STUDY PROTOCOL

A protocol for a systematic review of clinical practice guidelines for recurrent miscarriage [version 1; peer review: 2 approved, 2 approved with reservations]

Marita Hennessy, Rebecca Dennehy, Sarah Meaney, Declan Devane, Keelin O'Donoghue

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Abstract

Recurrent miscarriage (RM) was recently re-defined by the European Society of Human Reproduction and Embryology (ESHRE) as the loss of two or more consecutive pregnancies. Before this, and indeed still in some countries, RM was defined as three or more consecutive pregnancy losses. While the incidence of RM depends on the definition employed and population studied, it is generally accepted to affect 1-6% of women of reproductive age. Clinical practice guidelines (CPGs) for RM have been published by some professional organisations. While there are CPGs on miscarriage in Ireland, there are none concerning RM specifically. The aim of this systematic review is to identify, appraise and describe published CPGs for the management, investigation and/or follow-up of RM within high-income countries. Electronic databases (MEDLINE (Ovid®; 1946), Embase® (Elsevier; 1980), CINAHL Complete (EBSCOhost; 1994), Web of Science™ (Thomson Reuters), Scopus (Elsevier; 2004), and Open Grey (INIST-CNRS; 2011)), selected guideline repositories, and the websites of professional societies will be searched to identify CPGs, published within the last 20 years, for potential inclusion. Two reviewers will review abstracts and full texts independently against the eligibility criteria. Characteristics and recommendations of included CPGs will be extracted by one reviewer and double-checked by another. Two reviewers will use the Appraisal of Guidelines for Research and Evaluation version 2 (AGREE II) instrument independently to assess the quality of the included CPGs. Narrative synthesis will be conducted to appraise and compare CPGs and their
recommendations or guidance therein. The identification, appraisal and description of published CPGs in other high-income countries will be a valuable first step in informing efforts to promote the optimisation and standardisation of RM care.

**Keywords**
recurrent miscarriage, miscarriage, early pregnancy loss, systematic review, clinical guidelines, antenatal, care quality

This article is included in the **Maternal and Child Health** collection.
Abbreviations
AGREE, Appraisal of Guidelines for Research and Evaluation; CPG, Clinical Practice Guideline; ESHRE, European Society of Human Reproduction and Embryology; NCEC, National Clinical Effectiveness Committee; PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses; PROSPERO, International Prospective Register of Systematic Reviews; RM, Recurrent Miscarriage; SIGN, Scottish Intercollegiate Guidelines Network; WHO, World Health Organisation

Introduction
Recurrent miscarriage (RM) was recently re-defined by the European Society of Human Reproduction and Embryology (ESHRE) as the loss of two or more consecutive pregnancies1. Before this, it was defined as three or more consecutive pregnancy losses, and this definition is still in use in some countries, including the UK2. While the incidence of RM depends on the definition employed and population studied, it is generally accepted to affect 1–6% of the reproductive age population3. Given that 6% of women experience two or more consecutive miscarriages, more women will be accessing services for investigation and management as the new definition of RM is adopted internationally4.

There is a need for consistent clinical care of RM that follows the best evidence-based practice. Previous reproductive history is an independent predictor of future pregnancy outcome. The risk of a further miscarriage increases after each successive pregnancy loss, reaching approximately 40% after three consecutive pregnancy losses, and the prognosis worsens with increasing maternal age5. A previous live birth does not prevent a woman experiencing RM6. There are a few common established biological causes of miscarriage7, along with some more recent proposed aetiologies8, which are still controversial. However, a high proportion, even when recurrent, are classified as unexplained. Despite this, the standard investigations for RM continue to be important in evaluating potential factors responsible for pregnancy loss6, and similar procedures are included in all international clinical practice guidelines (CPGs)9,10. While some evidence-based treatments have improved the outcomes for couples with RM, almost half of cases remain unexplained and are empirically treated6. While future pregnancy may be difficult, the likelihood of subsequent live birth is approximately 70–75%.5,10. The psychological impact of RM can be both severe and protracted, and studies indicate that it can negatively affect both men’s and women’s psychological well-being in the medium- to long-term11. Studies have indicated that 32% of women with RM could be classified as depressed, against which having a living child was not a protective buffer12. Thus, given its high frequency, RM can significantly contribute to the overall burden of psychopathology within a population, and recognition of this impact is important, so that affected individuals may be cared for appropriately13–15.

