

BMJ Open

BMJ Open is committed to open peer review. As part of this commitment we make the peer review history of every article we publish publicly available.

When an article is published we post the peer reviewers' comments and the authors' responses online. We also post the versions of the paper that were used during peer review. These are the versions that the peer review comments apply to.

The versions of the paper that follow are the versions that were submitted during the peer review process. They are not the versions of record or the final published versions. They should not be cited or distributed as the published version of this manuscript.

BMJ Open is an open access journal and the full, final, typeset and author-corrected version of record of the manuscript is available on our site with no access controls, subscription charges or pay-per-view fees (<http://bmjopen.bmj.com>).

If you have any questions on BMJ Open's open peer review process please email info.bmjopen@bmj.com

BMJ Open

Cannabinoids versus placebo for pain. A systematic review with meta-analysis and Trial Sequential Analysis; Protocol

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2019-031574
Article Type:	Protocol
Date Submitted by the Author:	11-May-2019
Complete List of Authors:	Barakji, Jehad; The Copenhagen Trial Unit, Rigshospitalet Dept. 7812 Korang, Steven Kwasi; Rigshospitalet, Copenhagen Trial Unit; Holbaek Sygehus, Pediatric Dept. Feinberg, Joshua; Copenhagen Univ Hosp Maagard, Mathias; The Copenhagen Trial Unit, Rigshospitalet Dept. 7812 Gluud, Christian; Copenhagen Trial Unit (CTU), Center for Clinical Intervention Research Mathiesen, Ole; University of Copenhagen Jakobsen, Janus; Copenhagen Trial Unit, Centre for Clinical Intervention Research, Department 7812, Rigshospitalet, Copenhagen University Hospital
Keywords:	PAIN MANAGEMENT, Herbal medicine < THERAPEUTICS, Adverse events < THERAPEUTICS, CLINICAL PHARMACOLOGY, Health & safety < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

SCHOLARONE™
Manuscripts

Cannabinoids versus placebo for pain: A protocol systematic review with meta-analysis and Trial Sequential Analysis

Jehad A. Barakji¹, Steven Kwasi Korang¹, Joshua Rose-Hansen Feinberg¹, Mathias Maagaard¹, Christian Gluud¹,
Ole Mathiesen^{2,3}, Janus C. Jakobsen^{1,4,5}

¹ The Copenhagen Trial Unit, Centre for Clinical Intervention Research, Department 7812, Rigshospitalet, Copenhagen University Hospital, Blegdamsvej 9, DK 2100 Copenhagen, Denmark

² Centre for Anaesthesiological Research, Department of Anaesthesiology, Zealand University Hospital, Koege, Denmark

³ Department of Clinical Medicine, Faculty of Health and Medical Sciences, Copenhagen University, Copenhagen, Denmark

⁴ Department of Cardiology, Holbæk Hospital, Holbæk, Denmark

⁵ Department of Regional Health Research, The Faculty of Health Sciences, University of Southern Denmark, Odense, Denmark

Corresponding author

Jehad A. Barakji

Tlf.: +45 21 52 07 80

Email: jehad.barakji@ctu.dk

Abstract

Introduction Pain is a frequent clinical symptom, and with significant impact on patient well-being. Therefore, sufficient pain management is of utmost importance. While cannabinoids have become a more popular alternative to traditional types of pain medication among patients, the quality of evidence supporting the use of cannabinoids has been questioned. The beneficial and harmful effects of cannabinoids in patients with pain is unknown. Accordingly, we aim to assess the efficacy, tolerability, and safety of cannabinoids (herbal, plant-derived extracts and synthetic) compared with placebo for any type of pain.

Methods and analysis We will conduct a systematic review of randomised clinical trials with meta-analysis and Trial Sequential Analysis to assess the beneficial and harmful effects of cannabinoids in any dose, formulation, and duration. We will accept placebo or no treatment as control interventions. We will include participants with any type of pain (acute and chronic pain, cancer-related pain, headache, neuropathic pain or any other types of pain). We will systematically search The Cochrane Library, MEDLINE, EMBASE, Science Citation Index, and BIOSIS for relevant literature. We will follow the recommendations by Cochrane and the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) statement. The risk of systematic errors (bias) and random errors (play of chance) will be assessed. The overall certainty of evidence will be evaluated using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach.

Ethics and dissemination Ethical approval is not a requirement since no primary data will be collected. The findings of this systematic review will be submitted for peer-reviewed publication and disseminated in national and international conferences.

Discussion Although cannabinoids are now being used to manage different pain conditions, the evidence for the clinical effects are unclear. The present review will systematically assess the current evidence for the benefits and harms of cannabinoids to inform practice and future research.

Strengths and limitations of this study

- Our methodology is based on the Cochrane Handbook for Systematic Reviews of Interventions, the PRISMA guideline, and a systematic eight step procedure for valid assessments of statistical and clinical significance
- We systemically plan to assess risks of random errors ('play of chance) and systematic errors ('bias')
- We have systematically predefined minimal important differences for all outcomes
- The certainty of the evidence with be assessed using the GRADE approach

Description of pain

Pain is the most commonly reported symptom in the general population and in a medical setting [1-3]. Persistent pain is a major international health problem [4], prompting the World Health Organization (WHO) to endorse a global campaign against pain [5]. Pain is the leading reason for use of alternative medicines (e.g. acupuncture) [6]. Pain has been associated with a low degree of health-related quality of life and may lead to psychosocial distress, insomnia, and depressive symptoms [7-15]. Pain is also among the most common reasons for temporary or permanent work disability [16]. Pain is always subjective and may be defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage" [17].

Pain may be caused by or be related to different clinical disorders and classified according to several different characteristics [18-21]. Below, we describe shortly some of these classifications.

Acute and chronic pain

Pain may be classified as 'acute pain' or 'chronic pain'.

- Acute pain usually has a well-defined onset and most often a readily identifiable cause (e.g. surgery). Acute pain is expected to run its course in a short time frame and management typically focuses on symptomatic relief until this happens [22]. Acute pain is a common symptom, affecting between 37% to 84% of hospitalised patients [23].
- Chronic pain is often characterised by an ill-defined onset and a prolonged, fluctuating course [22]. Chronic pain often persists past normal healing time and hence lacks the acute warning function of

1
2
3
4 physiological nociception [24]. Pain is usually regarded as chronic when it lasts or recurs for more than
5 three to six months [17, 25]. A chronic pain patient usually does not appear to be in pain, and the only
6 definitive way to determine the presence of pain is to obtain a verbal report from the patient [22]. A
7 recent systematic review has demonstrated considerable heterogeneity in the criteria for a diagnosis of
8 chronic pain applied in large epidemiological studies [26]. Chronic pain is a frequent condition, affecting
9 an estimated 20% of people worldwide [27-30] and accounting for 15% to 20% of physician visits
10 according to European observational studies [31, 32].
11
12
13
14
15
16
17

18 *Cancer-related pain*

19 Pain may also be classified based on whether it is cancer-related or non-cancer-related. Cancer-related pain is
20 pain caused by the cancer itself (primary tumour and metastases) or its treatment (e.g. radiation therapy) [22,
21 33].
22
23
24
25

26 *Postoperative pain*

27 Postoperative pain includes pain from inflammation caused by tissue trauma (i.e. surgical incision, dissection,
28 burns) or direct nerve injury (i.e. nerve transection, stretching, or compression) [34]. Inflammation results in
29 activation and sensitisation of nociceptive pain pathways, resulting in primary and secondary hyperalgesia and
30 central sensitisation, which is characterized by clinically increased pain, allodynia, and increased sensitivity from
31 surrounding non-damaged anatomical areas [35].
32
33
34
35
36
37

38 *Headache*

39 Up to 90% of all patients with headaches may be classified as suffering from either tension-type headache,
40 migraine, or cluster headache. While episodic tension-type headache is the most frequent headache type in
41 population-based studies, migraine is the most common diagnosis in patients presenting to primary care
42 physicians with headache [36].
43
44
45
46
47

48 *Other types of pain*

49 Pain in one or more anatomic regions where the aetiology is unknown is defined as idiopathic pain [37]. Examples
50 of idiopathic pain are chronic widespread pain, fibromyalgia, irritable bowel syndrome, and back pain that is not
51 diagnosed as musculoskeletal or as neuropathic pain [33].
52
53
54
55
56
57
58
59
60

Pain types defined according to specific mechanism causing the pain

Somatic nociceptive pain

Nociceptive pain is the most frequent type of pain. It results from activity in neural pathways caused by actual tissue damage or potentially tissue-damaging stimuli [31, 38] originating from somatic nociceptors from skin, bone, joints, or muscles [39].

Visceral nociceptive pain

The visceral nociceptive pain is pain resulting from viscera in the thoracic, pelvis, or abdominal organs [40-42]. Visceral pain is diffuse, less distinctive, and difficult to localise [42]. It is often characterised by referred visceral pain and followed by symptoms from the autonomic nerve system (e.g. nausea, sweating, cardiovascular symptoms) [43].

Neuropathic pain

The 2011 International Association for the Study of Pain definition of neuropathic pain is "pain caused by a lesion or disease of the somatosensory system" [44]. Neuropathic pain leads to a heterogeneous group of symptoms, including unremitting and spontaneous burning or shooting sensations, abnormal pain sensation to normal and harmless stimuli (allodynia), or a raised sensitivity to noxious stimuli (hyperalgesia) [45].

Neuropathic pain may be classified as central neuropathic pain or peripheral neuropathic pain. Central neuropathic pain conditions are mainly attributed to multiple sclerosis and post-stroke pain [46], while peripheral neuropathic pain is largely due to post-herpetic neuralgia and diabetic neuropathy [47]. Persistent postoperative pain (incidence up to 10% of surgical patients) may mostly be considered as iatrogenic neuropathic pain [48].

Description of the intervention

Cannabis (also called marijuana) is the most common illegally used psychoactive substance worldwide [49]. Cannabis was used by an estimated 182 million people worldwide in 2014, this corresponds to approximately 3.8 percent of the global adult population [49]. Cannabinoids refer to a heteromorphous group of molecules that

1
2
3
4 demonstrate activity upon cannabinoid receptors [50]. Cannabinoids may be classified into three groups: 1)
5 endocannabinoids, 2) phytocannabinoids, and 3) synthetic cannabinoids [50].
6
7

8 9 *Endocannabinoids*

10
11 Endocannabinoids are characterised by being the endogenously generated cannabinoids [51]. The primary types
12 of endocannabinoids are the lipid endocannabinoid arachidonoyl ethanolamide (named anandamide) [52] and
13 the endocannabinoid 2-arachidonoylglycerol (2-AG) [53, 54]. Arachidonoyl ethanolamide binds to the brain
14 cannabinoid receptor with high affinity and mimics the behavioural actions of tetrahydrocannabinol when
15 injected into rodents (e.g. block peripheral pain, inhibiting gastric emptying) [52, 55-57]. A number of other
16 endocannabinoids have been discovered, but follow-up studies about biosynthesis, cellular transport,
17 metabolism, and biological function have focused primarily on anandamide and 2-AG [58].
18
19
20
21
22
23

24 25 *Phytocannabinoids*

26
27 Phytocannabinoids are cannabinoids found in the cannabis plant [59]. The best characterised phytocannabinoids
28 are the psychotropic tetrahydrocannabinol (THC) and the primarily anti-inflammatory cannabidiol (CBD) [60].
29 Nabiximols (marketed as Sativex®) is a sublingually administered oromucosal spray based on a mixture of
30 tetrahydrocannabinol and cannabidiol [61].
31
32
33

34 35 *Synthetic cannabinoids*

36
37 Synthetic cannabinoids are analogues of the cannabinoids found in natural marijuana that are chemically
38 synthesised. They may have been commercially available in Europe since 2004 and in the United States since
39 2008 [62]. The use of synthetic cannabinoids is increasing in Europe [63]. From 2005 to 2011, synthetic
40 cannabinoids represented two-thirds of all new substances reported to the European Monitoring Centre for
41 Drugs and Drug Addiction Early Warning System [63].
42
43
44
45

46
47 The most commonly prescribed cannabinoid-based medicines are the synthetic cannabinoids dronabinol
48 (marketed as Marinol®) and nabilone (marketed as Cesamet®) [61].
49
50

51 52 **Endocannabinoid system**

53
54
55
56
57
58
59
60

1
2
3
4 All cannabinoids act on cannabinoid receptors. These cannabinoid receptors are located throughout the body
5 but are mostly located in the brain [64]. The cannabinoid receptors and endocannabinoids (see paragraph above)
6 are together named the endocannabinoid system [65].
7
8
9

10
11 The endocannabinoid system is thought to have three broad and overlapping functions in mammals [66]. The
12 first function of the endocannabinoid system is a stress recovery role, operating in a feedback loop in which
13 endocannabinoid signalling is activated by stress and functions to return endocrine, nervous, and behavioural
14 systems to homeostatic balance [66]. The second function of the endocannabinoid system is to control energy
15 balance through regulation of the intake, storage, and utilisation of food [66]. The third function of the
16 endocannabinoid system involves immune regulation; endocannabinoid signalling is activated by tissue injury
17 and modulates immune and inflammatory responses [66].
18
19
20
21
22
23
24

25 *Cannabinoid receptors*

26
27 There are two types of cannabinoid receptors, type I and type II [67]. Cannabinoid receptor type I are most
28 abundant in the central nervous system, especially in areas promoting nociception, short-term memory, and in
29 the basal ganglia, but are also found in the peripheral nerves, uterus, testis, and bones [67].
30 Tetrahydrocannabinol activates cannabinoid type I receptors in the dopaminergic mesolimbic brain circuit,
31 resulting in enhanced release of dopamine [68]. Such activation of the so-called 'brain reward system' is
32 hypothesised to mediate the positive reinforcing and rewarding effects of almost all drugs of abuse [58]. More
33 than weekly use of cannabis downregulates brain cannabinoid type I receptors; abstinence results in receptor
34 upregulation within several days [69]. These receptor changes are associated with an often uncomfortable or
35 distressing cannabis withdrawal syndrome [70], which may serve as negative reinforcement to continue cannabis
36 use in order to suppress the withdrawal symptoms.
37
38
39
40
41
42
43
44

45 In contrast, cannabinoid receptor type II, is mostly found in the periphery, often in conjunction with immune
46 cells, but may appear in the central nervous system particularly under conditions of inflammation in association
47 with microcytes [67]. The physiological responses that result from cannabinoid receptor activation are euphoria,
48 psychosis, impaired memory and cognition, reduced locomotor function, increased appetite, as well as anti-
49 emetic, pain-relieving, anti-spasticity, and sleep-promoting effects [71].
50
51
52
53
54
55
56
57
58
59
60

Applicability of cannabinoid-based medicines

Cannabis is most commonly consumed via smoked, inhaled vapor, or oral routes of administration [72]. Vaporising cannabis ('vaping') heats the material without burning which theoretically minimises potential carcinogens compared to smoking and may produce less respiratory irritation [73, 74]. Sublingual administration is used for some medical cannabis preparations (e.g. nabiximols).

