General	General	General	General	General	General	General	General	General	General	General	General	General	General	General	Methodology	How well addressed (Risk of Bias)					Methodology	Study population	Study population	Study population	Study population	General	Study population	Interventions	Interventions	Outcomes	Study population	Interventions	Interventions	Outcomes	Study population	Interventions	Interventions	Outcomes
# No. Cosidence	Authors	Title	Year	Extraction performed by	Level of Evidence	Study Design	Source/Journal	Weblink	Related Study	Study Question	Primary Outcome	Findings	Comments	Include in Metanalyse (Yes/No)	**Methodology** **How well addressed: * = Mandatory** ***Was the group randomisation in this trial adequate (Describe the method used to generate the allocation sequence in sufficient detail to allow an assessment of whether it should produce comparable groups)?** ***Did allocation prevent prediction of the next treatment group?** ***Could any loss to follow up have affected the results of the study?** **Were patients blinded to the treatments they received?** **Were the outcome assessors (clinicians) blinded to treatments received?** **Were there differences between baseline characteristics?** **Was any group treated differently other than by the intervention?** **Were the outcomes correctly defined and measured in a standard way?** **Were any important outcome measures omitted?** **Was an intention to treat analysis done?** **Was the study stopped early?** **Was a power calculation performed?**	Low Risk	High Risk	Not clear	N/A	Funding	Country	Names of centres	Inclusion Criteria	Exclusion Criteria	Length of follow up	Age Mean 67.3, Average volume of prostate 48.87ml, mean total PSA 7.53ng/ml, Average number of biopsy 10.7	Arm A	Sample size	Outcome Arm A	Pat.Charact. Arm B	Am B	Sample Size	Outcome Arm B	Pat.Charact. Arm C	Am C	Sample Size	Outcome Arm C
325	Carmignani et al.	Transrectal ultrasound-guided prostate biopsies in patients taking aspirin for cardiovascular disease: A meta-analysis	2011	TS, GV	1b	systematic review and meta analysis	Transfus Apher Sci 2011;45:275–80			To understand whether continued anti-aggregant therapy is a risk factor for bleeding complications after ultrasound (US)-guided biopsy of the prostate	Rates of haematuria, rectal bleeding, hematospermia	Aspirin had an overall significant effect of increasing haematuria (30% more risk). Rectal bleeding and hematospermia did not show a statistically significant association with aspirin treatment	Continued use of aspirin does not increase the risk of overall bleeding or moderate and severe haematuria after prostate biopsy, and thus stopping aspirin before such biopsies is unnecessary		the sample size are different (Control group is double). Are not clear the inclusion and exclusion criteria about the selection study. the timing of follow up is not similar in order to analyse data			X		none	Italy	the centres are not described		not declared	From 7 to 30 days	Age mean 67.3, Average volume of prostate 48.87ml, mean total PSA 7.53ng/ml, Average number of biopsy 10.7	taking aspirine	739	Haematuria 493, mean 53.82%. Rectal bleeding 167, mean 19.18%. Haematospermia 245, mean 49.86%	Age mean 64.6, Average volume of prostate 40.4 ml, mean total PSA 7.53ng/ml, Average number of biopsy 10.7	not taking aspirine	1530	Haematuria 798, mean 50.06%. Rectal bleeding 253, mean 10.01%. Haematospermia 443, mean 49.36%				
