion	Exclusion
Participants	Human patients of any age*/sex*/ethnicity*/malocclusion* that are planned to receive comprehensive orthodontic treatment	Animal studies
Interventions	Comprehensive orthodontic treatment with fixed appliances on all teeth (with the possible exception of second molars) in a one-phase or a two-phase treatment with any co-interventions	Any orthodontic treatment that did not include a comprehensive phase with fixed appliances at all
	-	Comprehensive orthodontic treatment with novel appliances that have not yet been assessed by robust clinical evidence (aligners, lingual appliances, CAD/CAM- or surgery-assisted appliances)
Comparisons	No separate comparison group (single-group cohort studies)	-
	Similar patients that receive comprehensive treatment differing from the "Intervention" group only in the administered intervention or co-intervention (including patient, appliance or treatment characteristics)	-
Outcome – primary	Occlusal outcome after fixed appliance orthodontic treatment, assessed with the ABO OGS tool	-
Outcome – secondary	Treatment duration in months	-
Study design	Randomized controlled trials (parallel)	Cross-sectional studies that assess previous extractions
	Non-randomized prospective or retrospective clinical cohort studies with a single patient group	Case reports/ case series
	Non-randomized prospective or retrospective clinical cohort studies with at two or more experimental groups	Non-clinical studies (in vitro, ex vivo, in silico, etc)
		Systematic reviews (after checked for additional studies)

\*this factor's role is planned to be assessed through subgroup/meta-regression analyses

**Appendix B.** Literature databases searched (last search October, 2016).

Database	Site	Search strategy	Limit	Hits
PubMed	<a href="http://www.ncbi.nlm.nih.gov/pubmed/">http://www.ncbi.nlm.nih.gov/pubmed/</a>	orthodon* AND ("American Board" OR ABO OR "ABO-OGS" OR "objective grading")	<b>Article types:</b> Clinical Study; Clinical Trial; Comparative Study; Controlled Clinical Trial; Evaluation Studies; Journal article; Meta-analyses; Multicenter Study; Observational Study; Pragmatic Clinical Trial; Randomized Controlled Trial; Systematic Reviews <b>Species:</b> Human	185
Cochrane Library (CDSR/DARE)	<a href="http://onlinelibrary.wiley.com/cochranelibrary/search/">http://onlinelibrary.wiley.com/cochranelibrary/search/</a>	Same with PubMed	-	0
Cochrane Library (CENTRAL)	<a href="http://onlinelibrary.wiley.com/cochranelibrary/search/">http://onlinelibrary.wiley.com/cochranelibrary/search/</a>	Same with PubMed	-	4
Embase	<a href="http://www.embase.com/#advancedSearch/default">http://www.embase.com/#advancedSearch/default</a>	Same with PubMed	-	14
Virtual Health Library	<a href="http://pesquisa.bvsalud.org/portal/advanced/?lang=en">http://pesquisa.bvsalud.org/portal/advanced/?lang=en</a>	Same with PubMed	-	7
Scopus	<a href="http://www.scopus.com/">http://www.scopus.com/</a>	TITLE-ABS-KEY ( orthodon* AND ( "American Board" OR abo OR "ABO-OGS" OR "objective grading" ) ) AND ( LIMIT-TO ( SUBJAREA , "DENT" ) ) AND ( LIMIT-TO ( EXACTKEYWORD , "Human" ) OR LIMIT-TO ( EXACTKEYWORD , "Humans" ) ) AND ( EXCLUDE ( DOCTYPE , "re" ) OR EXCLUDE ( DOCTYPE , "ed" ) OR EXCLUDE ( DOCTYPE , "le" ) ) AND ( EXCLUDE ( EXACTKEYWORD , "Case Report" ) )	<b>Research area:</b> Dentistry	89
ISI Web of Knowledge	<a href="http://apps.webofknowledge.com">http://apps.webofknowledge.com</a>	Same with PubMed	<b>Research area:</b> Dentistry oral surgery medicine <b>Document type:</b> article	181
ClinicalTrials.gov	<a href="https://clinicaltrials.gov/">https://clinicaltrials.gov/</a>	Same with PubMed	-	0