In recent years, cannabinoid-based medicines have become increasingly available to patients in many countries [61]. Besides usage for treatment of different pain conditions [50], cannabinoid-based medicines are used for treatment of nausea and vomiting associated with cancer chemotherapy and the treatment of AIDS-associated anorexia [75]. Cannabinoid-based medicines are used to reduce seizure frequency in patients with drug-resistant epilepsy [76]. In Denmark, Sativex® (nabiximols) is approved for the treatment of moderate to severe spasticity due to multiple sclerosis in patients who have not responded adequately to other anti-spasticity medication [77]. An American survey indicated that 6% of adults (or 12 million) have utilised cannabis in attempts to treat chronic pain [78]. In pain clinics across Canada, the proportion of users of cannabinoid-based medicines is estimated to be between 12% to 15% [79].

Why it is important to do this review

We identified ten previous reviews with meta-analyses assessing the effects of cannabinoids on different types of pain [79-88]. Bearing in mind that some of the previous reviews investigated more than one type of pain, eight reviews assessed the effects of different cannabinoids on neuropathic pain [79-85, 88]; four reviews assessed the effects of different cannabinoids on nociceptive pain (e.g. rheumatoid arthritis) [79, 80, 83, 84]; three reviews assessed the effects of different cannabinoids on cancer-related pain [79, 83, 84]; four reviews assessed the effects of different cannabinoids on fibromyalgia-related pain [79, 80, 83, 87]; and three reviews assessed the effects of different cannabinoids on postoperative pain [79, 84, 86]. All the previous reviews included randomised clinical trials, but only two of the ten reviews systematically assessed the risk of bias in the trials [81, 88], and none of the previous reviews took into account the risks of random errors [79-88]. Only two out of the ten reviews used predefined Cochrane methodology [87, 88] and only four reviews used the GRADE approach [81, 86-88].

1
2
3
4 Most of the reviews concluded that the assessed cannabinoids were effective against pain [79-83, 85, 88]. In
5 **Table 1 (Additional file 1)**, we have summarised the results and conclusions of the previous reviews. Five of the
6 reviews reported serious adverse events (e.g. agitation, impaired memory, abuse, dissociation, acute psychosis,
7 and death) [79, 81-83, 88]. The reviews also showed that the most commonly reported adverse events were
8 sedation, dizziness, dry mouth, increased appetite, somnolence, confusion, nausea, and disturbances in
9 concentration [79-82, 84, 85, 87, 88].
10
11
12
13
14
15

16 A correlation between psychiatric disorders (e.g. schizophrenia and psychosis) and increased cannabinoid
17 consumption have previously been hypothesised [89-95]. Di Forti et. al recently conducted a study indicating
18 that daily cannabis use was associated with increased odds of psychotic disorder compared with never users
19 (adjusted odds ratio [OR] 3.2, 95% CI 2.2–4.1), increasing to nearly five-times increased odds for daily use of high-
20 potency (THC \geq 10%) types of cannabis (adjusted odds ratio [OR] 4.8, 95% CI 2.5–6.3) [96].
21
22
23
24
25
26

27 **Objective**

28 The objective of our systematic review is to assess the beneficial and harmful effects of cannabinoids versus
29 placebo or no intervention for any type of pain (acute and chronic pain, cancer-related pain, headache,
30 neuropathic pain, or any other types of pain).
31
32
33
34

35 **Methods**

36 This systematic review protocol has been developed based on Preferred Reporting Items for Systematic
37 Reviews and Meta-Analysis Protocols (PRISMA-P) guidelines for reporting systematic reviews evaluating
38 healthcare interventions [97, 98]. A PRISMA-P checklist file is attached (**Additional file 2**).
39
40
41
42
43
44

45 **Criteria for considering studies for this review**

46 *Type of studies*

47 Randomised clinical trials irrespective of trial design, setting, publication status, publication year, and language.
48 If we identify quasi-randomised studies and observational studies during our searches for randomised clinical
49 trials, we will only include their reporting on harms in a narrative way. By not systematically searching for all
50 observational studies on harm, we run the risk of putting more focus on benefit than harm. We are aware that
51 this is a limitation of our review.
52
53
54
55
56
57
58
59
60

Types of participants

Participants with any type of pain, i.e. acute and chronic pain, cancer-related pain, headache, neuropathic pain, or any other types of pain (as defined by the trialists). Participants will be included irrespective of age, sex, and comorbidities.

Types of interventions

Experimental intervention

Any type of cannabinoids such as: herbal cannabis (hashish, marijuana), plant-based extracts (e.g. nabiximole), or synthetic cannabinoids (e.g. cannabidiol, dronabinol, levonantradol, nabilone). We will accept cannabinoids at any dose, by any route, administered for the relief of pain.

Control intervention

Placebo or no intervention.

Co-interventions

We will accept any co-intervention but only if this co-intervention is planned to be delivered similarly in both intervention groups. If this plan is not followed, then these trials will be assessed as a subgroup due to potential confounding.

Patient and Public Involvement

We have had email correspondence with several relevant patient associations in Denmark to select the most patient relevant outcomes. The patient associations we have been in contact with include: The Danish Diabetes Association, Steno Diabetes Centre Copenhagen, The Danish Rheumatism Association, The Danish Multiple Sclerosis Society, and Danish Cancer Society. We are very thankful for their input.

Types of outcome measures

Primary outcomes

- All-cause mortality
- Pain assessment on visual analogue scale (VAS) or numerical rating scale (NRS)

- Proportion of participants with a serious adverse event defined as any untoward medical occurrence that resulted in death; was life threatening; was persistent; or led to significant disability, nephrotoxicity, superinfection, need for respiratory support, need for circulatory support, or prolonged hospitalisation [99]. As we expect the trialists' reporting of serious adverse events to be heterogeneous and not strictly according to the ICH-GCP recommendations, we will include the event as a serious adverse if the trialists either: 1) use the term 'serious adverse event' but not refer to ICH-GCP, or 2) report the proportion of participants with an event we consider fulfils the ICH-GCP definition (e.g. myocardial infarction or hospitalisation). If several of such events are reported then we will choose the highest proportion reported in each trial.
- Quality of life measured on any valid continuous scale

Secondary outcomes

- Dependence (as defined by trialists)
- Psychosis (as defined by trialists)
- Proportion of participants with one or more adverse event not considered to be serious
- Sleep quality measured on any valid continuous scale

Exploratory outcomes

- Each serious adverse event separately
- Each adverse event not considered serious separately.
- Twenty-four-hour morphine consumption (as defined by trialists)
- Physical function (as defined by trialists)
- Depressive symptoms (e.g. Hamilton Depression Rating Scale)

We will for all outcomes use the trial results reported at maximal follow-up except for acute pain. For acute pain, we will use the trials' results reported at the time point closest to 24 hours after the intervention is given.

Search methods for identification of studies

Electronic searches

We will search the Cochrane Central Register of Controlled Trials (CENTRAL), Medical Literature Analysis and Retrieval System Online (MEDLINE), Excerpta Medica database (EMBASE), Latin American and Caribbean Health

1
2
3
4 Sciences Literature (LILACS), Science Citation Index Expanded on Web of Science, and BIOSIS in order to identify
5 relevant trials.

6
7 We will search all databases from their inception to the present.

10 11 *Searching other resources*

12 The reference lists of relevant publications will be checked for any unidentified randomised trials. We will
13 contact authors of included studies, and major pharmaceutical companies, by email asking for unpublished
14 randomised trials. Further, we will search for ongoing trials on:

- 17 • ClinicalTrials.gov (www.clinicaltrials.gov)
- 18 • Google Scholar (<https://scholar.google.dk/>)
- 19 • The Turning Research into Practice (TRIP) Database (<https://www.tripdatabase.com/>)
- 20 • European Medicines Agency (EMA) ([http:// www.ema.europa.eu/ema/](http://www.ema.europa.eu/ema/))
- 21 • United States Food and Drug Administration (FDA) (www.fda.gov)
- 22 • China Food and Drug Administration (CFDA) (<http://eng.sfda.gov.cn/WS03/CL0755/>)
- 23 • Medicines and Healthcare products Regulatory Agency
24 ([https://www.gov.uk/government/organisations/
25 medicines-and-healthcare-products-regulatory-
26 agency](https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency))
- 27 • The World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP) search
28 portal ([http://apps.who.int/
29 trialsearch/](http://apps.who.int/trialsearch/))

30
31
32 We will also consider relevant for the review unpublished and grey literature trials, if we identify such trials.

33 34 35 **Data collection and analysis**

36 We will perform the review following the recommendations of Cochrane [100]. The analyses will be performed
37 using Review Manager 5 [101] and Trial Sequential Analysis [102]. In case of Review Manager statistical
38 software not being sufficient, we will use STATA 15 [103].

39 40 41 *Selection of studies*

42 Two authors (JB, SKK) will independently screen titles and abstracts. We will retrieve all relevant full-text study
43 reports/publications, and four review authors (JB, SKK, JRF, MM) will independently screen the full text and
44 identify and record reasons for exclusion of the ineligible studies. We will resolve any disagreement through
45

1
2
3
4 discussion or, if required, we will consult a fifth author (JCJ). Trial selection will be displayed in an adapted flow
5 diagram as per the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement
6 [104].
7
8
9

10 **Data extraction and management**

11
12 Four authors (JB, SKK, JRF, MM) will in pairs extract data independently from included trials. Disagreements will
13 be resolved by discussion with a fifth author (JCJ). We will assess duplicate publications and companion papers
14 of a trial together to evaluate all available data simultaneously (maximise data extraction, correct bias
15 assessment). We will contact the trial authors by email to specify any additional data, which may not have been
16 reported sufficiently or at all in the publication.
17
18
19
20
21

22 *Trial characteristics*

23
24 Bias risk components (as defined below); trial design (parallel, factorial, or crossover); number of intervention
25 arms; length of follow-up; estimation of sample size; inclusion and exclusion criteria.
26
27
28

29 *Participant characteristics and diagnosis*

30
31 Number of randomised participants; number of analysed participants; number of participants lost to follow-up/
32 withdrawals/crossover; compliance with medication; age range (mean or median) and sex ratio; type of pain
33 (acute and chronic pain, cancer-related pain, headache, neuropathic pain or any other types of pain); baseline
34 pain score; drug and dosing regimen; study design (placebo or active control); study duration and follow-up;
35 analgesic outcome measures and results; adverse events (participants experiencing any adverse event, or
36 serious adverse event).
37
38
39
40
41
42

43 *Co-intervention characteristics*

44
45 Type of co-intervention; dose of co-intervention; duration of co-intervention; and mode of administration.
46
47

48 *Outcomes*

49
50 All outcomes listed above will be extracted from each randomised clinical trial, and we will identify if outcomes
51 are incomplete or selectively reported according to the criteria described later in 'incomplete outcome data'
52 bias domain and 'selective outcome reporting' bias domain.
53
54
55
56
57
58
59
60

Notes

Funding of the trial and notable conflicts of interest of trial authors will be extracted, if available. We will note in the 'Characteristics of included studies' table if outcome data were not reported in a usable way. Four review authors (JB, SKK, JRF, MM) will independently transfer data into the Review Manager file [101]. Disagreements will be resolved through discussion or, if required, we will consult with a fifth author (JCJ).

Assessment of risk of bias in included studies

We will use the instructions given in the Cochrane Handbook for Systematic Reviews of Interventions [100] in our evaluation of the methodology and hence the risk of bias of the included trials. We will evaluate the methodology in respect of:

- Random sequence generation
- Allocation concealment
- Blinding of participants and treatment providers
- Blinding of outcome assessment
- Incomplete outcome data
- Selective outcome reporting
- For-profit bias
- Overall risk of bias

These components enable classification of randomised trials as being at low risk of bias and at high risk of bias. The latter trials tend to overestimate positive intervention effects and underestimate negative effects [105-111].

We will classify the trials according to the following criteria.

Random sequence generation

- Low risk: If sequence generation was achieved using computer random number generator or a random number table. Drawing lots, tossing a coin, shuffling cards, and throwing dice were also considered adequate if performed by an independent adjudicator.
- Unclear risk: If the method of randomisation was not specified, but the trial was still presented as being randomised.

- 1
2
3
4 • High risk: If the method of sequence generation was inadequate i.e. alternate medical record numbers
5 or other non-random sequence generation.
6
7
8

9 *Allocation concealment*

- 10
11 • Low risk: If the allocation of patients was performed by a central independent unit, on-site locked
12 computer, identical-looking numbered sealed envelopes, drug bottles, or containers prepared by an
13 independent pharmacist or investigator.
14
15 • Uncertain risk: If the trial was classified as randomised but the allocation concealment process was not
16 described.
17
18 • High risk: If the allocation sequence was familiar to the investigators who assigned participants.
19
20
21
22

23 *Blinding of participants and treatment providers*

- 24 • Low risk: If the participants and the treatment providers were blinded to intervention allocation and
25 this was described.
26
27 • Uncertain risk: If the procedure of blinding was insufficiently described.
28
29 • High risk: If blinding of participants and the treatment providers was not performed.
30
31
32

33 *Blinding of outcome assessment*

- 34 • Low risk of bias: If it was mentioned that outcome assessors were blinded and this was described.
35
36 • Uncertain risk of bias: If it was not mentioned if the outcome assessors in the trial were blinded or the
37 extent of blinding was insufficiently described.
38
39 • High risk of bias: If no blinding or incomplete blinding of outcome assessors was performed.
40
41
42

43 *Incomplete outcome data*

- 44 • Low risk of bias: If missing data were unlikely to make treatment effects depart from plausible values.
45 This could be either (1) there were no drop-outs or withdrawals for all outcomes or (2) the numbers
46 and reasons for the withdrawals and drop-outs for all outcomes were clearly stated and could be
47 described as being similar to both groups. Generally, the trial is judged as at a low risk of bias due to
48 incomplete outcome data if drop-outs are less than 5%. However, the 5% cut-off is not definitive.
49
50 • Uncertain risk of bias: If there was insufficient information to assess whether missing data were likely
51 to induce bias on the results.
52
53
54
55
56
57
58
59
60

- High risk of bias: If the results were likely to be biased due to missing data either because the pattern of drop-outs could be described as being different in the two intervention groups or the trial used improper methods in dealing with the missing data (e.g. last observation carried forward).

Selective outcome reporting

- Low risk of bias: If a protocol was published before or at the time the trial was begun, and the outcomes specified in the protocol were reported on. If there is no protocol or the protocol was published after the trial has begun, reporting pain assessment on VAS or NRS and serious adverse events will grant the trial a grade of low risk of bias.
- Uncertain risk of bias: If no protocol was published and the outcome pain assessment on VAS or NRS and serious adverse events were not reported on.
- High risk of bias: If the outcomes in the protocol were not reported on.

For-profit bias

- Low risk of bias: If the trial appeared to be free of other components of for-profit bias.
- Unclear risk of bias: If it was unclear whether the trial was free of for-profit bias.
- High risk of bias: If there was a high risk of for-profit bias.