CPGs are “statements that include recommendations intended to optimise patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options”16. CPGs for the management, investigation, and/or follow-up of those who experience RM have been issued by professional societies such as ESHRE17, the American College of Obstetricians and Gynaecologists18, and the Royal College of Obstetricians and Gynaecologists19; however, the existence of guidelines in other high-income countries is unknown to the study team. While there are CPGs on miscarriage in Ireland20,21, there are none concerning RM specifically. The identification, appraisal and description of published CPGs in other high-income countries would be a valuable first step in informing efforts to promote the optimise and standardise RM care.

Aim of this review
The aim of this systematic review is to identify, appraise and describe published CPGs for the management, investigation and/or follow-up of RM within high-income countries.

Objectives
• To identify published CPGs for the management, investigation and/or follow-up of RM within high-income countries;
• To appraise the quality of included CPGs using the Appraisal of Guidelines for Research and Evaluation version 2 (AGREE II) instrument;
• To describe recommendations from the included CPGs concerning first trimester RM.

Protocol
Details of the review have been submitted for registration to the PROSPERO database (ID: 173881). Any protocol amendments will be noted on PROSPERO and in any publications arising from the study. This protocol follows the PRISMA-P guidelines for the reporting of systematic review protocols22; the completed checklist is available as Extended Data23. Methodological guidance on conducting systematic reviews of CPGs was also followed in the preparation of this protocol, as such reviews require tailored approaches to, and greater subjectivity in, design and execution compared with other systematic reviews24.

Eligibility criteria
The “PICAR” framework was used to guide review inclusion and exclusion criteria (Table 1). For the purpose of this review, CPGs are defined as “systematically developed statements to assist practitioners about appropriate health care for specific clinical circumstances”; an adaptation of the definitions used by National Clinical Effectiveness Committee (NCEC)25 and Scottish Intercollegiate Guidelines Network (SIGN)26.

Information sources
While many CPGs are published in journals and can be identified through systematic bibliographic database searching, others may only be published in non-commercial or proprietary formats and are accessible only through extensive searches of grey (unpublished) literature sources or posted by professional
<table>
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<th>Table 1. PICAR statement.</th>
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<tr>
<td><strong>PICAR framework</strong></td>
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<td>Population, clinical indication(s), and condition(s)</td>
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<td>Interventions</td>
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<td>Comparator(s), Comparison(s), and (key) Content</td>
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<td>Attributes of eligible CPGs</td>
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medical associations on their websites behind membership paywalls. We will therefore use a range of information sources to locate CPGs concerning RM.

A systematic literature search, covering CPGs published from 2000 to present, will be performed using the following databases: MEDLINE (Ovid®, 1946), Embase® (Elsevier; 1980), CINAHL Complete (EBSCOhost; 1994), Web of Science™ (Thomson Reuters), Scopus (Elsevier; 2004), and Open Grey (INIST-CNRS; 2011). Guideline repositories (Table 2) and the websites of professional organizations/associations from around the world (Table 3) will also be searched.

Search strategy
This search strategy was developed with the assistance of a specialist librarian. Key word searches, using combinations of key words and Medical Subject Headings (or equivalent), will be used across two concepts using the AND Boolean operator: 1) clinical guidelines; 2) recurrent miscarriage (Table 4). Within each of the categories, keywords will be combined using the “OR” Boolean operators. The search strategy will be developed in Medline (see Extended Data for sample search strategy) and tailored for use within the other databases, and piloted, before final searches are run.

Study records
Data management. Records will be imported into EndNote X9 and de-duplicated using the ‘remove duplicates’ function, as well as manually screening results for accuracy.

Selection process. Two independent reviewers (MH and RD) will screen titles and abstracts of retrieved records against the

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Table 2. Information sources: Guideline repositories.

<table>
<thead>
<tr>
<th>Guideline repositories</th>
<th>Website</th>
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<tbody>
<tr>
<td>Canadian Agency for Drugs and Technology in Health (CADTH)</td>
<td><a href="http://www.cadth.ca">www.cadth.ca</a></td>
</tr>
<tr>
<td>Guidelines International Network (GIN)</td>
<td><a href="http://www.g-i-n.net/library/international-guidelines-library">http://www.g-i-n.net/library/international-guidelines-library</a></td>
</tr>
<tr>
<td>Institute for Clinical Systems Improvement (ICSI)</td>
<td><a href="http://www.icsi.org/guidelines">www.icsi.org/guidelines</a></td>
</tr>
<tr>
<td>Lenus: The Irish Health Repository</td>
<td><a href="https://www.lenus.ie/hse/">https://www.lenus.ie/hse/</a></td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence (NICE)</td>
<td><a href="http://www.nice.org.uk">www.nice.org.uk</a></td>
</tr>
<tr>
<td>Scottish Intercollegiate Guidelines Network (SIGN)</td>
<td><a href="http://www.sign.ac.uk/index.html">http://www.sign.ac.uk/index.html</a></td>
</tr>
<tr>
<td>TRIP database</td>
<td><a href="https://www.tripdatabase.com">https://www.tripdatabase.com</a></td>
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</tbody>
</table>

