Bibliographic reference [1]	Study type [2]	Number of patients [3]	Patient characteristics [4]	Intervention [5]	Comparison [6]	Length of follow-up [7]	Outcome measures [8]	Effect size [9]	Source of funding [10]	Additional comments [11]
Crawford T0, Mitchel G, Fishman LS, Snodgrass SR. Very-high-dose phenobarbital for refractory status epilepticus in children. Neurology. 1988;38:1035-1040	Retrospective review	50	Newborn to 13 yrs – therefore appropriate	Assessed all aspects of role of high dose Pb in Rx of status	Compared rapid IV bolus group to oral/ NG slow loading with Pb	Related to acute presentation i.e. whether the seizures were controlled	Control of seizures and side-effects	NA	none	Established that Pb could be tolerated at very high levels – found that side effects seemed more related to the underlying illness e.g. sepsis
Shanner DM, McCurdy SA, Herring MO, Gabor AJ. Treatment of status epilepticus. A prospective comparison study of diazepam and phenytoin versus phenobarbital and optional phenytoin. Neurology 1988;38:202-207	Prospective comparison, randomised	36	>15 yrs	Comparison of agents in the title	See title	Related to acute presentation i.e. whether the seizures were controlled	Control of seizures and side-effects	Study found that convulsive time was shorter for Pb group compared to DZ/PH group $p<0.06$ and also for response latency $p<0.10$	none	Although statistically couldn't proof superiority performed confidence intervals with better results and overall group convinced Pb better agent.
Trieman DM, Meyers PD, Walton NY et al. A comparison of four treatments for generalised convulsive status epilepsticus. N Eng J Med 1998;339:792-8	5 yr randomized, double-blind, multicentre trial	518	>18 yrs	Comparison of four Rx groups 1.diazepam/ Phenytoin 2.lorazepam 3phenobarb 4.phenytoin	Comparison as listed – blinded	30 days	Control of seizures, side-effects and optimal agent	Order of best outcome – groups 2, 3, 1 then 4 $p=0.02$	Veterans affairs status epilepticus cooperative study group	Concluded Lorazepam best with Pb after, both did far better than Ph alone

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Prasad A, Williamson JM, Bertram EH. Phenobarbital and MK-801, but Not Phenytoin, Improve the long-term outcome of status epilepticus. Ann Neurol 2002;51:175-181	Prospective study on rats	112	rats	Comparison of response to Rx for 3 group of rats in status (see title)	Measures short term behavioural outcome, short-term EEG outcome, long term outcome of SE of therapy, mortality	Long term for rats	Clinical sz control and overall outcome	Concluded Pb and MK-801 best. P<0.001	Work supported by National Institutes of Health (NS 25605 and NS 16102)	Concluded that high dose phenytoin could result in sz exacerbation. Authors felt changes could be extrapolated to humans
Handforth A, Trieman DM. A new, non-pharmacological model of convulsive status epilepticus induced by electrical stimulation: behavioural/electro encephalographic observations and response to phenytoin and Phenobarbital. Epilepsy Res 1994;19:15-25	Another prospective rat experiment	30	rats	Electically induced status in rats	Monitored pattern of seizures and response to either phenytoin or phenobarbital	Immediate outcome. Pm on cases which died	Sz control. Mortality	Concluded phenobarbital far more effective than phenytoin	NA	Felt data could be extrapolated to humans

[1] *Bibliographic reference*: author, title, journal, volume, year, pages.
[2] *Study type*: observational, cohort, case studies, etc.
[3] *Number of patients*: total number of patients included in the study, including number of patients in each arm; with inclusion/exclusion criteria, number of patients who started and completed.
[4] *Patient characteristics:* relevant characteristics to the area of interest: age, sex, ethnic origin, comorbidity, disease status, Community/hospital based
[5] *Intervention*: intervention (treatment, procedure) studied. If important for the study, specify length of treatment. *Note: for diagnostic studies the intervention is the diagnostic test studied.*
[6] *Comparison*: placebo, alternative treatment. *Note: for diagnostic studies comparison of the test is with another test*.
[7] *Length of follow-up*: the length of time patients take part in the study, from first staging treatment until either a pre-specified end-point (for example, death, specified length of disease-free remission) or the end of the data-gathering phase is reached. If the study is halted earlier than originally planned for any reason, this should also be noted here.
[8] *Outcome measures*: all outcome measures, including associated harms. For studies with a diagnostic component there will be two interventions to consider - the diagnostic test used and the associated treatment. *Note: separate line for each outcome*.
[9] *Effect size*: absolute risk reduction and relative risk (reduction), number needed to treat, number needed to harm, odds ratios, as required. *p* values and confidence intervals whenever possible.
[10] *Source of funding*: government funding (for example, NHS), voluntary charity (for example, Wellcome Trust), pharmaceutical company.
[11] *Additional comments*: additional characteristics/interpretations of the studies that the reviewer wishes to record. Important flaws in the study not identifiable from other data in the table. A range of additional questions or issues that will need to be considered, but do not figure in the results table.