Overall risk of bias

- Low risk of bias: The trial will be classified at overall 'low risk of bias' only if all of the bias domains described in the above paragraphs are classified at 'low risk of bias'.
- High risk of bias: The trial will be classified at 'high risk of bias' if any of the bias risk domains described in the above are classified at 'unclear' or 'high risk of bias'.

We will assess the domains 'blinding of outcome assessment', 'incomplete outcome data', and 'selective outcome reporting' for each outcome result. Thus, we can assess the bias risk for each outcome assessed in addition to each trial. Our primary conclusions will be based on the results of our primary outcome results at overall low risk of bias. Both our primary and secondary analyses will be presented in the summary of findings tables.

Differences between the protocol and the review

1
2
3
4 We will conduct the review according to this published protocol and report any deviations from it in the
5 'Differences between the protocol and the review' section of the systematic review.
6
7

8 9 **Measures of treatment effect**

10 *Dichotomous outcomes*

11
12 We will calculate risk ratios (RRs) with 95% confidence interval (CI) for dichotomous outcomes, as well as the
13 Trial Sequential Analysis- adjusted CIs (see below).
14
15

16 *Continuous outcomes*

17
18 We will calculate the mean differences (MDs) and the standardised mean difference (SMD) with 95% CI for
19 continuous outcomes, as well as the Trial Sequential Analysis-adjusted CIs (see below).
20
21
22

23 *Dealing with missing data*

24
25 We will, as first option, contact all trial authors to obtain any relevant missing data (i.e. for data extraction and
26 for assessment of risk of bias, as specified above).
27
28
29

30 *Dichotomous outcomes*

31
32 We will not impute missing values for any outcomes in our primary analysis. In two of our sensitivity analyses
33 (see paragraph below), we will impute data.
34
35
36

37 *Continuous outcomes*

38
39 We will primarily analyse scores assessed at single time points. If only changes from baseline scores are
40 reported, we will analyse the results together with follow-up scores [100]. If standard deviations (SDs) are not
41 reported, we will calculate the SDs using trial data, if possible. We will not use intention-to-treat data if the
42 original report did not contain such data. We will not impute missing values for any outcomes in our primary
43 analysis. In our sensitivity analysis (see paragraph below) for continuous outcomes, we will impute data.
44
45
46
47
48

49 *Assessment of heterogeneity*

50
51 We will primarily investigate forest plots to visually assess any sign of heterogeneity. We will secondly assess
52 the presence of statistical heterogeneity by chi² test (threshold P < 0.10) and measure the quantities of
53
54
55
56
57
58
59

1
2
3
4 heterogeneity by the I^2 statistic [112, 113]. We will investigate for heterogeneity through subgroup analyses.
5
6 Ultimately, we may decide that a meta-analysis should be avoided [100].
7
8

9 *Assessment of reporting biases*

10 We will use a funnel plot to assess reporting bias if ten or more trials are included. We will visually inspect
11 funnel plots to assess the risk of bias. We are aware of the limitations of a funnel plot (i.e. a funnel plot
12 assesses bias due to small sample size). From this information, we assess possible reporting bias. For
13 dichotomous outcomes, we will test asymmetry with the Harbord test [114] if τ^2 is less than 0.1 and with the
14 Rücker test if τ^2 is more than 0.1. For continuous outcomes, we will use the regression asymmetry test [115]
15 and the adjusted rank correlation [116].
16
17
18
19
20
21
22

23 *Unit of analysis issues*

24 We will only include randomised clinical trials. For trials using crossover design, only data from the first period
25 will be included [100, 117]. There will therefore not be any unit of analysis issues.
26
27
28

29 *Minimal important difference*

30 In clinical intervention research it is of utmost importance always to define minimal important differences (MID)
31 and to define thresholds for clinical significance [118]. If a large number of trial participants are randomised,
32 small and clinically irrelevant intervention effects may lead to statistically significant results and rejection of the
33 null hypothesis [119]. Jaeschke et al. defined the minimal important difference as “the smallest difference in
34 score in the domain of interest which patients perceive as beneficial” [120].
35
36
37
38
39
40

41 Estimations of minimal important differences should be used as arbitrary strict precise thresholds. However, to
42 avoid erroneous conclusions minimal important differences need to be estimated and predefined when assessing
43 the effects of interventions for pain. Olsen et al. have conducted two systematic reviews on this matter in order
44 to gather the evidence and present an estimate of the minimal important difference [121, 122]. Olsen et al.
45 conducted a systematic review on the minimal important difference in patients with acute pain and concluded
46 that the median of the studies' results was 17 mm on VAS (IQR 14 mm to 23 mm) [121]. Another systematic
47 review conducted by Olsen et al. was on the minimal important difference in patients with chronic pain and the
48 results showed a median of 23 mm on VAS (IQR 12 mm to 39 mm) when using the within-patient anchor-based
49 method, while the median in studies using the sensitivity- and specificity-based method was 20 mm on VAS (IQR
50
51
52
53
54
55
56
57
58
59
60

1
2
3
4 15 mm – 30 mm) [122]. We have described detailed considerations about minimal important differences in

5 6 **Appendix 1.**

7 Based on the previously conducted systematic reviews we will choose at minimal important difference
8 equivalent to 10 mm or 1 point on the visual analogue scale and the numerical rating scale, respectively,
9 regarding a pain-relieving effect.
10
11
12

13 14 **Data synthesis**

15 *Meta-analysis*

16 We will undertake this meta-analysis according to the recommendations stated in the Cochrane Handbook for
17 Systematic Reviews of Interventions [100], Keus et al. [123], and the eight-step assessment suggested by
18 Jakobsen et al. [118]. We will use the statistical software Review Manager 5.3 [101] provided by Cochrane to
19 analyse data. We will assess our intervention effects with both random-effects meta-analyses [124] and fixed-
20 effect meta-analyses [125]. We will use the more conservative point estimate of the two [118]. The more
21 conservative point estimate is the estimate closest to zero effect. If the two estimates are similar, we will use
22 the estimate with the highest P value [118]. We use four primary and four secondary outcomes, and therefore,
23 we will consider a P value of 0.02 as the threshold for statistical significance [118, 126]. We will investigate for
24 heterogeneity through subgroup analyses. Ultimately, we may decide that a meta-analysis should be avoided
25 [100]. We will use the eight-step procedure to assess if the thresholds for statistical and clinical significance are
26 crossed [118]. Our primary conclusion will be based on results with low risk of bias [118].
27
28
29
30
31
32
33
34
35
36
37

38 Where multiple trial intervention groups are reported in a single trial, we will include only the relevant groups.
39 If two comparisons are combined in the same meta-analysis, we will halve the control group to avoid double-
40 counting [100]. Trials with a factorial design will be included.
41
42
43

44 If quantitative synthesis is not appropriate, we will report the results in a narrative way.
45
46
47
48
49

50 *Trial Sequential Analysis*

51 Traditional meta-analysis runs the risk of random errors due to sparse data and repetitive testing of
52 accumulating data when updating reviews. We wish to control the risks of type I errors and type II errors. We
53 will therefore perform Trial Sequential Analysis on the outcomes, in order to calculate the required information
54
55
56
57
58
59
60

1
2
3
4 size (that is the number of participants needed in a meta-analysis to detect or reject a certain intervention
5 effect) and the cumulative Z-curve's breach of relevant trial sequential monitoring boundaries [102, 127-135].
6
7 A more detailed description of Trial Sequential Analysis can be found in the Trial Sequential Analysis manual
8 [128] and at <http://www.ctu.dk/tsa/>. For dichotomous outcomes, we will estimate the required information
9 size based on the observed proportion of patients with an outcome in the control group (the cumulative
10 proportion of patients with an event in the control groups relative to all patients in the control groups), a
11 relative risk reduction of 20%, an alpha of 2.0% for our primary and secondary outcomes, a beta of 10%, and
12 diversity as suggested by the trials in the meta-analysis. For the outcome "pain assessment on visual analogue
13 scale (VAS) or numerical rating scale (NRS)", we will use a minimal important difference estimate based on
14 previously conducted systematic reviews [121, 122]. We will accept a pain-relieving effect equivalent to 10 mm
15 or 1 point on the visual analogue scale and the numerical rating scale, respectively, or a consumption of at least
16 5 mg morphine.
17
18
19
20
21
22
23
24
25

26 For all remaining continuous outcome, we will in the Trial Sequential Analysis use the observed SD, a mean
27 difference of the observed SD/2, an alpha of 2.0% for our primary and secondary outcomes, and a beta of 10%.
28
29
30

31 **Subgroup analysis and investigation of heterogeneity**

32 *Subgroup analysis*

33 We will perform the following subgroup analysis when analysing the primary outcomes (All-cause mortality,
34 pain assessment on VAS or NRS, serious adverse event, and quality of life).
35
36
37

- 38 • Trials at high risk of bias compared to trials at low risk of bias
- 39 • Trials compared according to type of pain (acute pain, chronic pain and cancer pain)
- 40 • Trials compared according to type of chronic pain
- 41 • Trials compared according to type of cannabinoids used
- 42 • Trials compared according to dosage of cannabinoids used (below median compared to median and
43 above)
- 44 • Trials compared according to duration of cannabinoids administration (below median compared to
45 median and above)
- 46 • Age of participants: 0 to 59 years compared to 60 to 79 years compared to above 80 years
- 47 • Trials compared according to baseline pain score (below median compared to median and above)
- 48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3
4 We will use the formal test for subgroup interactions in Review Manager [101].
5
6

7 *Sensitivity analysis*

8
9 To assess the potential impact of the missing data for dichotomous outcomes, we will perform the two
10 following sensitivity analyses on both the primary and secondary outcomes.
11

- 12 • ‘Best-worst-case’ scenario: We will assume that all participants lost to follow-up in the cannabinoid
13 intervention group have survived and had no serious adverse event, and that all those participants lost
14 to follow-up in the placebo group have not survived, and had a serious adverse event.
15
- 16 • ‘Worst-best-case’ scenario: We will assume that all participants lost to follow-up in the cannabinoid
17 intervention group have not survived, and had a serious adverse event, and that all those participants
18 lost to follow-up in the placebo group have survived, and had no serious adverse event.
19
20
21
22

23
24 We will present results of both scenarios in our review.
25
26

27
28 For all continuous outcome when analysing a ‘beneficial outcome’ will be the group mean plus two standard
29 deviations (SDs) (we will secondly use one SD in another sensitivity analysis) of the group mean and a ‘harmful
30 outcome’ will be the group mean minus two SDs (we will secondly use one SD in another sensitivity analysis) of
31 the group mean [118].
32
33

34
35
36 To assess the potential impact of missing SDs for continuous outcomes, we will perform the following
37 sensitivity analysis.
38

- 39 • Where SDs are missing and it is not possible to calculate them, we will impute SDs from trials with
40 similar populations and low risk of bias. If we find no such trials, we will impute SDs from trials with a
41 similar population. As the final option, we will impute SDs from all trials.
42
43

44 We will present results of this scenario in our review. Other post hoc sensitivity analyses might be warranted if
45 unexpected clinical or statistical heterogeneity is identified during the analysis of the review results [118].
46
47

48 *Summary of Findings*

49
50 We will create a Summary of Findings table using each of the primary outcomes (all-cause mortality, pain
51 assessment on VAS or NRS, serious adverse event, and quality of life). We will use the five GRADE
52 considerations (bias risk of the trials, consistency of effect, imprecision, indirectness, and publication bias) to
53
54
55
56

1
2
3
4 assess the quality of a body of evidence as it relates to the studies which contribute data to the meta-analyses
5 for the prespecified outcomes [118, 136-138]. We will use methods and recommendations described in
6 Chapter 8 (Section 8.5) and Chapter 12 of the Cochrane Handbook for Systematic Reviews of Interventions
7 [100] using GRADEpro software. We will justify all decisions to downgrade the quality of studies using
8 footnotes, and we will make comments to aid the reader's understanding of the review where necessary.
9 Firstly, we will present our results in the Summary of Findings table based on the results from the trials with
10 low risk of bias, and secondly, we will present the results based on all trials.
11
12
13
14
15
16
17

18 **Ethics and Dissemination**

19 Ethical approval is not a requirement since no primary data will be collected. The findings of this systematic
20 review will be submitted for peer-reviewed publication and disseminated in national and international
21 conferences and is expected to inform healthcare workers and providers about the occurrence of serious and
22 non-serious adverse events following cannabinoid consumption. It is expected that the findings of this systematic
23 review will identify some research gaps for future trials.
24
25
26
27
28
29

30 **Discussion**

31
32 This protocol aims at investigating the beneficial and harmful effects of cannabinoids in patients with any type
33 of pain condition. The outcomes will be all-cause mortality, pain assessment on VAS or NRS, serious adverse
34 events, quality of life, dependence, psychosis, non-serious adverse events, and sleep quality.
35
36
37

38
39 This protocol has several strengths. The predefined methodology is based on the Cochrane Handbook for
40 Systematic Reviews of Interventions [100], the eight-step assessment suggested by Jakobsen et al. [118], Trial
41 Sequential Analysis [84], and GRADE assessment [136-138]. Hence, this protocol takes into account both the risk
42 of random error and the risk of systematic error. We predefined evidence-based estimations of minimal
43 important differences which will limit the risk of focusing on statistically significant results with questionable
44 clinical importance. This threshold of minimal important difference is based on the estimations of several
45 previously conducted studies and reviews [121, 122]. Moreover, we are including all types of cannabinoids and
46 all types of pain which will increase the statistical power and make it possible to perform essential subgroup
47 analyses. We have been in contact with several relevant patient associations which has assisted us in choosing
48 the most clinically relevant outcomes.
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3
4
5
6 Our protocol also has several limitations. One of the potential limitations is that we include participants with all
7 types of pain; cannabinoids might have different effects on different types of pain. It might e.g. be problematic
8 to combine trials assessing the effects of cannabinoids on acute pain and chronic pain because of different
9 underlying pathophysiological mechanisms [139]. On the other hand, the effects of cannabinoids on acute pain
10 and chronic pain might be comparable and hence it might be valid to combine trials assessing the effects of
11 cannabinoids on acute pain and chronic pain in meta-analysis, which would increase the statistical power. The
12 results of the subgroup analysis comparing trials including participants with acute pain to participants with
13 chronic pain will therefore be highlighted when reporting our review results. Moreover, we only intend to assess
14 cannabinoids versus placebo or no intervention. Further systematic reviews with meta-analyses and Trial
15 Sequential Analyses need to assess the benefits and harms of cannabinoids versus other pain killers, provided
16 that cannabinoids show more benefit than harm in the present systematic review.
17
18
19
20
21
22
23
24
25