Table 3. Information sources: Professional bodies/organisations.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Country/Region</th>
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<tbody>
<tr>
<td>Royal College of Physicians of Ireland Institute of Obstetricians and Gynaecologists</td>
<td>Ireland</td>
</tr>
<tr>
<td>Royal College of Obstetricians and Gynaecologists (RCOG)</td>
<td>UK</td>
</tr>
<tr>
<td>European Society of Human Reproduction and Embryology (ESHRE)</td>
<td>Europe</td>
</tr>
<tr>
<td>The International Federation of Gynaecology and Obstetrics (FIGO)</td>
<td>International</td>
</tr>
<tr>
<td>The American College of Obstetricians and Gynaecologists (ACOG)</td>
<td>US</td>
</tr>
<tr>
<td>The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)</td>
<td>Australia &amp; New Zealand</td>
</tr>
<tr>
<td>American Society for Reproductive Medicine (ASRM)</td>
<td>US</td>
</tr>
<tr>
<td>Society for Maternal-Fetal Medicine (SMFM)</td>
<td>International</td>
</tr>
<tr>
<td>Society of Obstetricians and Gynaecologists of Canada (SOGC)</td>
<td>Canada</td>
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</table>

Table 4. Search terms.

<table>
<thead>
<tr>
<th>Concept</th>
<th>Search terms</th>
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<tbody>
<tr>
<td>1: Clinical guidelines</td>
<td>guideline* OR standard* OR best practice* OR guidance</td>
</tr>
<tr>
<td>2: Recurrent miscarriage</td>
<td>Miscarriage* OR pregnancy loss* OR spontaneous abortion* OR recurrent fetal loss* OR recurrent foetal loss*</td>
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</table>
inclusion criteria. Records not meeting the eligibility criteria will be excluded. Two reviewers (MH and RD) will subsequently, and independently, screen the full text articles of records identified to identify studies to be included. Any disagreements in eligibility assessments will be discussed and resolved via consensus. If consensus on eligibility cannot be agreed between the two reviewers, a third reviewer (KOD) will review the particular record(s) in order to determine its eligibility of the CPG.

A Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) flow diagram will show the overall process of CPG selection and summarise the inclusion and exclusion of records/CPGs at each stage of the review.

**Data collection process.** Once the final set of included CPGs has been obtained, all documents related to the CPGs (cited as supplemental documents, summaries of recommendations, and others) will be retrieved by MH before data extraction or quality assessment is undertaken. If links to these documents are not included in the included CPG, MH will conduct searches to locate them. For CPGs published only in summary or where important information is missing, we will try to find complete information by contacting the authors. All documents collected will be verified independently by RD to confirm completeness and to ensure that companion documents are matched appropriately. MH will also conduct searches to ensure that the latest version of each included CPG has been included, and none is present in duplicate.

**Data items**

Key features of CPGs and recommendations, for all included CPGs, will be extracted using a structured data extraction form in Microsoft Excel (Microsoft Corporation, Redmond, WA) (see template in Extended Data[23]), which will be piloted in advance.

Key features of CPGs to be extracted, include:
- Title
- Year of publication
- Language
- Developing/publishing organisation and/or authors
- Country/countries of publication
- How described by the authors (e.g. guideline / standard)
- Version
- Type of CPG (formulated, adapted, updated or revised)
- Topic addressed (i.e. RM or broader)
- Development process (evidence- and/or expert consensus-based)
- Composition of guideline development group
- Peer-review conducted, or not
- Target users
- Definition of RM employed – to include number of miscarriages, whether consecutive/not, number of weeks gestation
- System of rating evidence/Quality instrument used during CPG development (GRADE, Oxford, not mentioned, or other), if any – some developers do not include levels of evidence with their recommendations[29]
- All recommendations related to first trimester RM within the CPG.