**Appendix C.** List of studies included/excluded from this systematic review with reasons.

AA	Paper	
Excluded during screening		
1	[No authors] A Comparative-Study of the Ages of American Board of Orthodontics Diplomates. Am J Orthod Dentofac Orthop 1991;100(5):482-3.	Excluded by title
2	[No authors] ABO presents typical case report examples for future candidates. American journal of orthodontics. 1978;73(1):79-84. Epub 1978/01/01.	Excluded by title
3	[No authors] American Board of Orthodontics - Past, present, and future. Am J Orthod Dentofac Orthop 1996;110(1):108-10.	Excluded by title
4	[No authors] American Board of Orthodontics sets new standards and requirements. American journal of orthodontics. 1973;64(2):199-200. Epub 1973/08/01.	Excluded by title
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6	[No authors] Foundations of excellence: the ABO in review--1984-1994. Am J Orthod Dentofac Orthop 1995;107(1):103-5.	Excluded by title
7	[No authors] Presentation of the Ketcham,Albert,H Memorial Award, 1954 by Webster,Raymond,L President of the American Board of Orthodontics. Am J Orthod Dentofac Orthop 1954;40(10):783-9.	Excluded by title
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18	Boskabadi H, Mafinezhad S, Bagher F, Bozorgnia Y. Incidence of thrombocytopenia in idiopathic hyperbilirubinemic newborns. Macedonian Journal of Medical Sciences. 2014;7(2):259-62.	Excluded by title
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35	Devries BG. Some views of the American Board of Orthodontics on orthodontic education. American journal of orthodontics.	Excluded by title



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42	Emrich SC. An American Board of Orthodontics case report: an adult nonsurgical patient whose treatment required combined dental disciplines. Am J Orthod Dentofac Orthop 1996;110(2):163-9. Epub 1996/08/01.	Excluded by title
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164	de Freitas KMS, Janson G, de Freitas MR, Pinzan A, Henriques JFC, Pinzan-Vercelino CRM. Influence of the quality of the finished occlusion on postretention occlusal relapse. <i>Am J Orthod Dentofac Orthop</i> 2007;132(4):U29-U34.	Excluded by abstract
165	Grunheid T, Gaalaas S, Hamdan H, Larson BE. Effect of clear aligner therapy on the buccolingual inclination of mandibular canines and the intercanine distance. <i>Angle Orthodontist</i> . 2016;86(1):10-6.	Excluded by abstract
166	Janson G, de Souza JEP, Alves FD, Andrade P, Nakamura A, de Freitas MR, et al. Extreme dentoalveolar compensation in the treatment of Class III malocclusion. <i>Am J Orthod Dentofac Orthop</i> 2005;128(6):787-94.	Excluded by abstract
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169	Kravitz ND, Kusnoto B, BeGole E, Obrez A, Agran B. How well does Invisalign work? A prospective clinical study evaluating the efficacy of tooth movement with Invisalign. <i>Am J Orthod Dentofac Orthop</i> 2009;135(1):27-35.	Excluded by abstract
170	Lee RJ, Weissheimer A, Pham J, Go L, de Menezes LM, Redmond WR, et al. Three-dimensional monitoring of root movement during orthodontic treatment. <i>Am J Orthod Dentofac Orthop</i> 2015;147(1):132-42.	Excluded by abstract
171	Mok CW, Zhou L, McGrath C, Hagg U, Bendeus M. Digital images as an alternative to orthodontic casts in assessing malocclusion and orthodontic treatment need. <i>Acta Odontol Scand</i> . 2007;65(6):362-8.	Excluded by abstract
172	Noar JH, Sharma S, Roberts-Harry D, Qureshi T. A discerning approach to simple aesthetic orthodontics. <i>Br Dent J</i> . 2015;218(3):157-66.	Excluded by abstract
173	Radeke J, von der Wense C, Lapatki BG. Comparison of orthodontic measurements on dental plaster casts and 3D scans. <i>J Orofac Orthop</i> . 2014;75(4):264-74.	Excluded by abstract
174	Shastry S, Park JH. Evaluation of the use of digital study models in postgraduate orthodontic programs in the United States and Canada. <i>Angle Orthodontist</i> . 2014;84(1):62-7.	Excluded by abstract
175	Song GY, Zhao ZH, Ding Y, Bai YX, Wang L, He H, et al. Reliability assessment and correlation analysis of evaluating orthodontic treatment outcome in Chinese patients. <i>Int J Oral Sci</i> . 2014;6(1):50-5.	Excluded by abstract
176	Tuncer C, Bavbek NC, Tuncer BB, Bani AA, Celik B. How Do Patients and Parents Decide for Orthodontic Treatment-Effects of Malocclusion, Personal Expectations, Education and Media. <i>J Clin Pediatr Dent</i> . 2015;39(4):392-9.	Excluded by abstract
177	White AJ, Fallis DW, Vandewalle KS. Analysis of intra-arch and interarch measurements from digital models with 2 impression materials and a modeling process based on cone-beam computed tomography. <i>Am J Orthod Dentofac Orthop</i> 2010;137(4).	Excluded by abstract
178	Wohl TS, Bamonte E, Pearson HE. Nonextraction treatment of unilateral Class II, Division 1 malocclusion with asymmetric headgear. <i>Am J Orthod Dentofac Orthop</i> 1998;113(5):483-7.	Excluded by abstract
179	Quinn B. Considerations in case acceptance for ABO Phase III examination. <i>Am J Orthod Dentofac Orthop</i> 2004;126(4):20A; author reply A-1A.	Excluded by abstract
180	Medina VJ. Tipo sde aparelhos ortopédicos usados em pacientes que apresentam mesioclusão funcional. 2006:88-.	Excluded by abstract
Excluded by full-text		
181	Condie JH. Evaluation of the University at Buffalo orthodontic resident's finished cases with the American Board of Orthodontics Discrepancy Index and Objective Grading System. 2010, University of Buffalo, Thesis.	Excluded; full-text unobtainable
182	Cook MK. Evaluation of Board-certified orthodontist's sequential finished cases with the ABO objective grading system. <i>Orthodontics</i> . Saint Louis: Saint Louis University; 2003: p. 56.	Excluded; full-text unobtainable
183	Cordua T, Ursini R, Giuliani L, Deli R. The excellence challenge in orthodontics: clinical use of an objective grading system for orthodontic cases. <i>Progress in orthodontics</i> . 2009;10(2):4-15. Epub 2009/01/01.	Excluded; full-text unobtainable
184	Fetouh O. Comparison of treatment outcome of Invisalign(RTM) and traditional fixed orthodontics by model analysis using	Excluded; full-text