325	Carmignani et al.	Transrectal ultrasound-guided prostate biopsies in patients taking aspirin for cardiovascular disease: A meta-analysis	2011	Ingrid an Gijs	1b	systematic review and meta analysis	Transfus Apher Sci 2011;45:275–80			No clear question only an aim is discribed To understand whether continued anti-aggregant therapy is a risk factor for bleeding complications after ultrasound (US)-guided biopsy of the prostate	Rates of haematuria, rectal bleeding, hematospermia. also was qualitatively evaluated the occurence of mild, moderate and severe bleeding complications	Aspirin had an overall significant effect of increasing haematuria in a mild form (30% more risk). Rectal bleeding and hematospermia did not show a statistically significant association with aspirin treatment	Continued use of aspirin does not increase the risk of overall bleeding or moderate and severe haematuria after prostate biopsy, and thus stopping aspirin before such biopsies is unnecessary		the sample size are different (Control group is double). Are not clear the inclusion and exclusion criteria about the selection study. the timing of follow up is not similar in order to analyse data			X		none	Italy, 4 studies in UK, 1 Greece and 1 Italy	the centres are not described		not declared	From 7 to 30 days	Age mean 67.3, Average volume of prostate 48.87ml, mean total PSA 7.53ng/ml, Average number of biopsy 10.7	taking aspirine	739	Haematuria 493, mean 53.82%. Rectal bleeding 167, mean 19.18%. Haematospermia 245, mean 49.86%	Age mean 64.6, Average volume of prostate 40.4 ml, mean total PSA 7.53ng/ml, Average number of biopsy 10.7	not taking aspirine	1530	Haematuria 798, mean 50.06%. Rectal bleeding 253, mean 10.01%. Haematospermia 443, mean 49.36%				
170	Chowdhury et al.	Should warfarin or aspirin be stopped prior to prostate biopsy? An analysis of bleeding complications related to increasing sample number regimes	2012	TS, GV	3	single centre prospective study	Clin Radiol 2012;67:464–70			To determine whether patients undergoing TRUS biopsy with increased sampling numbers are more likely to experience bleeding complications and whether warfarin or low-dose aspirin are independent risk factors	Immediate or delayed bleeding complications	Significant association between increasing sampling number and occurence of all bleeding complications types. There was no significant association between minor bleeding complications and warfarin use. There was a significant association between minor bleeding complications and low-dose aspirin use. There was no severe bleeding complications	TRUS-guided prostate biopsy up to 10 cores continues to be a safe low-risk outpatients test regardless of low-dose aspirin or warfrin use		very confused. not clear the endpoint		X			none	UK	University Hospital Southampton NHS Foundation Trust	none. 902 consecutive patients	not declared	10-14 days after the procedure or after any bleeding complications had ceased	mean age 68, mean prostate volume 59.2, mean PSA 19	no medications	617	Haematuria 228, mean 37%. Rectal bleeding 71, mean 11.5%. Haematospermia 85, mean 13.8%	mean age 72, mean prostate volume 56.6, mean PSA 14.4	warfarin group	68	Haematuria 19, mean 27%. Rectal bleeding 8, mean 13.2%. Haematospermia 4 5, mean 7.4%	mean age 71, mean prostate volume 63.7, mean PSA 18.6	aspirin group	216	Haematuria 73, mean 33.8%. Rectal bleeding 31, mean 14.4%. Haematospermia 26, mean 12%
170	Chowdhury et al.	Should warfarin or aspirin be stopped prior to prostate biopsy? An analysis of bleeding complications related to increasing sample number regimes	2012	Ingrid	3	single centre prospective study	Clin Radiol 2012;67:464–70			To determine whether patients undergoing TRUS – guided prostate biopsy with increased sampling numbers are more likely to experience bleeding complications and whether warfarin or low-dose aspirin are independent risk factors	Immediate or delayed bleeding complications	Significant association between increasing sampling number and occurence of all bleeding complications types. There was no significant association between minor bleeding complications and warfarin use. and conclude with that it's probably safe to continued to use. There was a significant association between minor bleeding complications and low-dose aspirin use. There was no severe bleeding complications	TRUS-guided prostate biopsy up to 10 cores continues to be a safe low-risk outpatients test regardless of low-dose aspirin or warfrin use		Not clear		X			none	UK	University Hospital Southampton NHS Foundation