26 Furthermore, more than one active cannabinoid agent is often combined in the different intervention options
27 provided to the patients with a pain condition, thereby making difficult to explore the analgesic effect and
28 adverse event associated with a single cannabinoid agent. Hence, if we show a difference between the
29 intervention options, it will be difficult to conclude what exactly caused the difference in effect. To minimise
30 these limitations, we have planned a careful assessment of statistical and clinical heterogeneity as well as several
31 subgroup analyses and sensitivity analyses. Another limitation is the large number of comparisons which increase
32 the risk of type 1 error. We have adjusted our thresholds for significance according to the number of primary
33 outcomes, but, as mentioned, we have also included multiple subgroup analyses. This large risk of type 1 error
34 will be taken into account when interpreting the review results.
35
36
37
38
39
40
41
42
43

44 **Acknowledgements**

45 We hugely appreciate the contribution of The Danish Diabetes Association, Steno Diabetes Centre Copenhagen,
46 The Danish Rheumatism Association, The Danish Multiple Sclerosis Society, and Danish Cancer Society in
47 selecting the most patient relevant outcomes.
48
49
50

51 **Funding statement**

52
53
54
55
56
57
58
59
60

1
2
3
4 This research received no specific grant from any funding agency in the public, commercial or not-for-profit
5 sectors.
6
7

8 9 **Authors' contributions**

10 JB drafted the protocol. JCJ, SKK, OM, CG, JRF and MM amended the protocol. All authors read and approved the
11 final manuscript.
12
13

14 15 16 **Competing interests**

17 The authors declare that they have no competing interests
18
19

20 21 **Ethics approval and consent to participate**

22 Not applicable.
23
24

25 26 **Word Count**

27 10835 words, including the full references.
28
29

30 31 **References**

- 32
33 1. Verhaak P, Kerssens J, Dekker J, Sorbi M, and Bensing J, *Prevalence of chronic benign pain*
34 *disorder among adults: a review of the literature*. PAIN, 1998. **77**(3): p. 231-9.
- 35 2. Kroenke K, *Patients presenting with somatic complaints: epidemiology, psychiatric comorbidity*
36 *and management*. Int J Methods Psychiatr Res, 2003. **12**(1): p. 34-43.
- 37 3. Sternbach RA, *Survey of pain in the United States: The nuprin pain report*. The Clinical Journal of
38 Pain, 1986. **2**(1): p. 49-53.
- 39 4. Gureje O, Von Korff M, Simon G, and Gater R, *Persistent pain and well-being: a World Health*
40 *Organization Study in Primary Care*. Jama, 1998. **280**(2): p. 147-51.
- 41 5. Breivik H, *International association for the study of pain: update on WHO-IASP activities*. J Pain
42 Symptom Manage, 2002. **24**(2): p. 97-101.
- 43 6. Astin J, *Why patients use alternative medicine: Results of a national study*. JAMA, 1998. **279**(19):
44 p. 1548-1553.
- 45 7. Davison SN, Jhangri GS, and Johnson JA, *Cross-sectional validity of a modified Edmonton*
46 *symptom assessment system in dialysis patients: a simple assessment of symptom burden*.
47 Kidney Int, 2006. **69**(9): p. 1621-5.
- 48 8. Davison SN, Jhangri GS, and Johnson JA, *Longitudinal validation of a modified Edmonton*
49 *symptom assessment system (ESAS) in haemodialysis patients*. Nephrol Dial Transplant, 2006.
50 **21**(11): p. 3189-95.
51
52
53
54
55
56
57
58
59
60

- 1
- 2
- 3
- 4 9. Davison SN and Jhangri GS, *Impact of pain and symptom burden on the health-related quality of*
- 5 *life of hemodialysis patients*. J Pain Symptom Manage, 2010. **39**(3): p. 477-85.
- 6
- 7 10. Davison S, *Chronic pain in end-stage renal disease*. Adv Chronic Kidney Dis, 2005. **12**(3): p. 326-
- 8 34.
- 9
- 10 11. Kimmel PL, Emont SL, Newmann JM, Danko H, and Moss AH, *ESRD patient quality of life:*
- 11 *symptoms, spiritual beliefs, psychosocial factors, and ethnicity*. Am J Kidney Dis, 2003. **42**(4): p.
- 12 713-21.
- 13
- 14 12. Leinau L, Murphy TE, Bradley E, and Fried T, *Relationship between conditions addressed by*
- 15 *hemodialysis guidelines and non-ESRD-specific conditions affecting quality of life*. Clin J Am Soc
- 16 Nephrol, 2009. **4**(3): p. 572-8.
- 17
- 18 13. Weisbord SD, Carmody SS, Bruns FJ, Rotondi AJ, Cohen LM, Zeidel ML, et al., *Symptom burden,*
- 19 *quality of life, advance care planning and the potential value of palliative care in severely ill*
- 20 *haemodialysis patients*. Nephrol Dial Transplant, 2003. **18**(7): p. 1345-52.
- 21
- 22 14. Weisbord SD, Fried LF, Arnold RM, Fine MJ, Levenson DJ, Peterson RA, et al., *Prevalence,*
- 23 *severity, and importance of physical and emotional symptoms in chronic hemodialysis patients*.
- 24 J Am Soc Nephrol, 2005. **16**(8): p. 2487-94.
- 25
- 26 15. Gamondi C, Galli N, Schonholzer C, Marone C, Zwahlen H, Gabutti L, et al., *Frequency and*
- 27 *severity of pain and symptom distress among patients with chronic kidney disease receiving*
- 28 *dialysis*. Swiss Med Wkly, 2013. **143**: p. w13750.
- 29
- 30 16. Smith BH, Elliott AM, Chambers WA, Smith WC, Hannaford PC, and Penny K, *The impact of*
- 31 *chronic pain in the community*. Fam Pract, 2001. **18**(3): p. 292-9.
- 32
- 33 17. Merskey H, Lindblom U, Mumford JM, Nathan PW, and Sunderland S, *Part III: Pain terms—a*
- 34 *current list with definitions and notes on usage with definitions and notes on usage.. In: Merskey*
- 35 *H, Bogduk N editor(s). Classification of Chronic Pain, IASP Task Force on Taxonomy*. IASP Press,
- 36 1994(2nd Edition): p. 209-14.
- 37
- 38 18. Carr DB and Goudas LC, *Acute pain*. The Lancet, 1999. **353**(9169): p. 2051-2058.
- 39
- 40 19. Ashburn MA and Staats PS, *Management of chronic pain*. The Lancet, 1999. **353**(9167): p. 1865-
- 41 1869.
- 42
- 43 20. Kanner R, *Pain Management*. JAMA, 1986. **256**(15): p. 2112-2114.
- 44
- 45 21. Loeser J, Melzack R, *Pain: an overview*. The Lancet, 1999. **353**(9164): p. 1607-1609.
- 46
- 47 22. Portenoy R and Dhingra L. *Assessment of cancer pain*. 2017 [cited 18/04 2018].
- 48
- 49 23. Gregory J and McGowan L, *An examination of the prevalence of acute pain for hospitalised adult*
- 50 *patients: a systematic review*. J Clin Nurs, 2016. **25**(5-6): p. 583-98.
- 51
- 52 24. Treede R, *Entstehung der schmerzchronifizierung. Rückenschmerzen und nackenschmerzen*.
- 53 2016: Springer, Berlin, Heidelberg.
- 54
- 55 25. American Geriatrics Society Panel *Pharmacological management of persistent pain in older*
- 56 *persons*. J Am Geriatr Soc, 2009. **57**: p. 1331-46.
- 57
- 58 26. Steingrimsdottir OA, Landmark T, Macfarlane GJ, and Nielsen CS, *Defining chronic pain in*
- 59 *epidemiological studies: a systematic review and meta-analysis*. Pain, 2017. **158**(11): p. 2092-
- 60 2107.
27. Breivik H, Collett B, Ventafridda V, Cohen R, and Gallacher D, *Survey of chronic pain in Europe:*
- prevalence, impact on daily life, and treatment*. Eur J Pain, 2006. **10**(4): p. 287-333.

- 1
- 2
- 3
- 4 28. Goldberg DS and McGee SJ, *Pain as a global public health priority*. BMC Public Health, 2011. **11**:
5 p. 770.
- 6 29. Gureje O, Von Korff M, Kola L, Demyttenaere K, He Y, Posada-Villa J, et al., *The relation between*
7 *multiple pains and mental disorders: results from the World Mental Health Surveys*. PAIN, 2008.
8 **135**(1-2): p. 82-91.
- 9 30. Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education, *Relieving pain in America: A blueprint for transforming prevention, care, education, and*
10 *research*. National Academies Press 2011.
- 11 31. Koleva D, *Pain in primary care: an Italian survey*. Eur J Public Health, 2005. **15**: p. 475–79.
- 12 32. Mantyselka P, Kumpusalo E, Ahonen R, Kumpusalo A, Kauhanen J, Viinamaki H, et al., *Pain as a*
13 *reason to visit the doctor: a study in Finnish primary health care*. PAIN, 2001. **89**(2-3): p. 175-80.
- 14 33. Treede RD, Rief W, Barke A, Aziz Q, Bennett MI, Benoliel R, et al., *A classification of chronic pain*
15 *for ICD-11*. PAIN, 2015. **156**(6): p. 1003-7.
- 16 34. Kelly DJ, Ahmad M, and Brull SJ, *Preemptive analgesia I: physiological pathways and*
17 *pharmacological modalities*. Canadian Journal of Anaesthesia, 2001. **48**(10): p. 1000-1010.
- 18 35. Pogatzki-Zahn EM, Segelcke D, and Schug SA, *Postoperative pain-from mechanisms to*
19 *treatment*. Pain Rep, 2017. **2**(2): p. e588.
- 20 36. Bajwa ZH, Wootton J, and Wippold II FJ. *Evaluation of headache in adults*. 2018 [cited 2018].
- 21 37. Lipowski Z, *Chronic idiopathic pain syndrome*. Annals of Medicine, 1990. **22**(4): p. 213-217.
- 22 38. Goucke C, *The management of persistent pain*. Med J Aust, 2003. **178**(9): p. 444-7.
- 23 39. Chang V. *Approach to symptom assessment in palliative care*. 2018 [cited 2018].
- 24 40. Knowles CH and Aziz Q, *Basic and clinical aspects of gastrointestinal pain*. Pain, 2009. **141**(3): p.
25 191-209.
- 26 41. Stein S L, *Chronic pelvic pain*. Gastroenterol Clin North Am, 2013. **42**(4): p. 785-800.
- 27 42. Schwartz ES and Gebhart GF, *Visceral pain*. Curr Top Behav Neurosci, 2014. **20**: p. 171-97.
- 28 43. Giamberardino M, Affaitati G, and Costantini R, *Chapter 24 Referred pain from internal organs*.
29 *Handb Clin Neurol*, 2006. **81**: p. 343-61.
- 30 44. Jensen TS, Baron R, Haanpaa M, Kalso E, Loeser JD, Rice AS, et al., *A new definition of neuropathic*
31 *pain*. Pain, 2011. **152**(10): p. 2204-5.
- 32 45. Mannion RJ and Woolf CJ, *Pain mechanisms and management: a central perspective*. Clin J Pain,
33 2000. **16**(3 Suppl): p. S144-56.
- 34 46. Headache Classification Committee of the International Headache Society, *The International*
35 *Classification of Headache Disorders, 3rd edition (beta version)*. Cephalalgia, 2013. **33**: p. 629-
36 808.
- 37 47. Institute for clinical systems improvement, *Health care guideline: Assessment and management*
38 *of chronic pain*. 2009.
- 39 48. Kehlet H, Jensen TS, and Woolf CJ, *Persistent postsurgical pain: Risk factors and prevention*. The
40 *Lancet*, 2006. **367**(9522):1618-25.
- 41 49. United Nations office on drugs and crime, *World Drug Report, United Nations*. 2016.
- 42 50. Russo E, *Cannabinoids in the management of difficult to treat pain*. Ther Clin Risk Manag, 2008.
43 **4**(1): p. 245-59.
- 44
- 45
- 46
- 47
- 48
- 49
- 50
- 51
- 52
- 53
- 54
- 55
- 56
- 57
- 58
- 59
- 60

- 1
- 2
- 3
- 4 51. Ueda N, Tsuboi K, and Uyama T, *Metabolic enzymes for endocannabinoids and endocannabinoid-like mediators*. 2015, Boston: Academic Press.
- 5
- 6 52. Devane WA, Hanus L, Breuer A, Pertwee RG, Stevenson LA, Griffin G, et al., *Isolation and structure of a brain constituent that binds to the cannabinoid receptor*. *Science*, 1992. **258**(5090): p. 1946-9.
- 7
- 8
- 9
- 10 53. Mechoulam R, Ben-Shabat S, Hanus L, Ligumsky M, Kaminski NE, Schatz AR, et al., *Identification of an endogenous 2-monoglyceride, present in canine gut, that binds to cannabinoid receptors*. *Biochem Pharmacol*, 1995. **50**(1): p. 83-90.
- 11
- 12
- 13 54. Sugiura T, Kondo S, Sukagawa A, Nakane S, Shinoda A, Itoh K, et al., *2-Arachidonoylglycerol: a possible endogenous cannabinoid receptor ligand in brain*. *Biochem Biophys Res Commun*, 1995. **215**(1): p. 89-97.
- 14
- 15
- 16 55. Shook JE and Burks TF, *Psychoactive cannabinoids reduce gastrointestinal propulsion and motility in rodents*. *Journal of Pharmacology and Experimental Therapeutics*, 1989. **249**(2): p. 444-449.
- 17
- 18
- 19 56. Calignano A, La Rana G, Giuffrida A, and Piomelli D, *Control of pain initiation by endogenous cannabinoids*. *Nature*, 1998. **394**(6690): p. 277-81.
- 20
- 21 57. Jaggar SI, Hasnie FS, Sellaturay S, and Rice AS, *The anti-hyperalgesic actions of the cannabinoid anandamide and the putative CB2 receptor agonist palmitoylethanolamide in visceral and somatic inflammatory pain*. *Pain*, 1998. **76**(1-2): p. 189-99.
- 22
- 23 58. Pacher P, Bátkai S, and Kunos G, *The endocannabinoid system as an emerging target of pharmacotherapy*. *Pharmacol Rev*, 2006. **58**(3): p. 389-462.
- 24
- 25 59. Fisar Z, *Phytocannabinoids and endocannabinoids*. *Curr Drug Abuse Rev*, 2009. **2**(1): p. 51-75.
- 26
- 27 60. Häuser W, Fitzcharles M, Radbruch L, and Petzke F, *Cannabinoids in pain management and palliative medicine*. *Deutsches Arzteblatt international*, 2017. **114**(38): p. 627-634.
- 28
- 29 61. Hazekamp A, Ware MA, Muller-Vahl KR, Abrams D, and Grotenhermen F, *The medicinal use of cannabis and cannabinoids—An international cross-sectional survey on administration forms*. *Journal of Psychoactive Drugs*, 2013. **45**(3): p. 199-210.
- 30
- 31 62. European Monitoring Centre for Drugs and Drug Addiction, *Understanding the spice phenomenon*. Lisbon, 2009.
- 32
- 33 63. EMCDDA, *Annual report on the state of the drugs problem in Europe*. 2012.
- 34
- 35 64. Watson SJ, Benson JA, and Joy JE, *Marijuana and medicine: assessing the science base: a summary of the 1999 Institute of Medicine report*. *Arch Gen Psychiatry*, 2000. **57**(6): p. 547-52.
- 36
- 37 65. Brenneisen R, *Chemistry and analysis of phytocannabinoids and other cannabis constituents*, in *Marijuana and the Cannabinoids*, ElSohly MA, Editor. 2007, Humana Press: Totowa, NJ. p. 17-49.
- 38
- 39 66. Hillard C, Weinlander K, and Stuhr K, *Contributions of endocannabinoid signaling to psychiatric disorders in humans: genetic and biochemical evidence*. *Neuroscience*, 2012. **204**: p. 207-29.
- 40
- 41 67. Pertwee R, *Cannabis and cannabinoids: Pharmacology and rationale for clinical use*. *Pharmacy and Pharmacology Communications*, 1997. **3**(11): p. 539-545.
- 42
- 43 68. Solinas M, Goldberg SR, and Piomelli D, *The endocannabinoid system in brain reward processes*. *Br J Pharmacol*, 2008. **154**(2): p. 369-83.
- 44
- 45
- 46
- 47
- 48
- 49
- 50
- 51
- 52
- 53
- 54
- 55
- 56
- 57
- 58
- 59
- 60