	ABO Objective Grading System. STATE UNIVERSITY OF NEW YORK AT BUFFALO, 2009, 50 pages; 1461733.	unobtainable
185	Palmer M. Variables affecting treatment outcomes in a 30-month post-graduate orthodontic residency. 2012, Thesis, Nova Southeastern University.	Excluded; full-text unobtainable
186	Rangwala T. Treatment outcome assessment of SureSmile compared to conventional orthodontic treatment using the American Board of Orthodontics Grading System. 2012 - Thesis at Albert Einstein College of	Excluded; full-text unobtainable
187	Song GY, Jiang RP, Zhang XY, Liu SQ, Yu XN, Chen Q, et al. [Validation of subjective and objective evaluation methods for orthodontic treatment outcome]. Beijing da xue xue bao Yi xue ban = Journal of Peking University Health sciences. 2015;47(1):90-7. Epub 2015/02/17.	Excluded; full-text unobtainable
188	Yang-Powers LC. Treatment outcome in a university graduate orthodontic clinic using the ABO grading system [dissertation]. Chicago: University of Illinois at Chicago; 2001.	Excluded; full-text unobtainable
189	Yilmaz RBN, Nalbantgil D, Ozdemir F. The Effect of Awareness of American Board of Orthodontics Criteria on Treatment Outcomes in a Postgraduate Dental Clinic. J Dent Educ. 2016;80(9):1091-7.	Excluded; full-text unobtainable
190	Murakami K, Deguchi T, Hashimoto T, Imai M, Miyawaki S, Takano-Yamamoto T. Need for training sessions for orthodontists in the use of the American Board of Orthodontics objective grading system. Am J Orthod Dentofac Orthop 2007;132(4):427 e1-6. Epub 2007/10/09.	Excluded; not a clinical study
191	Bergersen EO. A cephalometric study of the clinical use of the mandibular labial bumper. American journal of orthodontics. 1972;61(6):578-602.	Excluded; ABO OGS not used
192	Sachdeva RC, Aranha SL, Egan ME, Gross HT, Sachdeva NS, Currier GF, Kadioglu O. Treatment time: SureSmile vs conventional. Orthodontics (Chic.). 2012;13(1):72-85.	Excluded; ABO OGS not used
193	Silva LNBC. Estudo comparativo do tempo de tratamento em pacientes com e sem apinhamento nos casos de má oclusão de Classe II tratados com extrações de quatro pré-molares. Thesis, Faculdade de Odontologia de Bauru, 2013	Excluded; ABO OGS not used
194	Vasilakou ND. Quantitative assessment of the effectiveness of phase 1 orthodontic treatment utilizing the ABO discrepancy index. Saint Louis University , Thesis, 2014.	Excluded; ABO OGS not used
195	Abel Y, Nelson S, Amberman BD, Hans MG. Comparing orthodontic treatment outcome between orthodontists and general dentists with the ABO index. Am J Orthod Dentofac Orthop 2004;126(5):544-8. Epub 2004/11/03.	Excluded; not all ABO OGS items scored
196	Bauss O, Kiliaridis S. Evaluation of tooth position, occlusion, and interproximal contacts after transplantation of immature third molars. European journal of orthodontics. 2009;31(2):121-8. Epub 2008/12/09.	Excluded; not all ABO OGS items scored
197	Buschang PH, Ross M, Shaw SG, Crosby D, Campbell PM. Predicted and actual end-of-treatment occlusion produced with aligner therapy. Angle Orthodontist. 2015;85(5):723-7.	Excluded; not all ABO OGS items scored
198	Cameron DL. The relationship between American Board of Orthodontics pretreatment dental cast Discrepancy Index scores and posttreatment dental cast Objective Grading System scores. Thesis, Saint Louis, 2010.	Excluded; not all ABO OGS items scored
199	Chaison ET, Liu X, Tuncay OC. The quality of treatment in the adult orthodontic patient as judged by orthodontists and measured by the Objective Grading System. Am J Orthod Dentofac Orthop 2011;139(4 Suppl):S69-75. Epub 2011/04/01.	Excluded; not all ABO OGS items scored
200	Cook DR, Harris EF, Vaden JL. Comparison of university and private-practice orthodontic treatment outcomes with the American Board of Orthodontics objective grading system. Am J Orthod Dentofac Orthop 2005;127(6):707-12.	Excluded; not all ABO OGS items scored
201	Costalos PA, Sarraf K, Cangialosi TJ, Efstratiadis S. Evaluation of the accuracy of digital model analysis for the American Board of Orthodontics objective grading system for dental casts. Am J Orthod Dentofac Orthop 2005;128(5):624-9.	Excluded; not all ABO OGS items scored