Trust	none. 902 consecutive patients	not declared	10-14 days after the procedure or after any bleeding complications had ceased	mean age 68, mean prostate volume 59.2, mean PSA 19	no medications	617	Haematuria 228, mean 37%. Rectal bleeding 71, mean 11.5%. Haematospermia 85, mean 13.8%	mean age 72, mean prostate volume 56.6, mean PSA 14.4	warfarin group	68	Haematuria 19, mean 27%. Rectal bleeding 8, mean 13.2%. Haematospermia 4 5, mean 7.4%	mean age 71, mean prostate volume 63.7, mean PSA 18.6	aspirin group	216	Haematuria 73, mean 33.8%. Rectal bleeding 31, mean 14.4%. Haematospermia 26, mean 12%
138	Culkin et al.	Anticoagulation and antiplatelet therapy in urological practice: ICUD/AUA review paper	2014	TS, GV	3	consensus based on systematic review of the literature	J Urol 2014;192:1026–34			What procedures can be safely performed without discontinuing anticoagulant/antiplatelet prophylaxis?	Rates of haematuria, rectal bleeding, hematospermia	the risk of significant bleeding complications is low for patients who require continuation of aspirin for TRUS		No	in our opinion this study should be excluded because: it is a consensus, the methodology is not clear						none	USA	Health Sciences Center, University of Oklahoma	Guidelines, systematic review from other professional organisation, key-references in the fields of cardiology and hematology. Searches in Pubblied and Embase, only in English, published between 1 January 2001 and 1 August 2012	Abstract only, insufficient information or unrelated to topic, unreodunancy		more than 3000 patients	no medications						aspirin group (3000 patients)			
138	Culkin et al.	Anticoagulation and antiplatelet therapy in urological practice: ICUD/AUA review paper	2014	Gijs	3	consensus based on systematic review of the literature	J Urol 2014;192:1026–34			What (urological) procedures can be safely performed without discontinuing anticoagulant/antiplatelet prophylaxis?	Rates of haematuria, rectal bleeding, hematospermia after TRUS biopsy	the risk of significant bleeding complications is low for patients who require continuation of aspirin for TRUS		No	in our opinion this study should be excluded because: it is a consensus, the methodology is not clear. There is just a small part about complications after TRUS biopsy and anticoagulation.						none	USA	Health Sciences Center, University of Oklahoma	Guidelines, systematic review from other professional organisation, key-references in the fields of cardiology and hematology. Searches in Pubblied and Embase, only in English, published between 1 January 2001 and 1 August 2012	Abstract only, insufficient information or unrelated to topic, unreodunancy		more than 3000 patients	no medications						aspirin group (3000 patients)			
3348	Zelf Atli et al.	Efficacy of a short prophylaxis with tranexamic acid on hemostasis during transrectal prostate biopsy in patients taking oral anti-platelet treatment. NO PDF YET ! Found it at: https://www.jbuon.com/pdfs/JBUON-21-3-322.pdf (Ingrid)	2016	Ingrid, Kadir	2b	Prospective study	Journal of BUON. Official journal of the Balkan Union of Oncology. 21(3): 683-684	https://www.jbuon.com/pdfs/JBUON-21-3-322.pdf	Cant find related studies	The efficacy of a short prophylaxis with tranexamic acid in reducing blood loss during TRUSBs in patients taking oral anti-platelet low-dose aspirin (comparing to no oral anaphylaxis)	Bleeding complications after TRUS biopsy	No severe bleeding complications after TRUS biopsy, for patients taking oral anti-platelet low-dose aspirin	Continued low-dose ASA treatment under TRUS biopsy, is not associated with severe bleeding complications	No	The methodology seems clear						None	Italy	University Hospital "St. Anna", Ferrara, Italy	Abnormal digital rectal examination (DRE), high prostate-specific antigen (PSA) levels (> 4 ng/mL), or both.	Patients with a history of biopsy, surgical treatment of prostatic disease, neoadjuvant therapy or	14 days after TRUSBs	Age mean 64.2, PV of 38.5, PSA of 10.3	A short oral prophylaxis with tranexamic acid (LGURIOLB, Rottapharm, MB, Italy) 500 mg (250 mg tabs x 2 taken one hr before the procedure.		170	Hematuria was present in 10.7% (19/178) of the patients	Age mean 64.2, PV of 38.5, PSA of 10.3	No oral anaphylaxis		181	Hematuria was present in 19.9% (34/181) of the patients	None arm-D			