Data will be extracted by one reviewer (MH) and independently verified for accuracy and completeness by a second reviewer (SM), with discrepancies resolved through consensus. If agreement cannot be reached, a third reviewer (KOD) will review and make a final decision. If a member of the review team has been involved in the development of any of the CPGs eligible for the review, an independent reviewer will extract the required data from the study.

**Outcomes and prioritisation**

Not applicable.

**Risk of bias in individual studies/quality assessment**

The quality of included CPGs will be assessed using the Appraisal of Guidelines, Research and Evaluation version 2 (AGREE II) criteria[34]. The criteria encompass 23 items, over six domains, rated on a 7-point Likert scale: (i) Scope and purpose of the guideline; (ii) Stakeholder involvement in the development of the guidelines; (iii) Rigour of development and formulation of the recommendations within the guideline; (iv) Clarity of presentation of the guideline; (v) Applicability of the guideline; (vi) editorial independence in the formulation of recommendations within the guideline. As part of the overall assessment, two global ratings are included: (i) a rating on the overall quality of the guideline, and (ii) whether the guideline would be recommended for use in practice. AGREE II is an accepted and validated tool for assessing the methodological quality of CPGs[35]. It has limitations, however; for example, it does not assess the implementation of the guideline[36].

Two reviewers with methodological and clinical expertise (MH/SM and KOD) will conduct an independent quality assessment of the CPGs. Domain scores will be calculated by summing up all the scores of the individual items in a domain and by scaling the total as a percentage of the maximum possible score for that domain, as per the AGREE II User Manual. The six domains are independent, and the scores will be calculated as the sum of the individual items in each domain.

To make the scores more relevant to readers and enable fair comparison, our review will report the AGREE II outcomes categorically rather than statistically, using the 5-point Likert scale described by other reviews[36,37]: excellent (>80%), good (>60%–80%), average (>40%–60%), fair (>20%–40%) and poor (≤20%).
Data synthesis
A narrative synthesis approach will be used to describe and appraise CPGs and their recommendations or guidance therein, taking account of quality appraisal (using the AGREE II tool), and recency of publication. The levels of evidence associated with the recommendations within each CPG will be reported, and quality assessment rating system used; we will not attempt to standardise evidence ratings across CPGs.

Dissemination
The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist will be used to report findings of the review, as there is currently no specific checklist for systematic reviews of CPGs. We will share the findings in a peer-reviewed journal, through communications with professional bodies and policymakers (through briefings), and participation in scientific meetings and national and international conferences.

Patient and public involvement (PPI)
This systematic review protocol was developed in conjunction with a Pregnancy Loss Patient Representative and through consultations with Specialist Bereavement and Loss Midwives. A PPI group is currently being established and will have input into discussions and decisions concerning the conduct, findings and outputs of this review.

Study status
Database searches have been completed.

Conclusions/discussion
CPGs for RM have been published by some professional organisations. In Ireland, there is currently no national standard for the management, investigation or follow-up of those who experience RM. The aim of this systematic review is to identify, appraise and describe published CPGs for the management, investigation and/or follow-up of RM within high-income countries. This will be a valuable first step in informing efforts to promote the optimisation and standardisation of the management, investigation and follow-up of RM.

Data availability
Underlying data
No data are associated with this article.

Extended data
Open Science Framework: A systematic review of clinical practice guidelines for recurrent miscarriage, [https://doi.org/10.17605/OSF.IO/X7Y4N](https://doi.org/10.17605/OSF.IO/X7Y4N)

This project contains the following extended data:
- Supplementary File 1. PRISMA-P checklist for the reporting of systematic review protocols
- Supplementary File 2. Sample search strategy
- Supplementary File 3. Data extraction form template

Data are available under the terms of the Creative Commons Zero “No rights reserved” data waiver (CC0 1.0 Public domain dedication).

Acknowledgments
We wish to thank Donna Ó Doibhilín, Medicine & Health Sciences Liaison Librarian at University College Cork for her assistance when developing the search strategy for this review.

References

15. Kolte AM, Olsen LR, Mikkelsen EM, et al.: Depression and emotional stress is...


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Matthew Coleman
University Hospital Southampton, University of Southampton, Southampton, UK

Sarah Bailey
University Hospital Southampton, University of Southampton, Southampton, UK

This peer review report was updated on 22nd September 2020 to incorporate further comments from the reviewers.

Matthew Coleman:
Summary
A few comments to help guide the authors. The vision is laudable however I am uncertain about the process especially in this highly emotive area.

