Table 25: Clinical evidence profile: Antidepressants (fluoxetine) versus combined antidepressants (fluoxetine) & graded exercise

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants (fluoxetine) versus combined antidepressants (fluoxetine) & graded exercise	Control	Relative (95% CI)	Absolute		
Fatigue: 14-item Chalder fatigue scale (follow-up 26 weeks; range of scores: not reported; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[3]	none	35	33	-	MD 3 higher (1.47 lower to 7.47 higher)	⊕OOO VERY LOW	CRITICAL
Psychological status: HADS depression (follow-up 26 weeks; range of scores: 0-21; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[3]	none	35	34	-	MD 0.3 higher (1.51 lower to 2.11 higher)	⊕OOO VERY LOW	CRITICAL
Exercise performance measure: VO2 max (mL O2/kg/min) (follow-up 26 weeks; Better indicated by higher values)												
1	randomised trials	very serious[2]	no serious inconsistency	serious[2]	serious[3]	none	35	33	-	MD 1 lower (3.41 lower to 1.41 higher)	⊕OOO VERY LOW	CRITICAL

[1] Downgraded by 1 increment if the majority of the evidence was at high risk of bias, and downgraded by 2 increments if the majority of the evidence was at very high risk of bias
[2] The majority of the evidence included an indirect population (downgraded by one increment) or a very indirect population (downgraded by two increments). Populations were downgraded if the ME/CFS diagnostic criteria used did not include PEM as a compulsory feature
[3] Downgraded by 1 increment if the confidence interval crossed one MID or by 2 increments if the confidence interval crossed both MIDs