202	Fabels LN, Nijkamp PG. Interexaminer and intraexaminer reliabilities of 3-dimensional orthodontic digital setups. Am J Orthod Dentofac Orthop 2014;146(6):806-11. Epub 2014/11/30.	Excluded; not all ABO OGS items scored
203	Fleming J. An analysis of variability in Class I non-extraction treatment outcomes in a resident clinic using the American Board of Orthodontics Objective Grading System. Masters Thesis. Saint Louis: Saint Louis University; 2006.	Excluded; not all ABO OGS items scored
204	Greco PM, English JD, Briss BS, Jamieson SA, Kastrop MC, Castelein PT, et al. Posttreatment tooth movement: for better or for worse. Am J Orthod Dentofac Orthop 2010;138(5):552-8. Epub 2010/11/09.	Excluded; not all ABO OGS items scored
205	Hildebrand JC, Palomo JM, Palomo L, Sivik M, Hans M. Evaluation of a software program for applying the American Board of Orthodontics objective grading system to digital casts. Am J Orthod Dentofac Orthop 2008;133(2):283-9. Epub 2008/02/06.	Excluded; not all ABO OGS items scored
206	Im J, Cha JY, Lee KJ, Yu HS, Hwang CJ. Comparison of virtual and manual tooth setups with digital and plaster models in extraction cases. Am J Orthod Dentofac Orthop 2014;145(4):434-42. Epub 2014/04/08.	Excluded; not all ABO OGS items scored
207	Lassaire J, Costi A, Charpentier E, Castro M. Post-orthodontic intra- and interarch changes at 1 year: a retrospective study assessing the impact of anterior fixed retention. International orthodontics . 2012;10(2):165-76.	Excluded; not all ABO OGS items scored
208	Lee SM, Lee JW. Computerized occlusal analysis: correlation with occlusal indexes to assess the outcome of orthodontic treatment or the severity of malocclusion. Korean J Orthod. 2016;46(1):27-35.	Excluded; not all ABO OGS items scored
209	Lieber WS, Carlson SK, Baumrind S, Poulton DR. Clinical use of the ABO-Scoring Index: reliability and subtraction frequency. The Angle orthodontist. 2003;73(5):556-64. Epub 2003/10/29.	Excluded; not all ABO OGS items scored
210	Ling KK, Ho CT, Kravchuk O, Olive RJ. Comparison of surgical and non-surgical methods of treating palatally impacted canines. II. Aesthetic outcomes. Australian orthodontic journal. 2007;23(1):8-15. Epub 2007/08/08.	Excluded; not all ABO OGS items scored
211	Lyotard N, Hans M, Nelson S, Valiathan M. Short-term postorthodontic changes in the absence of retention. The Angle orthodontist. 2010;80(6):1045-50. Epub 2010/08/04.	Excluded; not all ABO OGS items scored
212	Nett BC, Huang GJ. Long-term posttreatment changes measured by the American Board of Orthodontics objective grading system. Am J Orthod Dentofac Orthop 2005;127(4):444-50; quiz 516. Epub 2005/04/12.	Excluded; not all ABO OGS items scored
213	Okunami TR, Kusnoto B, BeGole E, Evans CA, Sadowsky C, Fadavi S. Assessing the American Board of Orthodontics objective grading system: digital vs plaster dental casts. Am J Orthod Dentofac Orthop 2007;131(1):51-6. Epub 2007/01/09.	Excluded; not all ABO OGS items scored
214	Onyeaso CO, BeGole EA. Associations between pretreatment age and treatment time with orthodontic treatment outcome: a comparison by means of two orthodontic indices. Hell Orthod Rev. 2008;1:8-20.	Excluded; not all ABO OGS items scored
215	Onyeaso CO, Begole EA. Relationship between index of complexity, outcome and need, dental aesthetic index, peer assessment rating index, and American Board of Orthodontics objective grading system. Am J Orthod Dentofac Orthop 2007;131(2):248-52. Epub 2007/02/06.	Excluded; not all ABO OGS items scored
216	Ormiston JP, Huang GJ, Little RM, Decker JD, Seuk GD. Retrospective analysis of long-term stable and unstable orthodontic treatment outcomes. Am J Orthod Dentofac Orthop 2005;128(5):568-74; quiz 669. Epub 2005/11/16.	Excluded; not all ABO OGS items scored
217	Saxe AK, Louie LJ, Mah J. Efficiency and effectiveness of SureSmile. World journal of orthodontics. 2010;11(1):16-22.	Excluded; not all ABO OGS items scored