Whilst the overall methods quote and follow national and international recommended methodology, the original challenge is made extremely complex by any number of human factors and biases. Current evidence is largely opinion based and confounded by bias and human factors. And given the distress caused by the disease these have sometimes been exaggerated. For example, the reasons behind the recent change in Rm definition, which might include as many as 6% of women, is complex and multi factorial and makes evaluating possible interventions difficult for the majority of women for whom the outlook is already consistent with women who have not experienced to consecutive miscarriages.

Understanding the psychology and reasons behind the recommendations would provide much more useful background for developing future guidelines which are rational fair and achievable.

Scope There appears to be some conflict in the defined scope of this review;
Scope:
○ Must have a primary/secondary focus on the investigation/treatment of RM.
○ Must be national/international in scope.
Covers any aspect of RM care and its organisation.

○ Must be clearly identified as a CPG.

○ Must be published.

Time span: given the rapid evolution of recommended managements in this particular area including recent and distant past guideline recommendations (as far back as 2000) any review is likely to produce significant inconsistencies related to change over time. Amalgamating them together will require some complexity to control for these changes, which are also destabilised by the paucity of data, bias and frequent personal opinion.

Sarah Bailey:
The objective of this protocol for a systematic review of clinical practice guidelines (CPG) is to identify, appraise and describe published CPGs of the management, investigation and follow-up of recurrent miscarriage (RM) within high-income countries. The aim being to take the timely and important first step to promote consistent and evidence based care for couples with RM in Ireland.

The protocol is well-written and easy to follow and the proposed methodology is, overall, clearly described using recognised frameworks and tools to assist.

Please see below comments;

Introduction:
○ In addition to highlighting that the definition of RM, with regards to number of miscarriages that constitute the term, varies from country to country, it would be useful to note at this point that actual term used to describe the condition can significantly vary between countries and CPGs – e.g. ESHRE uses term recurrent pregnancy loss (ESHRE 2017).

Protocol:
○ The PICAR statement provides a useful and thorough framework to guide the review of inclusion and exclusion criteria, as clearly demonstrated in Table 1.

○ Clarification is required of how the researchers plan to identify relevant ‘grey’ unpublished literature and I would advise the authors to make clear the exact range of information sources that will be utilised to locate CPGs concerning RM to allow a reproducible literature search. However, the PICAR statement in Table 1, also identifies that unpublished CPGs will be excluded. This is confusing given the plan to locate unpublished literature sources and this inconsistency should be addressed.

○ I was pleased to see the protocol was developed in conjunction with a Pregnancy Loss Patient Representative and encourage the prompt establishment of a PPI group to support this research.

Conclusion:
I assume the overall aim of the systematic review is to develop a CPG on RM to promote consistent and standardized care for couples with RM in Ireland, but the actual planned outcome is not clearly articulated and it would be useful to have clarification of this.

Is the rationale for, and objectives of, the study clearly described?
Yes

Is the study design appropriate for the research question?
Partly

Are sufficient details of the methods provided to allow replication by others?
Yes

Are the datasets clearly presented in a useable and accessible format?
Not applicable

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Obstetric medicine, haematology and pregnancy, diabetes pregnancy, hypertension pregnancy. Clinical Specialist in Recurrent Miscarriage.

We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however we have significant reservations, as outlined above.

Author Response 02 Oct 2020

Marita Hennessy, University College Cork, Cork, Ireland

Matthew Coleman

Comment 1:
A few comments to help guide the authors. The vision is laudable however I am uncertain about the process especially in this highly emotive area. Whilst the overall methods quote and follow national and international recommended methodology, the original challenge is made extremely complex by any number of human factors and biases. Current evidence is largely opinion based and confounded by bias and human factors. And given the distress caused by the disease these have sometimes been exaggerated. For example, the reasons behind the recent change in Rm definition, which might include as many as 6% of women, is complex and multi factorial and makes evaluating possible interventions difficult for the majority of women for whom the outlook is already consistent with women who have not experienced to consecutive miscarriages. Understanding the psychology and reasons behind the recommendations would provide much more useful background for developing future guidelines which are rational fair and achievable.

