APPENDIX 1

Predefined questions that the subgroups addressed.

1.	What are the red flags upon admission that suggest a particularly severe course in children?
2.	How to dose intravenous corticosteroids in severe pediatric UC?
3.	What are the recommendations regarding antibiotic therapy?
4.	What are the recommendations regarding other medical therapies (e.g., enemas, 5-ASA, heparin)?
5.	Should children with severe colitis undergo active evaluation for CMV and *C. difficile* infections? If so, what is the preferred way?
6.	How and when should children with severe attacks be monitored for change in disease activity? When should endoscopic evaluation of the colonic mucosa be evaluated?
7.	When and on what grounds to introduce second-line therapy?
8.	Which second-line therapy should be preferred (colectomy, infliximab, cyclosporine, or tacrolimus)?
9.	What are the prescription recommendations of cyclosporine, tacrolimus, and infliximab (route, dose, monitoring levels and toxicity, and duration of treatment)?
10.	How to determine success/failure of second-line therapy?
11.	When second-line therapy fails, should salvage (i.e., third line) medical therapy be administered or is it an absolute indication for colectomy?
12.	What should be the recommendations regarding dietary restriction and parenteral nutrition?
13.	How to manage severe abdominal pain in children?
14.	How should toxic megacolon be defined in children (including interpretation of abdominal radiography) and how should it be managed?
15.	When can a child with severe colitis be discharged and when to introduce maintenance therapy?
16.	Is there a preferred surgery in children?
17.	What are the ways, before the surgery, to minimize surgical complications?

APPENDIX 2

Levels of evidence and grades of recommendation based on the Oxford Centre for Evidence-Based Medicine (for details see http://www.cebm.net/levels_of_evidence.asp#refs)

Level	Diagnostic study	Therapeutic study
1a	Systematic review (SR) with homogeneity of level 1 diagnostic studies	SR with homogeneity of randomized controlled trials (RCTs)
1b	Validating cohort study with good reference standard	Individual RCT (with narrow confidence interval)
1c	Specificity or sensitivity are so high that a positive or a negative result rules out or in the diagnosis	All or none
2a	SR with homogeneity of level >2 diagnostic studies	SR (with homogeneity) of cohort studies
2b	Exploratory cohort study with good reference standards	Individual cohort study (including low-quality RCT; e.g., <80% follow-up)
2c		"Outcomes" research; ecological studies
3a	SR with homogeneity of 3b and better studies	SR with homogeneity of case–control studies
3b	Nonconsecutive study; or without consistently applied reference standards	Individual case–control study
4	Case–control study, poor, or nonindependent reference standard	Case series (and poor-quality cohort and case–control studies)
5	Expert opinion without explicit critical appraisal, or based on physiology, bench research, or "first principles"	Expert opinion without explicit critical appraisal, or based on physiology, bench research, or "first principles"

Grading of recommendation
A, Consistent level 1 studies
B, Consistent level 2 or 3 studies or extrapolations from level 1 studies
C, Level 4 studies or extrapolations from level 2 or 3 studies
D, Level 5 evidence or troublingly inconsistent or inconclusive studies of any level