218	Son WS, Cha KS, Chung DH, Kim TW. Quantitative evaluation and affecting factors of post-treatment relapse tendency. Korean J Orthod. 2011;41(3):154-63.	Excluded; not all ABO OGS items scored
219	Song GY, Baumrind S, Zhao ZH, Ding Y, Bai YX, Wang L, et al. Validation of the American Board of Orthodontics Objective Grading System for assessing the treatment outcomes of Chinese patients. Am J Orthod Dentofac Orthop 2013;144(3):391-7.	Excluded; not all ABO OGS items scored
220	Stock GJ, McNamara JA, Jr., Baccetti T. Efficacy of 2 finishing protocols in the quality of orthodontic treatment outcome. Am J Orthod Dentofac Orthop 2011;140(5):688-95. Epub 2011/11/05.	Excluded; not all ABO OGS items scored
221	Struble BH, Huang GJ. Comparison of prospectively and retrospectively selected American Board of Orthodontics cases. Am J Orthod Dentofac Orthop 2010;137(1):6 e1-8; discussion 6-8. Epub 2010/02/04.	Excluded; not all ABO OGS items scored
222	Vincent S. Evaluation of Invisalign treatment utilizing the American Board of Orthodontics Objective Grading System for dental casts. Oregon Health & Science University, Thesis, 2014.	Excluded; not all ABO OGS items scored
223	Wes Fleming J, Buschang PH, Kim KB, Oliver DR. Posttreatment occlusal variability among angle Class I nonextraction patients. The Angle orthodontist. 2008;78(4):625-30. Epub 2008/02/28.	Excluded; not all ABO OGS items scored
Included		
224	Akinci Cansunar H, Uysal T. Comparison of orthodontic treatment outcomes in nonextraction, 2 maxillary premolar extraction, and 4 premolar extraction protocols with the American Board of Orthodontics objective grading system. Am J Orthod Dentofac Orthop 2014;145(5):595-602. Epub 2014/05/03.	Included
225	Alford TJ, Roberts WE, Hartsfield JK, Eckert GJ, Snyder RJ. Clinical outcomes for patients finished with the SureSmile (TM) method compared with conventional fixed orthodontic therapy. Angle Orthodontist. 2011;81(3):383-8.	Included
226	Anthopoulou C, Konstantonis D, Makou M. Treatment outcomes after extraction and nonextraction treatment evaluated with the American Board of Orthodontics objective grading system. Am J Orthod Dentofac Orthop 2014;146(6):717-23.	Included
227	Aszkler RM, Preston CB, Saltaji H, Tabbaa S. Long-term occlusal changes assessed by the American Board of Orthodontics' model grading system. Am J Orthod Dentofac Orthop 2014;145(2):173-8. Epub 2014/02/04.	Included
228	Barbosa Lis DM, Zapata Noreña O, Carvajal A, Franco CM, Rodriguez Aguirre SA, Florez Pino AA, et al. Resultado de Tratamientos Ortodóncicos y su Relación con la Complejidad de la Maloclusión. Int j odontostomatol (Print). 2014;8(2):201-6.	Included
229	Brown MW, Koroluk L, Ko CC, Zhang K, Chen M, Nguyen T. Effectiveness and efficiency of a CAD/CAM orthodontic bracket system. Am J Orthod Dentofac Orthop 2015;148(6):1067-74. Epub 2015/12/18.	Included
230	Brown PN, Kulbersh R, Kaczynski R. Clinical outcomes assessment of consecutively finished patients in a 24-month orthodontic residency: a 5-year perspective. Am J Orthod Dentofac Orthop 2011;139(5):665-8. Epub 2011/05/04.	Included
231	Campbell CL, Roberts WE, Hartsfield JK, Jr., Qi R. Treatment outcomes in a graduate orthodontic clinic for cases defined by the American Board of Orthodontics malocclusion categories. Am J Orthod Dentofac Orthop 2007;132(6):822-9.	Included
232	Cansunar HA, Uysal T. Outcomes of different Class II treatments Comparisons using the American Board of Orthodontics Model Grading System. J Orofac Orthop. 2016;77(4):233-41.	Included
233	Cansunar HA, Uysal T. Relationship between pretreatment case complexity and orthodontic clinical outcomes determined by the American Board of Orthodontics criteria. The Angle orthodontist. 2014;84(6):974-9. Epub 2014/04/04.	Included
234	Carvajal-Flórez A, Barbosa-Lis DM, Zapata-Noreña OA, Marín-Velásquez JA, Afanador-Bayona SA. Orthodontic treatment outcomes obtained by application of a finishing protocol. Dental Press J Orthod. 2016;21(2):88-94.	Included
235	Chalabi O, Preston CB, Al-Jewair TS, Tabbaa S. A comparison of orthodontic treatment outcomes using the Objective Grading System (OGS) and the Peer Assessment Rating (PAR) index. Australian orthodontic journal. 2015;31(2):157-64.	Included
236	Deguchi T, Honjo T, Fukunaga T, Miyawaki S, Roberts WE, Takano-Yamamoto T. Clinical assessment of orthodontic outcomes with the peer assessment rating, discrepancy index, objective grading system, and comprehensive clinical assessment. Am J Orthod Dentofac Orthop 2005;127(4):434-43. Epub 2005/04/12.	Included
237	Deguchi T, Kurosaka H, Oikawa H, Kuroda S, Takahashi I, Yamashiro T, et al. Comparison of orthodontic treatment outcomes in adults with skeletal open bite between conventional edgewise treatment and implant-anchored orthodontics. Am J Orthod Dentofac Orthop 2011;139(4 Suppl):S60-8. Epub 2011/04/01.	Included
238	Deguchi T, Terao F, Aonuma T, Kataoka T, Sugawara Y, Yamashiro T, et al. Outcome assessment of lingual and labial appliances compared with cephalometric analysis, peer assessment rating, and objective grading system in Angle Class II extraction cases. Angle Orthodontist. 2015;85(3):400-7.	Included
239	Detterline DA, Isikbay SC, Brizendine EJ, Kula KS. Clinical outcomes of 0.018-inch and 0.022-inch bracket slot using the ABO objective grading system. The Angle orthodontist. 2010;80(3):528-32. Epub 2010/01/07.	Included
240	Djeu G, Shelton C, Maganzini A. Outcome assessment of Invisalign and traditional orthodontic treatment compared with the American Board of Orthodontics objective grading system. Am J Orthod Dentofac Orthop 2005;128(3):292-8.	Included
241	Farhadian N, Miresmaeili AF, Soltani MK. Comparison of extraction and non extraction orthodontic treatment using the objective grading system. Journal of Dentistry, Tehran University of Medical Sciences, Tehran, Iran (2005; Vol: 2, No.3)	Included
242	Ferguson DJ, Nazarov AD, Makki L, Wilcko MT, Wilcko WM. Posttreatment and retention outcomes with and without periodontally accelerated osteogenic orthodontics assessed using ABO objective grading system. APOS Trends Orthod 2016;6:194-9.	Included
243	Hoybjerg AJ, Currier GF, Kadioglu O. Evaluation of 3 retention protocols using the American Board of Orthodontics cast and radiograph evaluation. Am J Orthod Dentofac Orthop 2013;144(1):16-22. Epub 2013/07/03.	Included
244	Hsieh TJ, Pinskaya Y, Roberts WE. Assessment of orthodontic treatment outcomes: early treatment versus late treatment. The Angle orthodontist. 2005;75(2):162-70. Epub 2005/04/14.	Included
245	Jain M, Varghese J, Mascarenhas R, Mogra S, Shetty S, Dhakar N. Assessment of clinical outcomes of Roth and MBT bracket prescription using the American Board of Orthodontics Objective Grading System. Contemp Clin Dent. 2013 Jul;4(3):307-12.	Included
246	Junqueira CHZ. Influência de extrações de pré-molares na estética facial em longo prazo. 2012, Thesis, University of Sao Paulo.	Included
247	Knierim K, Roberts WE, Hartsfield J, Jr. Assessing treatment outcomes for a graduate orthodontics program: follow-up study for the classes of 2001-2003. Am J Orthod Dentofac Orthop 2006;130(5):648-55, 55 e1-3. Epub 2006/11/18.	Included
248	Kuncio D, Maganzini A, Shelton C, Freeman K. Invisalign and traditional orthodontic treatment postretention outcomes compared using the American Board of Orthodontics objective grading system. The Angle orthodontist. 2007;77(5):864-9.	Included
249	Li W, Wang S, Zhang Y. The effectiveness of the invisalign appliance in extraction cases using the the ABO model grading	Included