Response:
Thank you for taking the time to review and provide considered feedback on our protocol paper. We acknowledge the challenges in this area. As noted in the protocol, this study is a first step in informing efforts to promote the optimisation and standardisation of RM care. This review is being conducted as part of a larger project titled “REcurrent miscarriage: Evaluating CURRENT services (RE:CURRENT)” which is looking at service provision in Ireland. The findings from the systematic review will be used by the RE:CURRENT Team to inform this evaluation; however, we did not detail this within the protocol as the findings of this
systematic review will have relevance to the field in general, not just the RE:CURRENT Team. A national guideline is not a planned output of this project; however, evidence gathered during the project may aid future development of a national guideline.

Comment 2:
There appears to be some conflict in the defined scope of this review;
Scope:
  ○ *Must have a primary/secondary focus on the investigation/treatment of RM.*
  ○ Must be national/international in scope.
  ○ *Covers any aspect of RM care and its organisation.*
  ○ Must be clearly identified as a CPG.
  ○ Must be published.

Time span; given the rapid evolution of recommended managements in this particular area including recent and distant past guideline recommendations (as far back as 2000) any review is likely to produce significant inconsistencies related to change over time. Amalgamating them together will require some complexity to control for these changes, which are also destabilised by the paucity of data, bias and frequent personal opinion.

Response:
Thank you for raising these important points. CPGs which focus specifically on RM, or address any aspect of RM care within a broader/different topic area (e.g. CPGs on pregnancy loss, or thrombophilia, which may have a section on RM), are eligible for inclusion.

While we are including CPGs published from 2000 onwards, we also state that CPGs must be ‘latest version only’ and note in the data collection process section that MH will conduct searches to ensure that the latest (i.e. current and valid) version of each included CPG has been included. We also state that when describing and appraising CPGs and recommendations therein in our narrative synthesis, we will take account of quality appraisal scores (as per the six domains within the AGREEII tool, including rigour of development and formulation of recommendations) and recency of publication. We will also extract systems of rating evidence used by CPGs and present these along with the recommendations.

*Sarah Bailey*

**General comment**
The objective of this protocol for a systematic review of clinical practice guidelines (CPG) is to identify, appraise and describe published CPGs of the management, investigation and follow-up of recurrent miscarriage (RM) within high-income countries. The aim being to take the timely and important first step to promote consistent and evidence based care for couples with RM in Ireland.

The protocol is well-written and easy to follow and the proposed methodology is, overall, clearly described using recognised frameworks and tools to assist. Please see below comments.

*General response*
Thank you for taking the time to review and provide considered feedback on our protocol paper.

Comment 1:
Introduction: In addition to highlighting that the definition of RM, with regards to number of miscarriages that constitute the term, varies from country to country, it would be useful to note at this point that actual term used to describe the condition can significantly vary between countries and CPGs – e.g. ESHRE uses term recurrent pregnancy loss (ESHRE 2017).

Response:
Thank you; we have added the following to the introduction: “The actual term used to describe the condition can also vary between countries and/or professional bodies; for example, ESHRE uses term ‘recurrent pregnancy loss’¹, while the Royal College of Obstetricians and Gynaecologists uses the term RM². “

Comment 2:
The PICAR statement provides a useful and thorough framework to guide the review of inclusion and exclusion criteria, as clearly demonstrated in Table 1.

Response:
Thank you; it was certainly helpful in thinking through the inclusion and exclusion criteria.

Comment 3:
Clarification is required of how the researchers plan to identify relevant ‘grey’ unpublished literature and I would advise the authors to make clear the exact range of information sources that will be utilised to locate CPGs concerning RM to allow a reproducible literature search. However, the PICAR statement in Table 1, also identifies that unpublished CPGs will be excluded. This is confusing given the plan to locate unpublished literature sources and this inconsistency should be addressed.

Response:
We have removed reference to “unpublished” after “grey” literature to avoid confusion between the search strategy and the PICAR statement. Grey literature will be used to identify CPGs that may be eligible for inclusion. We will use bibliographic databases (Web of Science, Scopus and Open Grey), as well as guideline repositories (detailed in Table 2) and the websites of professional bodies/organisations (detailed in Table 3), to identify grey literature including conference proceedings and/or technical reports. These, along with the other databases mentioned, comprise the full range of information sources used to locate CPGs. While search terms are presented in Table 4, the full search strategy will be published alongside the paper outlining the findings of this systematic review.

We have added the following sentence to the “information sources“ section to clarify what we mean by grey literature: “Searches of Web of Science, Scopus and Open Grey, as well as guideline repositories and the websites of professional bodies/organisations, will facilitate the identification of grey literature – such as conference proceedings and/or technical reports – which may contain information about potentially eligible CPGs.”