- 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10
 - 11
 - 12
 - 13
 - 14
 - 15
 - 16
 - 17
 - 18
 - 19
 - 20
 - 21
 - 22
 - 23
 - 24
 - 25
 - 26
 - 27
 - 28
 - 29
 - 30
 - 31
 - 32
 - 33
 - 34
 - 35
 - 36
 - 37
 - 38
 - 39
 - 40
 - 41
 - 42
 - 43
 - 44
 - 45
 - 46
 - 47
 - 48
 - 49
 - 50
 - 51
 - 52
 - 53
 - 54
 - 55
 - 56
 - 57
 - 58
 - 59
 - 60
69. D'Souza D, Cortes-Briones J, Ranganathan M, Thurnauer H, Creatura G, Surti T, et al., *Rapid Changes in CB1 Receptor Availability in Cannabis Dependent Males after Abstinence from Cannabis*. *Biol Psychiatry Cogn Neurosci Neuroimaging*, 2016. **1**(1): p. 60-67.
70. American Psychiatric Association, *Diagnostic and statistical manual of mental disorders. Fifth Edition*. 2013.
71. Koppel BS, Brust J, Fife T, Bronstein J, Yousof S, Gronseth G, et al., *Systematic review: efficacy and safety of medical marijuana in selected neurologic disorders: report of the Guideline Development Subcommittee of the American Academy of Neurology*. *Neurology*, 2014. **82**(17): p. 1556-63.
72. Gorelick D, Saxon A, and Hermann R *Cannabis use and disorder: Pathogenesis and pharmacology*. UpToDate Cannabis use and disorder: Pathogenesis and pharmacology, 2018.[cited Access 2018 Access Date].
73. Morean ME, Kong G, Camenga DR, Cavallo DA, and Krishnan-Sarin S, *High school students' use of electronic cigarettes to vaporize cannabis*. *Pediatrics*, 2015. **136**(4): p. 611-616.
74. Loflin M and Earleywine M, *No smoke, no fire: What the initial literature suggests regarding vapourized cannabis and respiratory risk*. *Canadian journal of respiratory therapy*, 2015. **51**(1): p. 7-9.
75. Aggarwal SK, Carter GT, Sullivan MD, ZumBrunnen C, Morrill R, and Mayer JD, *Medicinal use of cannabis in the United States: historical perspectives, current trends, and future directions*. *J Opioid Manag*, 2009. **5**(3): p. 153-68.
76. Stockings E, Zagic D, Campbell G, Weier M, Hall WD, Nielsen S, et al., *Evidence for cannabis and cannabinoids for epilepsy: a systematic review of controlled and observational evidence*. *J Neurol Neurosurg Psychiatry*, 2018. **89**(7): p. 741-753.
77. GW Pharmaceuticals, *Sativex® approved in Denmark for the treatment of spasticity due to Multiple Sclerosis (MS)*. <https://www.gwpharm.com/about-us/news/sativex®-approved-denmark-treatment-spasticity-due-multiple-sclerosis-ms>, 2011. **2018**.
78. ABC NEWS, *STANFORD MEDICAL CENTER POLL: Broad Experience with Pain Sparks a Search for Relief*. 2005.
79. Aviram J and Samuelly-Leichtag G, *Efficacy of Cannabis-Based Medicines for Pain Management: A Systematic Review and Meta-Analysis of Randomized Controlled Trials*. *Pain Physician*, 2017. **20**(6): p. E755-e796.
80. Lynch M, Campbell, F, *Cannabinoids for treatment of chronic non-cancer pain; a systematic review of randomized trials*. *Br J Clin Pharmacol*, 2011. **72**(5): p. 735-44.
81. Meng H, Johnston B, Englesakis M, Moulin DE, and Bhatia A, *Selective Cannabinoids for Chronic Neuropathic Pain: A Systematic Review and Meta-analysis*. *Anesth Analg*, 2017. **125**(5): p. 1638-1652.
82. Boychuk DG, Goddard G, Mauro G, and Orellana MF, *The effectiveness of cannabinoids in the management of chronic nonmalignant neuropathic pain: a systematic review*. *J Oral Facial Pain Headache*, 2015. **29**(1): p. 7-14.
83. Martin-Sanchez E, Furukawa TA, Taylor J, and Martin JL, *Systematic review and meta-analysis of cannabis treatment for chronic pain*. *Pain Med*, 2009. **10**(8): p. 1353-68.

- 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10
 - 11
 - 12
 - 13
 - 14
 - 15
 - 16
 - 17
 - 18
 - 19
 - 20
 - 21
 - 22
 - 23
 - 24
 - 25
 - 26
 - 27
 - 28
 - 29
 - 30
 - 31
 - 32
 - 33
 - 34
 - 35
 - 36
 - 37
 - 38
 - 39
 - 40
 - 41
 - 42
 - 43
 - 44
 - 45
 - 46
 - 47
 - 48
 - 49
 - 50
 - 51
 - 52
 - 53
 - 54
 - 55
 - 56
 - 57
 - 58
 - 59
 - 60
84. Campbell FA, Tramèr MR, Carroll D, Reynolds DJ, Moore RA, and McQuay HJ, *Are cannabinoids an effective and safe treatment option in the management of pain? A qualitative systematic review*. BMJ (Clinical research ed.), 2001. **323**(7303): p. 13-16.
85. Deshpande A, Mailis-Gagnon A, Zoheiry N, and Lakha SF, *Efficacy and adverse effects of medical marijuana for chronic noncancer pain: Systematic review of randomized controlled trials*. Can Fam Physician, 2015. **61**(8): p. e372-81.
86. Stevens AJ and Higgins MD, *A systematic review of the analgesic efficacy of cannabinoid medications in the management of acute pain*. Acta Anaesthesiol Scand, 2017. **61**(3): p. 268-280.
87. Walitt B, Klose P, Fitzcharles MA, Phillips T, and Hauser W, *Cannabinoids for fibromyalgia*. Cochrane Database Syst Rev, 2016. **7**: p. Cd011694.
88. Mucke M, Phillips T, Radbruch L, Petzke F, and Hauser W, *Cannabis-based medicines for chronic neuropathic pain in adults*. Cochrane Database Syst Rev, 2018. **3**: p. Cd012182.
89. Boydell J, Van Os J, Caspi A, Kennedy N, Giouroukou E, Fearon P, et al., *Trends in cannabis use prior to first presentation with schizophrenia, in South-East London between 1965 and 1999*. Psychological Medicine, 2006. **36**(10): p. 1441-1446.
90. Andreasson S, Allebeck P, Engstrom A, and Rydberg U, *Cannabis and schizophrenia. A longitudinal study of Swedish conscripts*. Lancet, 1987. **2**(8574): p. 1483-6.
91. Arseneault L, Cannon M, Poulton R, Murray R, Caspi A, and Moffitt TE, *Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study*. Bmj, 2002. **325**(7374): p. 1212-3.
92. van Os J, Bak M, Hanssen M, Bijl R V, de Graaf R, and Verdoux H, *Cannabis use and psychosis: a longitudinal population-based study*. Am J Epidemiol, 2002. **156**(4): p. 319-27.
93. Zammit S, Allebeck P, Andreasson S, Lundberg I, and Lewis G, *Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study*. Bmj, 2002. **325**(7374): p. 1199.
94. Fergusson DM, Horwood LJ, and Ridder EM, *Tests of causal linkages between cannabis use and psychotic symptoms*. Addiction, 2005. **100**(3): p. 354-66.
95. Henquet C, Krabbendam L, Spauwen J, Kaplan C, Lieb R, Wittchen HU, et al., *Prospective cohort study of cannabis use, predisposition for psychosis, and psychotic symptoms in young people*. Bmj, 2005. **330**(7481): p. 11.
96. Di Forti M, Quattrone D, Freeman TP, Tripoli G, Gayer-Anderson C, Quigley H, et al., *The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe (EU-GEI): a multicentre case-control study*. Lancet Psychiatry, 2019. **6**(5): p. 427-436.
97. Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, et al., *Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and explanation*. Bmj, 2015. **350**: p. g7647.
98. Moher D, Shamseer L, Clarke M, Ghersi D, Liberati A, Petticrew M, et al., *Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement*. Syst Rev, 2015. **4**: p. 1.
99. *International conference on harmonisation of technical requirements for registration of pharmaceuticals for human use (ICH) adopts consolidated guideline on good clinical practice in*

- 1
2
3
4 *the conduct of clinical trials on medicinal products for human use*. *Int Dig Health Legis*, 1997.
5 **48**(2): p. 231-4.
6
7 100. Higgins J and Green S. *Cochrane handbook for systematic reviews of interventions version 5.1.0*.
8 www.handbook.cochrane.org. 2011.
9
10 101. *Review Manager (RevMan)*. 2014, Copenhagen: the Nordic Cochrane Centre, The Cochrane
11 Collaboration.
12
13 102. *TSA—trial sequential analysis*. Copenhagen Trial Unit.
14
15 103. *StataCorp: Stata: Release 14*. 2014, College Station, TX: StataCorp LP.
16
17 104. Moher D, Liberati A, Tetzlaff J, and Altman DG, *Preferred reporting items for systematic reviews*
18 *and meta-analyses: The PRISMA statement*. *PLOS Medicine*, 2009. **6**(7): p. e1000097.
19
20 105. Gluud LL, *Bias in clinical intervention research*. *Am J Epidemiol*, 2006. **163**(6): p. 493-501.
21
22 106. Kjaergard LL, Villumsen J, and Gluud C, *Reported methodologic quality and discrepancies*
23 *between large and small randomized trials in meta-analyses*. *Ann Intern Med*, 2001. **135**(11): p.
24 982-9.
25
26 107. Lundh A, Sismondo, S, Lexchin, J, Busuioac, OA, Bero, L, *Industry sponsorship and research*
27 *outcome*. *Cochrane Database Syst Rev*, 2012. **12**: p. Mr000033.
28
29 108. Moher D, Pham, B, Jones, A, Cook, DJ, Jadad, AR, Moher, M et al., *Does quality of reports of*
30 *randomised trials affect estimates of intervention efficacy reported in meta-analyses?* *Lancet*,
31 1998. **352**(9128): p. 609-13.
32
33 109. Schulz KF, Chalmers I, Hayes RJ, and Altman DG, *Empirical evidence of bias. Dimensions of*
34 *methodological quality associated with estimates of treatment effects in controlled trials*. *JAMA*,
35 1995. **273**(5): p. 408-12.
36
37 110. Wood L, Egger M, Gluud L, Schulz K, Jüni P, Altman D, et al., *Empirical evidence of bias in*
38 *treatment effect estimates in controlled trials with different interventions and outcomes: meta-*
39 *epidemiological study*. *BMJ*, 2008. **336**(7644): p. 601-605.
40
41 111. Savovic J, Jones H, Altman D, Harris R, Juni P, Pildal J, et al., *Influence of reported study design*
42 *characteristics on intervention effect estimates from randomised controlled trials: combined*
43 *analysis of meta-epidemiological studies*. *Health Technol Assess*, 2012. **16**(35): p. 1-82.
44
45 112. Higgins JP and Thompson SG, *Quantifying heterogeneity in a meta-analysis*. *Stat Med*, 2002.
46 **21**(11): p. 1539-58.
47
48 113. Higgins JP, Thompson SG, Deeks JJ, and Altman DG, *Measuring inconsistency in meta-analyses*.
49 *BMJ*, 2003. **327**(7414): p. 557-60.
50
51 114. Harbord RM, Egger M, and Sterne JA, *A modified test for small-study effects in meta-analyses of*
52 *controlled trials with binary endpoints*. *Stat Med*, 2006. **25**(20): p. 3443-57.
53
54 115. Egger M, Davey Smith G, Schneider M, and Minder C, *Bias in meta-analysis detected by a simple,*
55 *graphical test*. *BMJ*, 1997. **315**(7109): p. 629-34.
56
57 116. Begg CB and Mazumdar M, *Operating characteristics of a rank correlation test for publication*
58 *bias*. *Biometrics*, 1994. **50**(4): p. 1088-101.
59
60 117. Elbourne D, Altman D, Higgins J, Curtin F, Worthington H, and Vail A, *Meta-analyses involving*
cross-over trials: methodological issues. *International Journal of Epidemiology*, 2002. **31**(1): p.
140-149.

