Table 2. Results reported in prospective cohort studies

Outcomes	Individual study	N	Survival in months (95%CI)			Certainty of the Evidence (Quality of evidence)	Conclusions
			Complete	Submaximal*	HR (95%CI)		
Overall survival (critical)	Roder, 2023	277	27.9 (18.1–37.7)	19.4 (16.7–22.1)	1.59 (1.0–2.5, p=0.48)[†]	**Low[1]** Due to observational evidence	Complete resection may result in longer overall survival when compared with submaximal in patients with high-grade glioma. (Karschnia, 2024)
	Picart, 2023	171	NR	NR	0.65 (0.42–1.01, p=0.05)[§]		
	Beiko, 2014	335	19.6 (NR)	10.7 (NR)	NR		
		Received chemoradiation: NR	22.4 (15.7–29.1)	13.2 (8.5–18.0)	NR		
	Kreth, 2013	273	17.1 (12.6–21.5)	11.7 (10.0–13.5)	**NR, p=0.001**		
	Stummer, 2008	243	16.7 (13.4–19.0)	11.8 (10.4–13.7)	**1.75 (1.26–2.44, p=0.0004)**		
	Pichlmeier, 2008	243	16.7 (4.3–19.0)	11.8 (10.4–13.7)	**NR, p<0.0001**		

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Progression free survival (critical)	Roder, 2023	277	6.9 (5.0–8.9)	3.8 (3.5–4.1)	**1.77 (1.3–2.4, p=0.001)**[†]	**Low**[2] Due to observational evidence	Complete resection may result in longer progression free survival when compared with submaximal in patients with high-grade glioma. (Karschnia, 2024)	
	Picart, 2023	171	NR	NR	**0.56 (0.36–0.86, p=0.008)**[§]			
Functional neurological deficit (important)	-	-	-	-	-	**No GRADE** (no evidence was found)	No evidence was found regarding the effect of complete resection compared with submaximal resection in patients with high-grade glioma.	

All the study population was glioblastoma except for in study Beiko (2014) both astrocytoma grade 3 (N=128) and glioblastoma* (N=207) were included.

*Inconsistent terminology is used in the literature to describe the extent of resection. The RANO resect group proposed a validated new classification in 2023 to classify the extent of resection for glioblastomas. In this table, we used the terminology of this classification.

NR: not reported in the systematic review.

Significant results in the systematic review are shown in bold.

[§]complete resection was associated with higher overall and progression free survival.

[†]: Age was not adjusted.

[1]: **Observational evidence**: Most studies were observational (low GRADE).

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

 Risk of bias: Not all studies adjusted for age, which may have introduced bias. However, no additional level of certainty was downgraded, as this aspect was already accounted for by starting at a low level of evidence due to the observational nature of the data.

[2]: **Observational evidence**: Most of the participants were in observational studies (low GRADE).

 Risk of bias: Not all studies adjusted for age, which may have introduced bias. However, no additional level of certainty was downgraded, as this aspect was already accounted for by starting at a low level of evidence due to the observational nature of the data.

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