Comment 4:
I was pleased to see the protocol was developed in conjunction with a Pregnancy Loss Patient Representative and encourage the prompt establishment of a PPI group to support this research.
Response:
Thank you; this aspect of the work is incredibly important to us. We have since established our PPI group.

Comment 5:
Conclusion: I assume the overall aim of the systematic review is to develop a CPG on RM to promote consistent and standardized care for couples with RM in Ireland, but the actual planned outcome is not clearly articulated and it would be useful to have clarification of this.

Response:
As noted in the protocol, this study is a first step in informing efforts to promote the optimisation and standardisation of RM care. This review is being conducted as part of a larger project titled “REcurrent miscarriage: Evaluating CURRENT services (RE:CURRENT)” which is looking at service provision in Ireland. The findings from the systematic review will be used by the RE:CURRENT Team to inform this evaluation; however, we did not detail this within the protocol as the findings of this systematic review will have relevance to the field in general, not just the RE:CURRENT Team. A national guideline is not a planned output of this project; however, evidence gathered during the project may aid future development of a national guideline.

Competing Interests: No competing interests were disclosed.

Reviewer Report 15 September 2020
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Emma Rasmark Roepke
Department of Obstetrics and Gynecology, Institute of Clinical Sciences Lund, Skåne University Hospital, Lund University, Lund, Sweden

The aim of this systematic review protocol is to identify and describe published clinical practice guidelines for management, diagnostics and/or follow-up of women with RM. The authors will use an electronic database search to identify published guidelines in English within the last 20 years in high-income countries.

This study aims to assess a standardisation of RM care. Overall, the protocol is well described with an appropriate study design.

There are some concerns:
  ○ The PICAR states that only published guidelines will be included though "grey littleature" will also be serached for. Can the authors explaine this further?
Why is GRADE system not used instead of AGREE?

How will "low quality" guidelines be compared with “high quality”? How will different quality be implemented in the end result (a new guideline)?

What will the end results be from this expansive research? Is it a national guideline in Ireland?

Is the rationale for, and objectives of, the study clearly described?
Yes

Is the study design appropriate for the research question?
Partly

Are sufficient details of the methods provided to allow replication by others?
Yes

Are the datasets clearly presented in a useable and accessible format?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Recurrent pregnancy loss

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 02 Oct 2020

Marita Hennessy, University College Cork, Cork, Ireland

General comment:
The aim of this systematic review protocol is to identify and describe published clinical practice guidelines for management, diagnostics and/or follow-up of women with RM. The authors will use an electronic database search to identify published guidelines in English within the last 20 years in high-income countries. This study aims to assess a standardisation of RM care. Overall, the protocol is well described with an appropriate study design. There are some concerns.

Response:
Thank you for taking the time to review and provide considered feedback on our protocol paper.

Comment 1:
The PICAR states that only published guidelines will be included though "grey literature" will also be searched for. Can the authors explain this further?

Response:
We have removed reference to “unpublished” after “grey” literature to avoid confusion between the search strategy and the PICAR statement. Grey literature will be used to identify CPGs that may be eligible for inclusion. We will use bibliographic databases (Web of Science, Scopus and Open Grey), as well as guideline repositories (detailed in Table 2) and the websites of professional bodies/organisations (detailed in Table 3), to identify grey literature including conference proceedings and/or technical reports. These, along with the other databases mentioned, comprise the full range of information sources used to locate CPGs. While search terms are presented in Table 4, the full search strategy will be published alongside the paper outlining the findings of this systematic review.

We have added the following sentence to the “information sources” section to clarify what we mean by grey literature: “Searches of Web of Science, Scopus and Open Grey, as well as guideline repositories and the websites of professional bodies/organisations, will facilitate the identification of grey literature – such as conference proceedings and/or technical reports – which may contain information about potentially eligible CPGs.”

Comment 2:
Why is GRADE system not used instead of AGREE?
Response:
We are using AGREEII to assess the quality of included CPGs, across the six AGREEII domains. We are not using the GRADE system as we are not assessing the evidence behind the recommendations within each guideline. We are, however, extracting and noting the system of rating evidence used by each CPG. We note within the protocol that “The levels of evidence associated with the recommendations within each CPG will be reported, and quality assessment rating system used; we will not attempt to standardise evidence ratings across CPGs.”