118. Jakobsen JC, Wetterslev J, Winkel P, Lange T, and Gluud C, *Thresholds for statistical and clinical significance in systematic reviews with meta-analytic methods*. BMC Med Res Methodol, 2014. **14**: p. 120.
119. Hagg O, Fritzell P, and Nordwall A, *The clinical importance of changes in outcome scores after treatment for chronic low back pain*. Eur Spine J, 2003. **12**(1): p. 12-20.
120. Jaeschke R, Singer J, and Guyatt GH, *Measurement of health status. Ascertaining the minimal clinically important difference*. Control Clin Trials, 1989. **10**(4): p. 407-15.
121. Olsen MF, Bjerre E, Hansen MD, Hilden J, Landler NE, Tendal B, et al., *Pain relief that matters to patients: systematic review of empirical studies assessing the minimum clinically important difference in acute pain*. BMC Med, 2017. **15**(1): p. 35.
122. Olsen MF, Bjerre E, Hansen MD, Tendal B, Hilden J, and Hrobjartsson A, *Minimum clinically important differences in chronic pain vary considerably by baseline pain and methodological factors: systematic review of empirical studies*. J Clin Epidemiol, 2018. **101**: p. 87-106.e2.
123. Keus F, Wetterslev J, Gluud C, and van Laarhoven CJ, *Evidence at a glance: error matrix approach for overviewing available evidence*. BMC Med Res Methodol, 2010. **10**: p. 90.
124. DerSimonian R and Laird N, *Meta-analysis in clinical trials*. Control Clin Trials, 1986. **7**(3): p. 177-88.
125. Demets DL, *Methods for combining randomized clinical trials: strengths and limitations*. Stat Med, 1987. **6**(3): p. 341-50.
126. Jakobsen J C, Wetterslev J, Lange T, and Gluud C, *Viewpoint: taking into account risks of random errors when analysing multiple outcomes in systematic reviews*. Cochrane Database of Systematic Reviews, 2016(3).
127. Wetterslev J, Thorlund K, Brok J, and Gluud C, *Trial sequential analysis may establish when firm evidence is reached in cumulative meta-analysis*. J Clin Epidemiol, 2008. **61**(1): p. 64-75.
128. Thorlund K W J, Brok J, Imberger G, Gluud C, *User manual for trial sequential analysis (TSA)*. 2011.
129. Brok J, Thorlund K, Gluud C, and Wetterslev J, *Trial sequential analysis reveals insufficient information size and potentially false positive results in many meta-analyses*. J Clin Epidemiol, 2008. **61**(8): p. 763-9.
130. Brok J, Thorlund K, Wetterslev J, and Gluud C, *Apparently conclusive meta-analyses may be inconclusive--Trial sequential analysis adjustment of random error risk due to repetitive testing of accumulating data in apparently conclusive neonatal meta-analyses*. Int J Epidemiol, 2009. **38**(1): p. 287-98.
131. Thorlund K, Devereaux PJ, Wetterslev J, Guyatt G, Ioannidis JP, Thabane L, et al., *Can trial sequential monitoring boundaries reduce spurious inferences from meta-analyses?* Int J Epidemiol, 2009. **38**(1): p. 276-86.
132. Wetterslev J, Thorlund K, Brok J, and Gluud C, *Estimating required information size by quantifying diversity in random-effects model meta-analyses*. BMC Med Res Methodol, 2009. **9**: p. 86.
133. Thorlund K, Anema A, and Mills E, *Interpreting meta-analysis according to the adequacy of sample size. An example using isoniazid chemoprophylaxis for tuberculosis in purified protein derivative negative HIV-infected individuals*. Clin Epidemiol, 2010. **2**: p. 57-66.

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
134. Imberger G, Gluud C, Boylan J, and Wetterslev J, *Systematic reviews of anesthesiologic interventions reported as statistically significant: problems with power, precision, and type 1 error protection*. *Anesth Analg*, 2015. **121**(6): p. 1611-22.
 135. Imberger G, Thorlund K, Gluud C, and Wetterslev J, *False-positive findings in Cochrane meta-analyses with and without application of trial sequential analysis: an empirical review*. *BMJ Open*, 2016. **6**(8).
 136. Guyatt G, Oxman A, Vist G, Kunz R, Falck-Ytter Y, Alonso-Coello P, et al., *GRADE: an emerging consensus on rating quality of evidence and strength of recommendations*. *BMJ*, 2008. **336**(7650): p. 924-926.
 137. Guyatt GH, Oxman AD, Schunemann HJ, Tugwell P, and Knottnerus A, *GRADE guidelines: a new series of articles in the Journal of Clinical Epidemiology*. *J Clin Epidemiol*, 2011. **64**(4): p. 380-2.
 138. Schunemann HJ, Best D, Vist G, and Oxman AD, *Letters, numbers, symbols and words: how to communicate grades of evidence and recommendations*. *Cmaj*, 2003. **169**(7): p. 677-80.
 139. Voscopoulos C and Lema M, *When does acute pain become chronic?* *Br J Anaesth*, 2010. **105** **Suppl 1**: p. i69-85.

Appendix

Minimal important difference

For the determination of minimal important differences in clinical trials two types of methods are available; anchor-based methods and distributional-based methods [1].

Anchor-based methods

Anchor-based methods relate the change in on a person reported outcome score, (e.g. a score on the visual analog scale (VAS)) to a subjective global assessment rating (e.g. scores from the Clinical Global Impressions-Improvement (CGI-I)) which is used as an 'anchor' [1]. Ideally, there needs to be an established association between the person reported outcome score and the 'anchor' to make any meaningful inference about a minimal important difference [2].

There are two subtypes of anchor-based methods, i.e., the '*within-patient score*' and the '*between-patients score*' [1].

- Within-patient score defines minimal important difference as the average minimal change in a given person's reported outcome score that leads to a clinically observable change in the subjective global assessment rating (the latter is used as an anchor) [1]. For example, to ascertain the minimal important difference regarding depression management, Moncrieff et. al describes the linking of within-patient scores (change from baseline) scores on the Hamilton Depression Rating Scale (the most commonly used depression rating scale) to scores on the Clinical Global Impressions-Improvement (CGI-I) scale, a scale which rates improvement on a scale of 1 (very much improved from baseline) through 4 (no change from baseline) to 7 (very much worse from baseline) [3]. Moncrieff et. al conclude that seven points on the Hamilton Depression Rating Scale correspond to a minimal important difference when using within-patient scores [3].
- The between-patients score method, also known as 'the group difference' method, compare the reported outcome scores between a group of people with no clinically observable change (based on a subjective global assessment rating (used as an anchor)) to a group of people with clinically observable change (based on a subjective global assessment rating (used as an anchor)). The minimal important difference is then estimated as the mean difference between these two groups [4]. For example, Musoro et. al defines the minimal important difference (MID) as the group difference in terms of quality of life assessed by HRQOL scores [5]. Participants were assigned to distinct subgroups reflecting various levels of change (e.g. no change, small positive changes, large positive changes, small negative changes or large negative changes). The group difference was identified by the

1
2
3
4 comparison of the average of the HRQOL scores of the group of participants with at 'small change'
5 to the HRQOL scores of the group of participants with 'no change' [5].
6
7
8

9 There are also other anchor-based methods (e.g. the sensitivity- and specificity-based method and the social
10 comparison method) [1]. The sensitivity- and specificity-based method aims to identify the minimal
11 important difference that allows for the best discrimination between groups of patients (i.e., the score that
12 produces the greatest sensitivity and specificity) [1]. For example, an outcome measure (e.g. NRS score) is
13 considered a 'diagnostic test' and the anchor (e.g. Global Perceived Effect) is used as gold standard and hence
14 standard methods may be used to estimate sensitivity and specificity. Sensitivity is the proportion of patients
15 who report an improvement on the external criterion (anchor) and whose person reported outcome scores
16 are above the threshold minimal important difference value [1]. Specificity is the proportion of patients who
17 do not report an improvement on the external criterion (anchor) and whose person reported outcome scores
18 are below the threshold minimal important difference value [1]. Receiver operating characteristic (ROC)
19 curves are then used to identify the person reported outcome score with the greatest sensitivity and
20 specificity [6-8].
21
22
23
24
25
26
27
28
29
30

31 *The distributional-based methods*

32 Distribution-based methods are based on the statistical characteristics of the obtained sample [9]. Crosby et.
33 al [9] have identified two general types of distribution-based methods for estimations of minimal important
34 differences:
35
36

- 37 • The first type of distribution-based method evaluate change in relation to sample variation [9].
38 Different types of variation can be used: effect size, standardised response mean, and
39 responsiveness statistic [9]. The effect size represents individual change in relation to the number of
40 pre-test standard deviations (SDs) [9]. Cohen et. al has suggested benchmarks to better interpret the
41 effect sizes: .20 for "small" effects, .50 for "moderate" effects, and .80 for "large" effects [10].
42 Whereas the effect size is the ratio of individual change to the baseline standard deviation of the
43 sample, standardised response mean is the ratio of individual change to the standard deviation of
44 that change [11]. A large standardised response mean indicates that the change is large in
45 comparison to the background variability in the measurements [9]. Guyatt et. al has proposed a
46 responsiveness statistic as a variation of standardised response mean; calculated by dividing the
47 difference between pre-test and post-test by the standard deviation of change observed for a group
48 of stable participants [12].
49
50
51
52
53
54
55
56
57
58
59
60

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
- The second type distribution-based method is based on the measurement precision of the instrument [9]. This method include the standard error of the mean (SEM) and evaluate the change in relation to variation of the instrument as opposed to variation in the sample [9]. Standard error of the mean (SEM) is a measure of the precision of a test instrument and considered an attribute of the measure and not a characteristic of the sample per se [13]. The standard error of the mean (SEM) for a given measure is likely to vary across samples depending upon the method used to estimate reliability and the presence of extreme scores [9]. Different thresholds for a minimal important difference have been suggested, i.e., values of 1 SEM [14], 1.96 SEM [15], and 2.77 SEM [13, 15].

19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38

In conclusion, different methods for estimating minimal important differences exist, but no single method has been shown to be the optimal method. The question of whether to use anchor-based or distribution-based methods for determining clinically meaningful change has received considerable attention and debate [9]. Dworkin et. al defined the clinical importance of patient improvement as the clinically important changes in individuals that can be identified using either within-patient anchor-based method or distributional-based method [16, 17], while the clinical importance of group differences could be the clinical difference between a treatment group and a placebo group or between two different treatment groups [18]. Dworkin et. al claim that the clinical important difference identified in individuals cannot be directly extrapolated to the evaluation of group differences [17, 19-22]. The U.S. Food and Drug Administration also states in their web site “When defining meaningful change on an individual patient basis, that definition is generally larger than the minimum important difference for application to group mean comparisons” [22].

39
40
41
42
43
44
45

While it is claimed that the within-patient differences are larger the between-group difference [22], based on the studies included in our review we are not able to find a significant difference between the minimal important difference estimated by the two different methods.

46 47

Previously conducted reviews on this subject

- 48
49
50
51
52
53
54
55
56
57
58
59
60
- Lynch & Campbell and Boychuk et. al both concluded that cannabinoids are a modestly effective and a safe treatment option for neuropathic pain [23, 24]. Lynch & Campbell and Boychuk et. al did not publish a protocol on beforehand [23, 24].
 - Meng et. al concluded that there is moderate quality evidence to suggest that nabiximols (phytocannabinoid mixture) is effective in reducing neuropathic pain [25].

- Mücke et. al concluded that there is no high-quality evidence for the efficacy of any cannabis-based medicine in any condition with chronic neuropathic pain [26]. Mücke et. al further concluded that some adverse events may limit the clinical usefulness of cannabis-based medicines [26].
- Deshpande et. al concluded that current evidence suggests that very low-dose medical marijuana (< 34 mg/d) is associated with an improvement in refractory neuropathic pain of moderate severity in adults using concurrent analgesics. Deshpande et. al did not publish a protocol on beforehand [27].
- Martín-Sánchez et. al concluded that treatment of chronic pain based on cannabinoid compounds would entail more risk of adverse events than benefit [28]. Martín-Sánchez et. al included trials randomising participants with either neuropathic pain, cancer pain, fibromyalgia related pain and nociceptive pain [28]. Martín-Sánchez et. al did not publish a protocol on beforehand [28].
- Aviram et. al concluded that cannabinoid-based medicines were not effective for postoperative pain, however further investigation is advised [29]. Aviram et. al also concluded that evidence suggests a moderate to good treatment effect on neuropathic pain [29]. Furthermore, neuropathic pain patients should be advised that the inhalation of cannabinoids showed relatively better pain reduction effects than other routes of administration [29]. Aviram et. al stated that the total number of adverse events that were accumulated in the meta-analysis indicated that cannabinoid-based medicines should be used with caution [29]. Aviram et. al did not publish a protocol on beforehand [29].
- Campbell et. al concluded that levonantradol (synthetic cannabinoid analogue) was superior to placebo on postoperative pain but no more effective than codeine [30]. Campbell et. al also stated that there are suggestions of efficacy in spasticity and in neuropathic pain and that increasing the cannabinoid dose to increase the analgesia will increase adverse effects [30]. Campbell et. al did not publish a protocol on beforehand [30].
- Stevens et. al concluded that cannabinoids have no role in the management of acute pain, but cannabinoids were found to be well-tolerated, with most reported adverse effects only mild to moderate in severity [31].
- Walitt et. al concluded that no convincing, unbiased evidence suggests that nabilone (synthetic cannabinoid analog) is of value in treating people with fibromyalgia [32]. The tolerability of nabilone was low and adverse events (particularly somnolence, dizziness, vertigo) may limit its clinical usefulness [32].

TABEL 1

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
First author	Title	Year of publication	Design	Type of cannabinoid	Types of participants	Information sources	No. of trials	No. of participants	Published protocols	Outcomes	Assessment of adverse events	Assessment of risk of bias	Accounts for random error	Use of the GRADE	Conclusion																																												
Lynch & Campbell [23]	Cannabinoids for treatment of chronic non-cancer pain; a systematic review of random	2011	Systematic Review	Phytocannabinoids ; Smoked cannabis, oromucosal extracts of cannabis-based medicine, and synthetic cannabinoids ; nabilone, dronabin	Neuropathic pain, fibromyalgia, rheumatoid arthritis, and mixed chronic pain.	PubMed, EMBASE, CINAHL (EBSCO), PsycInfo (EBSCO), The Cochrane Library, ISI Web of Science, ABI Inform (Proquest), Dissertation Abstracts (Proquest), Academic Search	18	766	No	The primary outcome was pain in subjects with chronic non-cancer pain. The secondary outcomes were sleep, function, and quality of life.	Yes	Yes, except for reporting bias, publication bias and for-profit bias	No	No	Overall there is evidence that cannabinoids are safe and modestly effective in neuropathic pain with preliminary evidence of efficacy																																												

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

	mi ze d tria ls			ol and a nove l THC anal ogue .		Premie r (EBSCO) , Clinical Trials.g ov, TrialsC entral. org, individ ual pharm aceutic al compa ny trials sites for Eli Lilly and GlaxoS mithKli ne, OAlste r (OCLC) and Google Scholar .									in fibro myal gia and rheu mato id arthr itis. Did not pool data for meta - analy sis but data was descr ibed quali tativ ely.
Me ng et. al [25]	Sel ect ive Cann abino ids for Chro	20 17	Sys tema tic Re vie w and Meta-	Dron abin ol, nabil one and nabi ximo ls	Ne urop athic pai n	Medlin e, Embas e, Cochra ne Library , PROSP ERO, clinical	11 (1 0 trials com pa rin g th	12 19	N o	The primar y outco me was intensi ty of pain record ed	Ye s	Ye s	Bon ferr oni adju stm ent for multi ple testi	Y e s	Selec tive cann abin oids provi de a small analgesic bene