277	Karlidis et al.	Safety of ultrasound-guided transrectal infarcted prostate biopsy in patients receiving low-dose aspirin	2010	TS, GV	2a	Prospective study	Int Braz J Urol 2010;36:308–16			To determine whether the peri-procedural administration of low-dose aspirin increases the risk of bleeding complications for patients undergoing extended prostate biopsy	The incidence of hemorrhagic complications after an extended scheme (12 or more cores) prostatic biopsy is increased for patients who continue to take low-dose ASA compared to patient not receiving ASA	the continuing use of low-dose aspirin in patients undergoing extended prostate biopsy is a relatively safe option since it dose not increase the morbidity of the procedure	continued low-dose ASA treatment is not associated with an increased incidence of hemorrhagic complications after an extended (12 ore more cores) prostatic biopsy and therefore ASA withdrawal is not considered justified				X			none	Greece	Department of Urology, General Hospital, Athens	PSA value greater than 2.5 ng/ml and/or an abnormal DRE	Treatment with coumadin or antiplatelet drugs (clopidogrel, trifoiad), personal history of hemorrhagic diatheisis, inflammatory bowel disease, malignancy in other pelvic organs, chronic liver disease, renal failure, concomitant rectal diseases such as polyps, rectal fissures, hemorrhoids, strictures	one month	age mean 64.3, BMI 28.1, prostate volume mean 52.1, number of cores 13.1, PSA 7.3	no medications	282	Hematuria 171, 60.6%, rectal bleeding 73, 25.9%, hemospermia 159, 86.9%	age mean 65.4, BMI 28.5, prostate volume mean 51, number of cores 12.3, PSA 7.4	aspirin group	152	Hematuria 98, 64.5%, rectal bleeding 51, 33.5%, hemospermia 91, 90.1%				
277	Karlidis et al.	Safety of ultrasound-guided transrectal extended prostate biopsy in patients receiving low-dose aspirin	2010	Ingrid	2a	Prospective study	Int Braz J Urol 2010;36:308–16			To determine whether the peri-procedural administration of low-dose aspirin increases the risk of bleeding complications for patients undergoing extended prostate biopsy	The incidence of hemorrhagic complications after an extended scheme (12 or more cores) prostatic biopsy is increased for patients who continue to take low-dose ASA compared to patient not receiving ASA, only the duration of bleeding.	the continuing use of low-dose aspirin in patients undergoing extended prostate biopsy is a relatively safe option since it dose not increase the morbidity of the procedure	continued low-dose ASA treatment is associated with a small increased incidence of hemorrhagic complications after an extended (12 ore more cores) prostatic biopsy and therefore ASA withdrawal is not considered justified				X			none	Greece	Department of Urology, General Hospital, Athens	PSA value greater than 2.5 ng/ml and/or an abnormal DRE	Treatment with coumadin or antiplatelet drugs (clopidogrel, trifoiad), personal history of hemorrhagic diatheisis, inflammatory bowel disease, malignancy in other pelvic organs, chronic liver disease, renal failure, concomitant rectal diseases such as polyps, rectal fissures, hemorrhoids, strictures	one month	age mean 64.3, BMI 28.1, prostate volume mean 52.1, number of cores 13.1, PSA 7.3	no medications	282	Hematuria 171, 60.6%, rectal bleeding 73, 25.9%, hemospermia 159, 86.9%	age mean 65.4, BMI 28.5, prostate volume mean 51, number of cores 12.3, PSA 7.4	aspirin group	152	Hematuria 98, 64.5%, rectal bleeding 51, 33.5%, hemospermia 91, 90.1%				