Comment 3:
How will "low quality" guidelines be compared with "high quality"? How will different quality be implemented in the end result (a new guideline)?
Response:
We will report the AGREEII scores, by domain, for each CPG. In the narrative synthesis, we will describe CPGs, and recommendations therein, taking account of this quality appraisal. The aim of the review is to identify and appraise CPGs, and describe recommendations therein. We do not aim to develop a CPG from this work (see response 4 for further information).

Comment 4:
What will the end results be from this expansive research? Is it a national guideline in Ireland?
Response:
As noted in the protocol, this study is a first step in informing efforts to promote the optimisation and standardisation of RM care. This review is being conducted as part of a larger project titled “REcurrent miscarriage: Evaluating CURRENT services (RE:CURRENT)” which is looking at service provision in Ireland. The findings from the systematic review will be used by the RE:CURRENT Team to inform this evaluation; however, we did not detail this within the protocol as the findings of this systematic review will have relevance to the field in general, not just the RE:CURRENT Team. A national guideline is not a planned output of
This protocol outlines a systematic review of English language, high-income country CPGs for recurrent pregnancy loss in the first trimester. The intention is to identify and describe published CPGs in order to move towards standardization of management, investigation, and follow-up of RM. The strengths of this protocol include its registration with PROSPERO, utilization of a specialist librarian, and adherence to the PRISMA-P guidelines.

○ The "grey" literature is denoted as being "unpublished" in the protocol. However, in the PICAR statement, it states that unpublished material will be excluded. Please clarify this seeming inconsistency. Further detail on the "range of information sources" used to locate CPGs would improve reproducibility.

○ A lingering question is what the final product of this protocol will be. The aim is to identify, appraise, and describe CPGs with the intent of promoting standardization, but ultimately will this information be use to create a national CPG for Ireland? Or some other consensus statement? A clearer statement on its final uses would strengthen the rationale for this review further.

Is the rationale for, and objectives of, the study clearly described?
Yes

Is the study design appropriate for the research question?
Yes

Are sufficient details of the methods provided to allow replication by others?
Yes

Are the datasets clearly presented in a useable and accessible format?
Not applicable
**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Early pregnancy loss, miscarriage management

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

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Author Response 23 Sep 2020

**Marita Hennessy,** University College Cork, Cork, Ireland

Thank you for taking the time to review and provide feedback on our protocol paper.

**Comment 1:**
The "grey" literature is denoted as being "unpublished" in the protocol. However, in the PICAR statement, it states that unpublished material will be excluded. Please clarify this seeming inconsistency. Further detail on the "range of information sources" used to locate CPGs would improve reproducibility.

**Response:**
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**Comment 2:**
A lingering question is what the final product of this protocol will be. The aim is to identify, appraise, and describe CPGs with the intent of promoting standardisation, but ultimately will this information be used to create a national CPG for Ireland? Or some other consensus statement? A clearer statement on its final uses would strengthen the rationale for this review further.

**Response:**
As noted in the protocol, this study is a first step in informing efforts to promote the optimisation and standardisation of RM care. This review is being conducted as part of a larger project titled “REcurrent miscarriage: Evaluating CURRENT services (RE:CURRENT)” which is looking at service provision in Ireland. The findings from the systematic review will be used by the RE:CURRENT Team to inform this evaluation; however, we did not detail this within the protocol as the findings of this systematic review will have relevance to the field in general, not just the RE:CURRENT Team.
**Summary**

This systematic review identifies and describes published clinical practice guidelines for the management, diagnostics and/or follow-up of women with RM. This study focuses on high-income countries. Electronic databases, selected guideline repositories and the websites of professional societies will be searched to identify guidelines within the last 20 years.

This study is the first step for the optimisation and standardisation of RM care.

Overall, the protocol is clearly described. The aim of the study is clear with an appropriate study design.

The only thing what is unclear for me is how the researchers will search for the so-called grey literature. They state that 'We will therefore use a range of information sources to locate CPGs concerning RM.' What do they mean by that? How will they do that? This needs more clarification.

**Is the rationale for, and objectives of, the study clearly described?**

Yes

**Is the study design appropriate for the research question?**

Yes

**Are sufficient details of the methods provided to allow replication by others?**

Partly

**Are the datasets clearly presented in a useable and accessible format?**

Yes

**Competing Interests:** No competing interests were disclosed.
Reviewer Expertise: Early pregnancy.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Author Response 23 Sep 2020

Marita Hennessy, University College Cork, Cork, Ireland

Thank you for taking the time to review and provide feedback on our protocol paper.

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Competing Interests: No competing interests were disclosed.