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

	nic Ne ur op ath ic Pai n: A Sys te ma tic Re vie w an d Me ta- an aly sis		an aly sis			trials.g ov, and Google Scholar . Pain societi es (Ameri can Society of Anesth esiolog ists, Europe an Society of Anaest hesiolo gy, Intern ation al Associ ation for the Study of Pain, Americ an Society of Region al Anesth esia and Pain Medici ne, Europe an	e int er ve nti on wi th pla ce bo)			after a minim um of 2 weeks followi ng initiati on of selecti ve cannab inoid and placeb o/com parato r admini stratio n, expres sed on an NRS (0—no pain to 10— worst possibl e pain). Second ary outco mes were presen ce or absenc e of analge sia define d as			ng was not perf orm ed as per rec om me nda tion s in the Coc hra ne Han dbo ok.		fit in patie nts with chro nic neur opat hic pain.
--	--	--	------------------	--	--	---	---	--	--	--	--	--	--	--	---

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

						<p>Society of Regional Anesthesia and Pain Therapy, and World Institute of Pain) in the last 2 years were also searched.</p>			<p>reduction in pain scores (NRS/VAS) by $\geq 30\%$ at 2 weeks or more after initiation of intervention, quality of life (QoL), physical function, psychological function, sleep, overall patient satisfaction, and the incidence of adverse effects of selective cannabinoids.</p>					
--	--	--	--	--	--	--	--	--	---	--	--	--	--	--

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
Martín-Sánchez et al [28]	Systematic Review and Meta-analysis of Cannabinoids Treatment for Chronic Pain	2009	Meta-analysis	Phytocannabinoids and synthetic derivatives of THC, such as dronabinol, nabilone, or benzopyranoperidine (a synthetic nitrogen analog of THC)	Chronic pain of a pathological or traumatic origin	Medline/Pubmed, Embase, and The Cochrane Controlled Trials Register (CENTRAL)	18	?	No	The primary outcome was intensity of pain as scored by numerical rating scales. The Secondary outcomes were CNS related events	Yes	Yes, except for reporting bias, detection bias and for-profit bias	No	No	Currently available evidence suggests that cannabis treatment is moderately efficacious for treatment of chronic pain, but beneficial effects may be partially (or completely) offset by potentially serious																																												

															us harm s.
Boy chu k et. al [24]	The Eff ect ive ness of Cann abi noids in the Man age ment of Chro nic Non mali gnant Neur opath ic Pain: A Syste matic Re	20 15	Syste matic Re view	Phyt ocan nabi noid s ; smoked cann abis, cann abis- base d medi cinal extra cts (CB ME) in the form of oro muc osal spra ys (nabi ximo ls), vapo rized cann abis, and synt hetic cann abin oids ; dron	Neur opath ic pain	PubMe d, Embas e, Web of Scienc e, and all eviden ce- based medici ne review s and databa ses (Cochr ane Databa se of System atic Review s, ASP Journal Club, Databa se of Abstra cts of Review s of Effects [DARE] , and Cochra ne Contro lled	13	77 1	No	Outco mes consid ered were reducti on in pain intensi ty and advers e events.	Yes	Yes, exce pt for, repor ting bias, publi cations bias and for- profi t bias	No	No	Cann abis- base d medi cinal extra cts used in diffe rent popu lations of chro nic non- mali gnant neur opath ic pain patie nts may provi de effec tive analge sia in condi tions that are refra ctory

	view			abinol, nabilone, and CT-3		Trials Register [CCTR])									to other treatments.
Mücke et. al [26]	Cannabis products for adults with chronic neuropathic pain	2018	Cochrane Review	Phytocannabinoid ; oromucosal spray containing THC or THC/CBD mix, smoked cannabis containing THC, THC and CBD as extract of cannabis sativa L., and synt	Neuropathic pain	Cochrane Library, MEDLINE and EMBASE. Following clinical trials databases were searched for additional data including unpublished data: US National Institutes of Health clinical trial register (www.ClinicalTrials.gov)	16 (15 of the trials compared)	1750	Yes	Primary outcomes: Participant-reported pain relief of 50% or greater. We preferred composite neuropathic pain scores over single-scale generic pain scores if both measures were used by studies;	Yes	Yes	No	Yes	The potential benefits of cannabis-based medicine (herbal cannabis, plant-derived or synthetic THC, THC/CBD oromucosal spray) in chronic neuropathic pain might be

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

				<p>hetic cann abin oids; nabil one, dron abin ol</p>	<p>Trials.g ov), Europe an Union Clinical Trials Registe r (www. clinical trialsre gister. eu), World Health Organi zation (WHO) Interna tional Clinical Trials Registr y Platfor m (ICTRP) (apps. who.in t/trials earch/) , and Interna tional Associ ation for Canna binoid Medici nes (IACM) databa nk</p>	<p>PGIC (Patien t Global Impres sion of Chang e) much or very much improv ed;</p> <p>Withdr awals due to advers e events (tolera bility);</p> <p>Seriou s advers e events (safety). Seriou s advers e events typicall y include any untow ard medica l occurr ence</p>	<p>outw eigh ed by their pote ntial harm s.</p>
--	--	--	--	---	--	---	---

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

						www.cannabis-med.org/studies/study.php)				or effect that at any dose results in death, is life-threatening, requires hospitalisation or prolongation of existing hospitalisation, results in persistent or significant disability or incapacity, is a congenital anomaly or birth defect, is an 'important medical				
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

										I event' that may jeopar dise the person , or may requir e an interve ntion to preven t one of the above charac teristic s/cons equen ces.					
Avi ra m et. al [29]	Effi cac y of Cann abi s- Ba se d Me dic ine s for Pai n Ma na ge	20 17	Me ta- An aly sis	Phyt ocan nabi noid s; Sativ ex/n abixi mol, cann abidi ol, cann abin oid cigar ettes /vap orize r,	Ch ro nic (ca nc er an d no n- ca nc er) pai n an d ac ute po sto	MEDLI NE/Pu bmed and in Google Scholar using Medic al Subjec t Headin g (MeSH) terms	43 tri als co m pa rin g the int er ve nti on wi th bo th 'ac tiv	24 37	N o	The outco me measu re that was chosen was the variabl e "pain intensi ty", as scored by the numeri cal rating scale (NRS- 11),	Ye s	Ye s, ex ce pt fo r, re po rti ng bi as, pu bli ca tio n bi as an	No	N o	The curre nt syste mati c revie w sugg ests that cann abin oid- base d medi cines migh t be effec

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

	ment: A Systematic Review and Meta-Analysis of Randomized Controlled Trials		and synthetic cannabinoids; dronabinol and nabilone, CT-3, ajulemic acid, synthetic nitrogen analog of tetrahydrocannabinol (NIB), fatty acid amide hydrolase-1 (FAAH1) inhibitor (PF-04457845) (block	perative pain		drug and placebo			numerical 11-point box (BS-11), visual analog scale (VAS), and the VAS section of the questionnaire short form McGill Pain Questionnaire.		d for-profit bias		tive for chronic pain treatment, based on limited evidence, primarily for neuropathic pain patients.
--	---	--	--	---------------	--	------------------	--	--	---	--	-------------------	--	--

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

				king degr adati on of endo cann abin oids) , benz opyr anop eridi ne (BPP) , and levo nant radol											
Ca mp bell et. al [30]	Ar e cann abin oids an effe ctive and safe tre at ment opt ion in the mana	20 01	Sys tem atic Re vie w	Oral THC, an oral synt hetic nitro gen anal ogue of THC (NIB) , oral benz opyr anop eridi ne (BPP) , and intra mus cular	Ac ute , chro nic non- ma lig na nt pai n, and can cer pai n	MEDLI NE, EMBAS E, Oxford Pain Databa se, and Cochra ne Library	9	22 2	No	Outco me measu res for pain intensi ty; pain relief; the use of supple menta ry analge sia; patient s' prefer ences; and advers e effects .	Yes	Yes, ex cept for, re po rti ng bi as, pu bli ca tio n bi as and for- pr	No	No	Cann abin oids are no more effec tive than code ine in contr ollin g pain and have depr essa nt effec ts on the centr

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

	gement of pain? A qualitative systematic review			levonantadol								ofit bias			al nervous system that limit their use. Their widespread introduction into clinical practice for pain management is therefore undesirable. In acute post operative pain they should not be used.
Des hpa	Effi cac	20 15	Sys te	Cigar ettes	Ne ur	MEDLI NE,	6 tri	22 6	N o	For outco	Ye s	Ye s,	No	N o	Ther e is

nd e et. al [27]	y an d ad ver se eff ect s of me dic al mari ju an a for chro nic non can cer pai n		ma tic Re vie w	or vapo rizer cont ainin g delta -9- THC	op ath ic pai n	EMBAS E, and the Interna tional Pharm aceutic al Abstra cts	als co m pa rin g int er ve nti on wi th pla ce bo . Pla ce bo bei ng cigar ett es or va po riz er co nt ain ing 0% del ta- 9- TH C or wi th ca			mes, pain scores were extract ed using the visual analog ue scale (VAS) or an alterna tive numeri cal pain rating tool. If pain scores were not report ed, surrog ate measu res of effecti veness were include d (sleep, functio n, and quality of life). Freque ncy of serious and		ex ce pt fo r, re po rti ng bi as, pu bli ca tio n bi as and for pro fit bi as		evid ence for the use of low- dose medi cal mari juana in refra ctory neur opat hic pain in conj uncti on with tradi tiona l anal gesics. How ever, trials were limit ed by short dura tion, varia bility in dosi ng and
----------------------------------	---	--	-----------------------------	--	-----------------------------	--	--	--	--	---	--	---	--	--

															una rema in unkn own.
11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60	Steven et. al [31]	20 17	Systematic Review	Levonant radol , nabilone, AZD 1940 , GW8 4216 6, dronabin ol, Δ-9-T HC	Acute postope rative pain	MEDLINE, EMBASE, Cochrane Library , and the World Health Organization International Clinical Trials Registry Platform	7 trials comparing interve ntion with placebo , Ketopro fen , Pethidine , Naproxen , and Ibupro	61 1	Yes	The primary outcome was the qualitative analysis of the analgesic efficacy of cannabinoids in the management of acute pain compared to placebo or active comparator. The secondary outcome was the qualitative	Yes	Yes, except for, publication bias and for- profit bias	No	Yes	Based on the available randomized controlled trial evidence, cannabinoids have no role in the management of acute pain.

							rof en			analysi s of the report ed advers e effects .					
Wa litt et. al [32]	Ca nn abinoids for fibro myalgia	20 16	Co chr ane Re vie w	Nabil one	Fibro myalgia	Cochra ne Library , MEDLI NE and EMBAS E	2 tri als com pa rin g the int er ve nti on wi th eit he r (1) pla ce bo or (1) a mi tri pt yline	72 (4 0)	Y es	Primar y outco mes: Partici pant-r eporte d pain relief of 50% or greate r. PGIC (Patien t Global Impres sion of Chang e) much or very much improv ed. Withdr awal due to advers e events	Ye s	Ye s, ex ce pt for pu bli ca tion bi as.	No	Y es	We foun d no convi ncing , unbi ased, high quali ty evid ence sugg estin g that nabil one is of value in treat ing peop le with fibro myalgia. The toler abilit y of nabil one

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

										existin g hospit alisatio n, results in persist ent or signific ant disabili ty or incapa city, is a conge nital anoma ly or birth defect, is an 'impor tant medica l event' that may jeopar dise the person , or may requir e an interve ntion to preven t one of the above						
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

										charac teristic s/cons equen ces.									
--	--	--	--	--	--	--	--	--	--	---	--	--	--	--	--	--	--	--	--

References

1. Copay AG, Subach BR, Glassman SD, Polly DW, and Schuler TC, *Understanding the minimum clinically important difference: a review of concepts and methods*. Spine J, 2007. **7**(5): p. 541-6.
2. Guyatt GH, Osoba D, Wu AW, Wyrwich KW, and Norman GR, *Methods to Explain the Clinical Significance of Health Status Measures*. Mayo Clinic Proceedings, 2002. **77**(4): p. 371-383.
3. Moncrieff J and Kirsch I, *Empirically derived criteria cast doubt on the clinical significance of antidepressant-placebo differences*. Contemp Clin Trials, 2015. **43**: p. 60-2.
4. Hagg O, Fritzell P, and Nordwall A, *The clinical importance of changes in outcome scores after treatment for chronic low back pain*. Eur Spine J, 2003. **12**(1): p. 12-20.
5. Musoro ZJ, Hamel J, Ediebah DE, Cocks K, King MT, Groenvold M, et al., *Establishing anchor-based minimally important differences (MID) with the EORTC quality-of-life measures: a meta-analysis protocol*. BMJ Open, 2018. **8**(1).
6. Stratford PW, Binkley JM, Riddle DL, and Guyatt GH, *Sensitivity to change of the Roland-Morris Back Pain Questionnaire: part 1*. Phys Ther, 1998. **78**(11): p. 1186-96.
7. Riddle DL, Stratford PW, and Binkley JM, *Sensitivity to change of the Roland-Morris Back Pain Questionnaire: part 2*. Phys Ther, 1998. **78**(11): p. 1197-207.
8. Van der Roer N, Ostelo RW, Bekkering GE, van Tulder MW, and de Vet HC, *Minimal clinically important change for pain intensity, functional status, and general health status in patients with nonspecific low back pain*. Spine (Phila Pa 1976), 2006. **31**(5): p. 578-82.
9. Crosby RD, Kolotkin RL, and Williams GR, *Defining clinically meaningful change in health-related quality of life*. J Clin Epidemiol, 2003. **56**(5): p. 395-407.
10. Cohen J, *CHAPTER 1 - The Concepts of Power Analysis*, in *Statistical Power Analysis for the Behavioral Sciences*, Cohen J, Editor. 1977, Academic Press. p. 1-17.
11. Fayers PM and Machin D, *Quality of life: assessment, analysis and interpretation*. John Wiley & Sons, 2000.
12. Guyatt GH, Bombardier C, and Tugwell PX, *Measuring disease-specific quality of life in clinical trials*. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne, 1986. **134**(8): p. 889-895.
13. Wyrwich KW, Tierney WM, and Wolinsky FD, *Further evidence supporting an SEM-based criterion for identifying meaningful intra-individual changes in health-related quality of life*. J Clin Epidemiol, 1999. **52**(9): p. 861-73.
14. Wolinsky FD, Wan GJ, and Tierney WM, *Changes in the SF-36 in 12 months in a clinical sample of disadvantaged older adults*. Med Care, 1998. **36**(11): p. 1589-98.
15. McHorney CA and Tarlov AR, *Individual-patient monitoring in clinical practice: are available health status surveys adequate?* Qual Life Res, 1995. **4**(4): p. 293-307.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

