

Table 2. Results of the included studies

Outcomes	Individual study	N (Awake/Asleep)	Survival in months			Certainty of the Evidence (Quality of evidence)	Conclusions
			Awake (mean±SD)	Asleep (mean±SD)	Difference (95%CI)		
Overall survival (critical)	Overall	233/749	NR	NR	2.86 (1.35–4.37)	Very low¹ Due to observational evidence and imprecision	The evidence is very uncertain about the effect of awake resection compared to asleep resection in patients with high grade glioma.
	Gerritsen, 2022	134/402	17±8.63	14±8.63	3.00 (1.31–4.69)		
	Gerritsen, 2019	37/111	17±10.06	15±10.06	2.00 (-1.74–5.74)		
	Li, 2021	48/61	28.1±6.04	23.4±60.04	4.07 (-3.96–13.36)		
Progression free survival (critical)	Gerritsen, 2022	134/402	9±6.17	7.3±6.16	1.70 (0.49–2.91)	Very low² Due to observational evidence and imprecision	The evidence is very uncertain about the effect of awake resection compared to asleep resection in patients with high grade glioma.

	Li, 2021	48/61	23.3±6.58	18.9±6.58	4.30 (1.81–6.79)		
			Neurological deficits				
Functional neurological deficit (Important)	Individual study	Timing of assessment	Awake	Asleep	Odds Ratio (95%CI)	Very low³ Due to observational evidence and imprecision	The evidence is very uncertain about the effect of awake resection compared to asleep resection in patients with high grade glioma.
	Gerritsen, 2022 [#]	6-month postoperative	26% (30/115)	41% (125/305)	P=0.0048		
	Gerritsen, 2019	3-month postoperative	3/37	30/111	0.24 (0.07–0.83)		
	Gerritsen, 2022 [#]	3-month postoperative	22% (26/120)	33% (107/323)	P=0.019		

NR: not reported in the systematic review. Significant results in the systematic review are shown in bold.

[#]: Reported in the study Karschnia 2024, the rest of the results were reported in Sattari 2023.

¹: **Observational evidence:** All studies were observational (low GRADE).

Imprecision: serious. Due to low number of patients, optimal information size not achieved.

Risk of bias: In the included individual studies, little or no additional concerns warranting downgrading were identified.

²: **Observational evidence:** All studies were observational (low GRADE).

Imprecision: serious. Due to low number of patients, optimal information size not achieved.

Risk of bias: In the included individual studies, little or no additional concerns warranting downgrading were identified.

³: **Observational evidence:** All studies were observational (low GRADE).

Imprecision: serious. Due to low number of patients, optimal information size not achieved.

Risk of bias: In the included individual studies, little or no additional concerns warranting downgrading were identified.