	system: A multicenter randomized controlled trial. <i>International J Clinical and Experimental Medicine</i> . 2015;8(5):8276-82.	
250	Marques LS, Freitas Junior N, Pereira LJ, Ramos-Jorge ML. Quality of orthodontic treatment performed by orthodontists and general dentists. <i>The Angle orthodontist</i> . 2012;82(1):102-6. Epub 2011/08/03.	Included
251	Mendes LM. Influência em longo prazo dos protocolos de tratamento da Classe II na atratividade do perfil. Thesis, 2012, University of Sao Paolo.	Included
252	Mislik B, Konstantonis D, Katsadouris A, Eliades T. University clinic and private practice treatment outcomes in Class I extraction and nonextraction patients: A comparative study with the American Board of Orthodontics Objective Grading System. <i>Am J Orthod Dentofac Orthop</i> 2016;149(2):253-8. Epub 2016/02/02.	Included
253	Park Y, Hartsfield JK, Katona TR, Eugene Roberts W. Tooth positioner effects on occlusal contacts and treatment outcomes. <i>The Angle orthodontist</i> . 2008;78(6):1050-6. Epub 2008/10/25.	Included
254	Pinskaya YB, Hsieh TJ, Roberts WE, Hartsfield JK. Comprehensive clinical evaluation as an outcome assessment for a graduate orthodontics program. <i>Am J Orthod Dentofac Orthop</i> 2004;126(5):533-43. Epub 2004/11/03.	Included
255	Pulfer RM, Drake CT, Maupome G, Eckert GJ, Roberts WE. The association of malocclusion complexity and orthodontic treatment outcomes. <i>The Angle orthodontist</i> . 2009;79(3):468-72. Epub 2009/05/06.	Included
256	Rodríguez JEB, León DMM, Vargas CAH. Evaluación de los tratamientos terminados en un posgrado de ortodoncia según los parámetros ABOs. <i>Revista Latinoamericana de Ortodoncia y Odontopediatría</i> 20xx;1-17	Included
257	Santiago JJ, Martinez CJ. Use of the Objective Grading System of the American Board of Orthodontics to evaluate treatment at the Orthodontic Graduate Program Clinic, University of Puerto Rico, 2007-2008. <i>Puerto Rico health sciences journal</i> . 2012;31(1):29-34. Epub 2012/03/22.	Included
258	Schabel BJ, McNamara JA, Baccetti T, Franchi L, Jamieson SA. The relationship between posttreatment smile esthetics and the ABO Objective Grading System. <i>The Angle orthodontist</i> . 2008;78(4):579-84. Epub 2008/02/28.	Included
259	Sohrabi K. Does initial malocclusion predict the outcome of orthodontic treatment? Thesis, University of Washington 2016.	Included
260	Soltani M, Saedi B, Mohammadi Z. Outcome of MBT and Standard Edgewise Techniques in Treating CI I Malocclusion. <i>AJDR</i> 2012; Vol.4, No.2:61-65.	Included
261	Viwattanatipa N, Buapuean W, Komoltri C. Relationship between Discrepancy Index and the Objective Grading System in Thai board of orthodontics Patients. <i>Orthodontic Waves</i> 2016; 75(3):54-63.	Included
262	Vu CQ, Roberts WE, Hartsfield JK, Jr., Ofner S. Treatment complexity index for assessing the relationship of treatment duration and outcomes in a graduate orthodontics clinic. <i>Am J Orthod Dentofac Orthop</i> 2008;133(1):9 e1-13.	Included
263	Yang-Powers LC, Sadowsky C, Rosenstein S, BeGole EA. Treatment outcome in a graduate orthodontic clinic using the American Board of Orthodontics grading system. <i>Am J Orthod Dentofac Orthop</i> 2002;122(5):451-5. Epub 2002/11/20.	Included