112	Raheem et al.	Does anticoagulant or antiplatelet therapy need to be discontinued for transrectal ultrasound-guided prostate biopsies? A systematic literature review	2011	Corinna	1b (only for low aspirin) 2 for warfarin	Systematic literature review	Curr Urol 2011;5:121–4.			To determine the current published evidence regarding the continuation of the anticoagulation/antiplatelet therapy at TRUS Biopsy and evaluate the safety of aspirin, warfarin and clopidogrel in patient undergoing TRUS biopsy	Continuation of anticoagulation/antiplatelet therapy during TRUS Bx without additional morbidity	Continue taking aspirin for men undergoing TRUS biopsy does not increase bleeding morbidity. Wide variation in managing warfarin or clopidogrel in patients undergoing TRUS Bx	In this systematic literature review: one prospective randomized study (level of evidence 1-1) about aspirin and TRUS bx, three prospective studies of which two about aspirin and one about warfarin (4 these studies level of evidence II-2) and two UK based nationwide survey. On the 6 studies selected, 4 studies about aspirin and 2 studies about warfarin(clopidogrel. Only 6 studies in this review. The 2 UK nationwide surveys do not have high level of evidence. It means only one "useful" study about warfarin and TRUS bx- but with as bias the little number of cores taken (6). The only prospective study with warfarine concerned few biopsy cores (6 cores). The 2 UK nationwide surveys do not have high level of evidence.	yes	The methodology of this review is clear (search terms in PubMed, Web of science and Cochrane library)				N/A (Review)	none	UK (4x), Italy (1x) and Austria (1x)	Review. Studies in differents centers	TRUS be and use of anticoagulant	not declared	Not mentioned	Several studies	Range of number patients not mentioned in all the studies (especially in the UK surveys and the prospective study about warfarin) In the other prospective studies, range of number patients in anticoagulant groups between 36-387		One survey(Conor et al.): wide variation of practice (urologists and radiologists) terminated aspirin 5-12 days prior to TRUS bx. Maan et al. no staotical significant difference in the incidence of hematuria or overall bleeding between group with aspirin and group without aspirin. Halfeed et al. : incidence of hematuria and rectal bleeding (but not hematospermia) was higher in the aspirin user (n=387) compared to no aspirin user (n=731). BUT no serious bleeding events in both groups. Giannerini et al.: no significant bleeding difference for hematuria, rectal bleeding or hematuria in aspirin group and non aspirin group. Ihezue et al.: incidence of hematuria, hematospermia and rectal bleeding higher in the warfarin group compared to patients group without anticoagulation. Berger et al.: increased number of biopsy cores did not result in an increased incidence of major post TRUS bx complications in non anticoagulation/antiplatelet patients. Mukerji et al (survey): wide variation in practice with regards to pre and post operative management of clopidogrel in patients undergoing urological procedures									
112	Raheem et al.	Does anticoagulant or antiplatelet therapy need to be discontinued for transrectal ultrasound-guided prostate biopsies? A systematic literature review	2011	Gijs	1b (only for low aspirin) 2 for warfarin	Systematic literature review	Curr Urol 2011;5:121–4.			No clear question just an aim: assess the current published evidence regarding the continuation of the anticoagulation/antiplatelet therapy at TRUS Biopsy and evaluate the safety of aspirin, warfarin and clopidogrel in patient undergoing TRUS biopsy	Continuation of anticoagulation/antiplatelet therapy during TRUS Bx without additional morbidity	Continue taking aspirin for men undergoing TRUS biopsy does not increase bleeding morbidity. Wide variation in managing warfarin or clopidogrel in patients undergoing TRUS Bx	In this systematic literature review: one prospective randomized study (level of evidence 1-1) about aspirin and TRUS bx, three prospective studies of which two about aspirin and one about warfarin (all these studies level of evidence II-2) and two UK based nationwide survey. On the 6 studies selected, 4 studies about aspirin and 2 studies about warfarin(clopidogrel. Only 6 studies in this review. The 2 UK nationwide surveys do not have high level of evidence. It means only one "useful" study about warfarin and TRUS bx- but with as bias the little number of cores taken (6). The only prospective study with warfarine concerned few biopsy cores (6 cores). The 2 UK nationwide surveys do not have high level of evidence.	