**Supplementary File 3: Potential source of heterogeneity in qSOFA dataset**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Subgroup** |  | **AUC**  **(95% CI)** | **I2 (%)** | ***p-*values#** |
| **Primary outcome** |  |  |  |  |
|  |  |  |  |  |
| Study design | Prospective | 0.720  (0.685-0.754) | 96.85 | 0.0875 |
|  | Retrospective | 0.693  (0.676-0.710) | 99.57 |  |
|  |  |  |  |  |
| Populations | ED | 0.709  (0.687-0.731) | 98.50 | 0.1990 |
|  | ICU | 0.667  (0.618-0.716) | 99.04 |  |
|  |  |  |  |  |
| Setting | Developed countries | 0.693  (0.678-0.709) | 99.49 | 0.0298 |
|  | Resource-limited countries | 0.740  (0.687-0.793) | 97.94 |  |
|  |  |  |  |  |
| Study quality | All studies\* | 0.710  (0.692-0.798) | 99.44 | 0.6946 |
|  | Low quality studies excluded | 0.703  (0.680-0.726) | 99.63 |  |
|  |  |  |  |  |
| Publication type | Full text | 0.710  (0.692-0.728) | 99.44 | 0.0586 |
|  | Conference abstract | 0.666  (0.634-0.697) | 97.72 |  |
|  |  |  |  |  |
| **Secondary outcome¥** | |  |  |  |
|  |  |  |  |  |
| Study design | Prospective | 0.712  (0.666-0.757) | 95.26 | 0.6359 |
|  | Retrospective | 0.696  (0.663-0.730) | 99.73 |  |
|  |  |  |  |  |
| Populations | ED | 0.700  (0.676-0.724) | 95.22 | 0.5116 |
|  | ICU | 0.722  (0.560-0.884) | 99.67 |  |
|  |  |  |  |  |
| Setting | Developed countries | 0.700  (0.673-0.727) | 99.66 | 0.7118 |
|  | Resource-limited countries | 0.709  (0.590-0.828) | 95.80 |  |
|  |  |  |  |  |
| Study quality | All studies\* | 0.706  (0.673-0.740) | 99.70 | 0.7993 |
|  | Low quality studies excluded | 0.700  (0.662-0.738) | 99.76 |  |
|  |  |  |  |  |
| Publication type | Full text | 0.705  (0.675-0.734) | 99.67 | 0.4242 |
|  | Conference abstract | 0.678  (0.619-0.737) | 94.30 |  |
|  |  |  |  |  |

#*p*-values were calculated by comparing between pre-defined subgroups (e.g. ED vs ICU).

**¥**Secondary outcome is a composite outcome including organ dysfunction, ICU admission, ventilatory support, prolonged ICU stay or 30-day readmission.

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\*Adequate data was available for quality assessment to be performed in 93 of the 121 studies. The remaining 28 studies were in abstract format, which did not contain enough data for quality assessment. Of these 93 studies in which quality assessment was performed, 63 studies (shown in this table) reported AUC for mortality prediction. Thus, the quality assessment presented in this table is limited to the 63 studies in which sufficient data were available.