**Appendix D.** Downs and Black tool used for the risk of bias assessment of included cohort studies with guidance.

Category	Item	Guidance
Reporting	Are the characteristics of the study's patients clearly described?	Are the patients' age, gender, and malocclusion described?
	Are the interventions of interest clearly defined?	Are the appliances and the treatment approach (ex/non-ex) described to a minimum?
	Are the distributions of principal confounders in each group clearly described?	Are confounders (DI, Tx time) described in each group?
	Does the study provide estimates of the random variability in the data for the main outcomes?	Is the variability of the estimate given (SD, SE or 95% CI)?
External validity	Were the subjects asked to participate in the study representative of the entire population?	Are patients representative of the average orthodontic patient in terms of age (10-20 years) and sex (%male 30%-60%)
	Can we be confident that finishing quality not used as a patient selection criterion?	Patients must not be selected according to the treatment results.
	Were the staff, places, and facilities where the patients were treated, representative of what the majority of patients receive?	Patients should be treated by a skilled clinician (either orthodontist, last year postgraduate, or experienced clinician)
	Can we be confident that patients were treated?	In this case, treatment is fairly obvious to ascertain
Internal validity -bias	Was the study prospectively planned and conducted?	Prospective design
	Was an attempt made to blind those measuring the main outcome?	Was blinding implemented during model scoring with OGS?
	If any of the results of the study were based on "data dredging", was this made clear?	Are there more than 5 subgroups/comparisons?
	Were the main outcome measures used accurate (valid and reliable)?	For us, it is straightforward, as OGS is very valid.
Power	Did the study have sufficient power to accurately detect an existing effect?	Sample size for the study (cohort) or for each compared group (comparative cohort studies with at least two groups). Cut-offs used to give 0, 1, 2, 3, 4 or 5 points: 0-20, 20-40, 40-60, 60-80, 80-100, >100 patients.