yes	The methodology of this review is clear (search terms in PubMed, Web of science and Cochrane library)				N/A (Review)	none	UK (4x), Italy (1x) and Austria (1x)	Review. Studies in differents centers	TRUS be and use of anticoagulant	not declared	Not mentioned	Several studies	Range of number patients not mentioned in all the studies (especially in the UK surveys and the prospective study about warfarin) In the other prospective studies, range of number patients in anticoagulant groups between 36-387		One survey(Conor et al.): wide variation of practice (urologists and radiologists) terminated aspirin 5-12 days prior to TRUS bx. Maan et al. no staotical significant difference in the incidence of hematuria or overall bleeding between group with aspirin and group without aspirin. Halfeed et al. : incidence of hematuria and rectal bleeding (but not hematospermia) was higher in the aspirin user (n=387) compared to no aspirin user (n=731). BUT no serious bleeding events in both groups. Giannerini et al.: no significant bleeding difference for hematuria, rectal bleeding or hematuria in aspirin group and non aspirin group. Ihezue et al.: incidence of hematuria, hematospermia and rectal bleeding higher in the warfarin group compared to patients group without anticoagulation. Berger et al.: increased number of biopsy cores did not result in an increased incidence of major post TRUS bx complications in non anticoagulation/antiplatelet patients. Mukerji et al (survey): wide variation in practice with regards to pre and post operative management of clopidogrel in patients undergoing urological procedures									
2937	Vasudeva et al.	Safety of 12 core transrectal ultrasound guided prostate biopsy in patients on aspirin	2015	Corinna	2a	prosepective non randomized study	Int Braz J Urol 1096;41:1096–100.			Safety of continuing low dose aspirin during TRUS-Bx	No difference in post biopsy bleeding in patient on aspirin versus patient not on aspirin or stop aspirin before procedure	Continue low dose aspirin (75 mg per day) during TRUS-Bx is safed		Yes	Non randomized setting. Big difference in number between both groups (191/490). For patients who stop aspirin before procedure, it is not clear how many days before the biopsy			X			none	India	V.M. Medical College and Safdarjang Hospital New Delhi	All patients eligible for US guide be regardless use of aspirin or not. PSA>4ng/ml and/or abnormal digital rectal examination. Only 12 cores bx	History of bleeding disorder. Patient on coagulant other than aspirin. <or=12 cores. Patients who did not sign informed consent	3 weeks	Mean: Age: 67.25, Prostate volume 61.14ml, PSA 31.25,Hb 12.92 gm (%) Platelet count 137.34 x10 3 per microlitre. Serum creatinine 1.21 mg/dL	patient on low aspirine	191	Post biopsy complications: Mean: num of hematuria 1.87. Number of patients reporting hematuria 86 (45.02%). Hematuria requiring intervention 0. Number of patients reporting hematospermia 21 (10.99%). Number of patients reporting rectal bleeding 29 (15.18%)	Mean: Age: 66,97. Prostate volume 62.51ml. PSA20.70 Hb 12.78 gm (%) Platelet count 142.67 x10 3 per microlitre. Serum creatinine 1.17 mg/dL	No aspirin or stop aspirin before the biopsy	490	Post biopsy complications: Mean: num of hematuria 1.83. Number of patients reporting hematuria 247 (50.40%). Hematuria requiring intervention 0. Number of patients reporting hematospermia 40 (8.16%). Number of patients reporting rectal bleeding 65 (13.26%)				
2937	Vasudeva et al.	Safety of 12 core transrectal ultrasound guided prostate biopsy in patients on aspirin	2015	Gijs	2a	prosepective non randomized study	Int Braz J Urol 1096;41:1096–100.			Safety outcome of TRUS guided pyrostate biopsy in low dose aspirin users	post biopsy complications: number of hematuria episodes, number of patient reporting hematuria, hematuria requiring intervention, number of patient reporting hematospermia, number of patient reporting rectal bleeding	None of the complications were significantly different between the two groups. Conclusion: Continue low dose aspirin (75 mg per day) during TRUS-Bx is safed		yes	Non randomized setting. Big difference in number between both groups (191/490). For patients who stop aspirin before procedure, it is not clear how many days before the biopsy						none	India	V.M. Medical College and Safdarjang Hospital New Delhi	All patients eligible for US guide be regardless use of aspirin or not. PSA>4ng/ml and/or abnormal digital rectal examination. Only 12 cores bx	History of bleeding disorder. Patient on coagulant other than aspirin. <or=12 cores. Patients who did not sign informed consent	3 weeks	Mean: Age: 67.25, Prostate volume 61.14ml, PSA 31.25,Hb 12.92 gm (%) Platelet count 137.34 x10 3 per microlitre. Serum creatinine 1.21 mg/dL	patient on low aspirine	191	Post biopsy complications: Mean: num of hematuria 1.87. Number of patients reporting hematuria 86 (45.02%). Hematuria requiring intervention 0. Number of patients reporting hematospermia 21 (10.99%). Number of patients reporting rectal bleeding 29 (15.18%)	Mean: Age: 66,97. Prostate volume 62.51ml. PSA20.70 Hb 12.78 gm (%) Platelet count 142.67 x10 3 per microlitre. Serum creatinine 1.17 mg/dL	No aspirin or stop aspirin before the biopsy	490	Post biopsy complications: Mean: num of hematuria 1.83. Number of patients reporting hematuria 247 (50.40%). Hematuria requiring intervention 0. Number of patients reporting hematospermia 40 (8.16%). Number of patients reporting rectal bleeding 65 (13.26%)				
139	Wang et al.	Risk of bleeding complications after preoperative antiplatelet withdrawal versus continuing antiplatelet drugs during transurethral resection of the prostate and prostate puncture biopsy: A systematic review and meta analysis	2012	Corinna	We are not using this review. See my comments	systematic review	Urol Int 2012;89:433–8.						This review has included 4 articles for TRUS bx and use of low dose aspirine. 2 articles (Maan et al and Giannarin et al.) are already in the review of Raheem and we have the data extraction of one article (Karlidis et al). Only one important thing: Wang et al write that the article from Maan et al is a retrospective study. Raheem et al wrote prospective study (but doesn't make a difference in level of evidence) In Wang et al. only one article was do not have: Herget et al from 1999; but does not give more evidence than what we already have. Another remark. In the review of Wang et al the randomized study of Giannarin et al. is included in meta-analysis (this study probablicantly which is a big mistake) (the study of Giannarin et al. is a randomized trial comparing low dose aspirin before transrectal prostate puncture biopsy: result of a prospective randomized trial. Urologe 2007;70:501-505.	No																								
139	Wang et al.	Risk of bleeding complications after preoperative antiplatelet withdrawal versus continuing antiplatelet drugs during transurethral resection of the prostate and prostate puncture biopsy: A systematic review and meta analysis	2012	Gijs	We are not using this review. See my comments	systematic review	Urol Int 2012;89:433–8.						This review has included 4 articles for TRUS bx and use of low dose aspirine. 2 articles (Maan et al and Giannarin et al.) are already in the review of Raheem and we have the data extraction of one article (Karlidis et al). In Wang et al. only one article are do not have: Herget et al from 1999; but does not give more evidence than what we already have.	No																								