DI, discrepancy index; Tx, treatment; SD, standard deviation; SE, standard error; CI, confidence interval; OGS, objective grading system.



Appendix E. Risk of bias assessment for the included studies.

		Junqueira 2012	Marques 2012	Li 2015*	Carvajal-Florez 2016	Barbosa Lis 2014	Rodriguez 2014	Anihopolou 2014	Jain 2013	Soltani 2012	Farhadian 2005	Deguchi 2011	Deguchi 2015	Viwattananitpa 2016	Akinci Cansunar 2014	Brown 2015	Kuncio 2007*	Djeu 2005*	Alford 2011*	Aszkler 2014	Chalabi 2015	Brown 2011	Yang-Powers 2002	Knierim 2006	Vu 2008	Detterline 2010	Park 2008	Pinskaya 2004	Campbell 2007	Deguchi 2005	Schabel 2008	Hoyberg 2013	Santiago 2012	Ferguson 2016*	Sohrabi 2016		
Reporting	Are the characteristics of the study's patients clearly described?																																				
	Are the interventions of interest clearly defined?																																				
	Are the distributions of principal confounders in each group clearly described?																																				
	Does the study provide estimates of the random variability in the data for the main outcomes?																																				
External validity	Were the subjects asked to participate in the study representative of the entire population?																																				
	Can we be confident that finishing quality not used as a patient selection criterion?																																				
	Were the staff, places, and facilities where the patients were treated, representative of what the majority of patients receive?																																				
	Can we be confident that patients were treated?																																				
Internal validity - bias	Was the study prospectively planned and conducted?																																				
	Was an attempt made to blind those measuring the main outcome?																																				
	If any of the results of the study were based on "data dredging", was this made clear?																																				
	Were the main outcome measures used accurate (valid and reliable)?																																				
Power	Did the study have sufficient power to accurately detect an existing effect?	3	3	3	1	1	1	2	2	3	3	1	2	5	5	4	0	2	3	1	2	5	5	5	5	5	5	5	5	5	5	2	4	3	1	5	
		not applicable																																			
		definitely yes																																			
		probably yes																																			
		probably no																																			
		definitely no																																			
		unclear																																			

Rationale for judging 'Power' domain: 0-20 patients, 0 points; 20-40 patients, 1 point; 40-60 patients, 2 points; 60-80 patients, 3 points; 80-100 patients, 4 points; 5 >100 patients, 5 points.

**Appendix F.** Assessment of study-level explorative factors assessed with random-effects meta-regression for the subgroup of studies that assessed 1-phase fixed appliance treatment,

Factor	ABO OGS score				Tx duration			
	Studies	Coefficient	95% CI	P	n	Coefficient	95%CI	P
Mean age (yrs)	10	-0.12	-0.93,0.70	0.751	8	0.59	-0.33,1.51	0.166
% male	9	-7.92	-46.60,30.75	0.643	7	-15.12	-48.04,17.80	0.291
% extraction rate* (per 10%)	12	-0.65	-1.42,0.13	<b>0.093</b>	8	-0.01	-0.12,0.10	0.861
Mean duration/ABO OGS score	8	0.13	-1.26,1.52	0.826	7	0.05	-0.86,0.96	0.885
Mean DI	8	-0.02	-0.25,0.20	0.798	4	1.22	-4.45,6.89	0.453

¥Sohradi et al 2016 assessed the ABO OGS scores after 1-/2-phase treatment, but measured treatment duration only for the 1-phase treatment and was excluded from the durations,

**Appendix G.** Results of the Egger's test for reporting bias for the primary and secondary outcome.

	ABO OGS score				Tx duration <sup>*</sup>			
	Studies	Coeff	95% CI	P	n	Coeff	95%CI	P
Overall	29	1.68	-2.87,6.24	0.455	<b>16</b>	<b>6.96</b>	<b>0.74,13.19</b>	<b>0.031</b>
For subgroup: only FA	15	4.17	-1.15,9.49	0.114	8	1.70	-14.86,18.26	0.810

<sup>\*</sup>Sohradi et al 2016 assessed the ABO OGS scores after 1-/2-phase treatment, but measured treatment duration only for the 1-phase treatment and was excluded from the durations,

## Appendix H. Meta-epidemiological assessment of matching within-studies.