16. Lydick E and Epstein RS, *Interpretation of quality of life changes*. Qual Life Res, 1993. **2**(3): p. 221-6.
17. Beaton DE, Bombardier C, Katz JN, Wright JG, Wells G, Boers M, et al., *Looking for important change/differences in studies of responsiveness. OMERACT MCID Working Group. Outcome Measures in Rheumatology. Minimal Clinically Important Difference*. J Rheumatol, 2001. **28**(2): p. 400-5.
18. Dworkin RH, Turk DC, McDermott MP, Peirce-Sandner S, Burke LB, Cowan P, et al., *Interpreting the clinical importance of group differences in chronic pain clinical trials: IMMPACT recommendations*. Pain, 2009. **146**(3): p. 238-44.
19. Cella D, Bullinger M, Scott C, and Barofsky I, *Group vs individual approaches to understanding the clinical significance of differences or changes in quality of life*. Mayo Clin Proc, 2002. **77**(4): p. 384-92.
20. Guyatt GH, *Making sense of quality-of-life data*. Med Care, 2000. **38**(9 Suppl): p. li175-9.
21. Testa MA, *Interpretation of quality-of-life outcomes: issues that affect magnitude and meaning*. Med Care, 2000. **38**(9 Suppl): p. li166-74.
22. U.S. Department of Health Human Services FDA Center for Drug Evaluation Research, U.S. Department of Health Human Services FDA Center for Biologics Evaluation Research, U.S. Department of Health Human Services FDA Center for Devices Radiological Health, *Guidance for industry: patient-reported outcome measures: use in medical product development to support labeling claims: draft guidance*. 2006. **4**: p. 79.
23. Lynch M E and Campbell F, *Cannabinoids for treatment of chronic non-cancer pain; a systematic review of randomized trials*. Br J Clin Pharmacol, 2011. **72**(5): p. 735-44.
24. Boychuk D G, Goddard G, Mauro G, and Orellana M F, *The effectiveness of cannabinoids in the management of chronic nonmalignant neuropathic pain: a systematic review*. J Oral Facial Pain Headache, 2015. **29**(1): p. 7-14.
25. Meng H, Johnston B, Englesakis M, Moulin D E, and Bhatia A, *Selective Cannabinoids for Chronic Neuropathic Pain: A Systematic Review and Meta-analysis*. Anesth Analg, 2017. **125**(5): p. 1638-1652.
26. Mücke M, Phillips T, Radbruch L, Petzke F, and Häuser W, *Cannabis-based medicines for chronic neuropathic pain in adults*. Cochrane Database of Systematic Reviews, 2018(3).
27. Deshpande A, Mailis-Gagnon A, Zoheiry N, and Lakha S F, *Efficacy and adverse effects of medical marijuana for chronic noncancer pain: Systematic review of randomized controlled trials*. Can Fam Physician, 2015. **61**(8): p. e372-81.
28. Martin-Sanchez E, Furukawa T A, Taylor J, and Martin J L, *Systematic review and meta-analysis of cannabis treatment for chronic pain*. Pain Med, 2009. **10**(8): p. 1353-68.
29. Aviram J and Samuelli-Leichtag G, *Efficacy of Cannabis-Based Medicines for Pain Management: A Systematic Review and Meta-Analysis of Randomized Controlled Trials*. Pain Physician, 2017. **20**(6): p. E755-e796.
30. Campbell F A, Tramèr M R, Carroll D, Reynolds D J M, Moore R A, and McQuay H J, *Are cannabinoids an effective and safe treatment option in the management of pain? A qualitative systematic review*. Bmj, 2001. **323**(7303): p. 13.
31. Stevens A J and Higgins M D, *A systematic review of the analgesic efficacy of cannabinoid medications in the management of acute pain*. Acta Anaesthesiol Scand, 2017. **61**(3): p. 268-280.

- 1
2
3
4 32. Walitt B, Klose P, Fitzcharles M A, Phillips T, and Hauser W, *Cannabinoids for fibromyalgia*.
5 Cochrane Database Syst Rev, 2016. **7**: p. Cd011694.
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

First author	Year of publication	Design	Type of cannabinoid	Types of participants	Information sources	No. of trials	No. of participants or interventions	Published protocol	Outcomes	Assessment of adverse events	Assessment of bias	Accounts for random error	Use of the GRADE	Conclusion	
Lynch & Campbell	2011	Systematic Review	Physician nabiximols; smoked cannabis; oromucosal extracts of cannabis; chronic pain; nabiximols, dronabinol and a novel THC analog.	Chronic pain; fibromyalgia; rheumatoid arthritis; and mixed chronic pain.	PubMed, EMBASE, CINAHL, EBSCO, Cochrane Library, ISI PsycInfo, Web of Science, AD Inform (Proquest), and Dissertation Abstracts (Proquest), Academic Search Premier, EBSCO, Clinical Trials.gov, TrialCentral.org, Individual pharmaceutical company trials sites for Eli Lilly and GlaxoSmithKline, Olaner (DOLC) and Google Scholar.	3	13	Yes	Primary outcome was pain in subjects with chronic non-cancer pain. The secondary outcomes were sleep, function, and quality of life.	Yes	Yes, except for reporting bias; publication bias and for-profit bias	No	Overall there is evidence that cannabinoids are safe and modestly effective in neuropathic pain with preliminary evidence of efficacy in fibromyalgia and rheumatoid arthritis. Did not pool data for meta-analysis but data was described qualitatively.		
Meng et al	2017	Selective Review and Meta-analysis	Nabiximols	Chronic pain	Medline, Embase, PROSPERO, Cochrane Library, ISI ClinicalTrials.gov, and Google Scholar. Pain societies (American Society of Anesthesiologists, European Society of Anaesthesiology, International Association for the Study of Pain, American Society of Regional Anesthesia and Pain Medicine, European Society of Regional Anesthesia and Pain Therapy, and World Federation of Pain) in the last 2 years were also searched.	11	1150	219	No	The primary outcome was intensity of pain recorded after a minimum of 2 weeks following initiation of selective cannabinoid or placebo/comparator administration, expressed on an NRS (0=no pain to 10=worst possible pain). Secondary outcomes were presence or absence of analgesia defined as reduction in pain scores (NRS/VAS) by ≥30% at 2 weeks or more after initiation of intervention, quality of life (QoL), physical function, psychological function, sleep, overall patient satisfaction, and the incidence of adverse effects of selective cannabinoids.	Yes	Yes	Bonferroni adjustment for multiple testing was not performed as per recommendations in the Cochrane Handbook.	Yes	Selective cannabinoids provide a small analgesic benefit in patients with chronic neuropathic pain.
Martin-Sanchez et al	2009	Systematic Review and Meta-analysis of Cannabis Treatment for Chronic Pain	Physician nabiximols; dronabinol, or benpropyriperidine (a synthetic tetrahydrocannabinol analog of THC)	Chronic pain of a pathological or traumatic origin	Medline, Embase, and the Cochrane Controlled Trials Register (CENTRAL)	18	7	No	The primary outcome was intensity of pain as scored by numerical rating scales. The secondary outcomes were CNS related events	Yes	Yes, except for reporting bias; detection bias and for-profit bias	No	Currently available evidence suggests that cannabis treatment is moderately efficacious for treatment of chronic pain, but beneficial effects may be partially (or completely) offset by potentially serious harms.		
Boychuk et al	2015	The Effectiveness of Cannabis in the Management of Chronic Neuropathic Pain: A Systematic Review	Physician nabiximols; cannabis-based medical extracts (CBME) in the form of oromucosal sprays (nabiximols), vaporized cannabis, and synthetic cannabinoids (dronabinol, nabilone, and CT-3)	Chronic pain	PubMed, Embase, Web of Science, and all evidence-based medicine reviews and databases (Cochrane Database of Systematic Reviews, ASP Journal Club, Database of Abstracts of Reviews of Effects [DARE], and Cochrane Controlled Trials Register [CCTR])	13	771	No	Outcomes considered were reduction in pain intensity and adverse events.	Yes	Yes, except for reporting bias; publication bias and for-profit bias	No	Cannabis-based medicinal extracts used in different populations of chronic non-malignant neuropathic pain patients may provide effective analgesia in conditions that are refractory to other treatments.		
Milicki et al	2018	Cannabis products for adults with chronic neuropathic pain	Physician nabiximols; THC oromucosal spray containing THC/ CBD, oromucosal cannabis containing THC, THC and CBD, an extract of cannabis sativa L., and synthetic cannabinoids (dronabinol, nabilone, and CT-3)	Chronic pain	Cochrane Library, MEDLINE and EMBASE, the following clinical trials the databases were searched for additional unpublished data: US National Institutes of Health clinical trial register (www.clinicaltrials.gov), European Union Clinical Trials Register (www.clinicaltrialsregister.eu), World Health Organization (WHO) and International Clinical Trials Registry Platform (ICTRP) (apps.who.int/trialsearch/), and International Association for Cannabinoid Medicines (IACM) database (www.cannabis-med.com).	16	115	1750	Yes	Primary outcomes: Participant-reported pain relief of 50% or greater. We preferred composite neuropathic pain scores over single-scale generic pain scores if both measures were used by studies; RIG (Patient Global Impression of Change) much or very much improved. Withdrawals due to adverse events (tolerability); Serious adverse events (safety). Serious adverse events typically include any untoward medical occurrence or effect that at any dose results in...	Yes	Yes	No	Yes	The potential benefits of cannabis-based medicines (herbal cannabis, plant-derived or synthetic THC, THCCBD oromucosal spray) in chronic neuropathic pain they might be outweighed by their potential harms.
Avram et al	2017	Efficacy of Cannabis-Based Medicines for Pain Management: A Systematic Review and Meta-Analysis of Randomized Controlled Trials	Physician nabiximols; Sativex (a non-nabilone, nabilone, and dronabinol) postoperative acute pain; cigarettes/vaporizer; and synthetic cannabinoids (dronabinol and nabilone, CT-3, ajulemic acid), synthetic nitrogen analog of tetrahydrocannabinol (Nabilone, Lety)	Chronic pain	Medline, Embase, and the International Medical Subject Heading (MeSH) terms in both active drug and placebo	43	2437	No	The outcome measure that was chosen was the variable "pain intensity," as scored by the numerical rating scale (NRS-11), numerical 11-point box (0-10), visual analog scale (VAS), and the VAS section of the questionnaire short form McGill Pain Questionnaire	Yes	Yes, except for reporting bias; publication bias and for-profit bias	No	No	The current systematic review suggests that cannabis-based medicines might be effective for chronic pain treatment, based on limited evidence, primarily for neuropathic pain patients.	
Campbell et al	2001	Acute cannabisoids as an effective and safe treatment option in the management of acute pain? A qualitative systematic review	Oral THC, synthetic cannabinoids, oromucosal spray of THC (Nabilone), oral benpropyriperidine (BPP), and tetrahydrocannabinol	Acute non-malignant cancer pain	MEDLINE, EMBASE, and Cochrane Library, and the World Health Organization International Clinical Trials Registry Platform	9	222	No	Outcome measures for pain intensity, pain relief, the use of supplementary analgesic patients' preferences; and adverse effects.	Yes	Yes, except for reporting bias; publication bias and for-profit bias	No	No	Cannabinoids are no more effective than codeine in controlling pain and have depressant effects on the central nervous system that limit their use. The widespread introduction into clinical practice for pain management is therefore undesirable. In acute postoperative pain they should not be used.	
Deshbandh et al	2015	Efficacy and adverse effects of medical marijuana for chronic noncancer pain	Cigarettes or vaporizer containing delta-9-THC	Neuropathic pain	MEDLINE, EMBASE, and the International Pharmaceutical Abstracts	6	226	No	For outcomes, pain scores were extracted using the visual analogue scale (VAS) or an alternative numerical pain rating tool. If pain scores were not reported, surrogate measures of effectiveness were included (sleep, function, and quality of life). Frequency of various and most commonly reported adverse effects was collected.	Yes	Yes, except for reporting bias; publication bias and for-profit bias	No	No	There is evidence for the use of low-dose medical marijuana in refractory neuropathic pain in conjunction with traditional analgesics. However, trials were limited by short duration, variability in dosing and strength of delta-9-tetrahydrocannabinol, and lack of functional outcomes. Although well tolerated in the short term, the long-term effects of psychoactive and neurocognitive effects of medical marijuana remain unknown.	
Stevens et al	2017	A systematic review of the analgesic efficacy of cannabisoid medication in the management of acute pain	Leonatrol, nabiximols, dronabinol, -9-THC	Acute postoperative pain	MEDLINE, EMBASE, Cochrane Library, and the World Health Organization International Clinical Trials Registry Platform	7	611	Yes	The primary outcome was the qualitative analysis of the analgesic efficacy of cannabinoids in the management of acute pain compared to placebo or active comparator. The secondary outcome was the qualitative analysis of the reported adverse effects	Yes	Yes, except for reporting bias and for-profit bias	No	Yes	Based on the available randomized controlled trial evidence, cannabinoids have no role in the management of acute pain.	
Walsh et al	2016	Cannabisoids for fibromyalgia	Nabilone	Fibromyalgia	Cochrane Library, MEDLINE and EMBASE	2	140	Yes	Primary outcomes: Participant-reported pain relief of 50% or greater; RIG (Patient Global Impression of Change) much or very much improved. Withdrawal due to adverse events (tolerability); Serious adverse events (safety). Serious adverse events typically include any untoward medical occurrence or effect that at any dose results in death, is life-threatening, requires hospitalization or prolongation of existing hospitalization, results in persistent or significant disability or...	Yes	Yes, except for reporting bias	No	Yes	We found no convincing, unbiased, high quality evidence suggesting that nabilone is of value in treating people with fibromyalgia. The tolerability of nabilone was low in people with fibromyalgia.	

PRISMA-P (Preferred Reporting Items for Systematic review and Meta-Analysis Protocols) 2015 checklist: recommended items to address in a systematic review protocol*

Section and topic	Item No	Checklist item	(Page No.#)
ADMINISTRATIVE INFORMATION			
Title:			
Identification	1a	Identify the report as a protocol of a systematic review	1
Update	1b	If the protocol is for an update of a previous systematic review, identify as such	
Registration	2	If registered, provide the name of the registry (such as PROSPERO) and registration number	
Authors:			
Contact	3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author	1
Contributions	3b	Describe contributions of protocol authors and identify the guarantor of the review	25-26
Amendments	4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments	
Support:			
Sources	5a	Indicate sources of financial or other support for the review	25
Sponsor	5b	Provide name for the review funder and/or sponsor	
Role of sponsor or funder	5c	Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol	
INTRODUCTION			
Rationale	6	Describe the rationale for the review in the context of what is already known	3-9
Objectives	7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)	9
METHODS			
Eligibility criteria	8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review	10-12
Information sources	9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage	12-13
Search strategy	10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated	

Study records:			
Data management	11a	Describe the mechanism(s) that will be used to manage records and data throughout the review	13-14
Selection process	11b	State the process that will be used for selecting studies (such as two independent reviewers) through each phase of the review (that is, screening, eligibility and inclusion in meta-analysis)	13
Data collection process	11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators	13-14
Data items	12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications	14
Outcomes and prioritization	13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale	11-12
Risk of bias in individual studies	14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis	15-17
Data synthesis	15a	Describe criteria under which study data will be quantitatively synthesised	16
	15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I ² , Kendall's τ)	19-21
	15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)	22-23
	15d	If quantitative synthesis is not appropriate, describe the type of summary planned	21
Meta-bias(es)	16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)	17
Confidence in cumulative evidence	17	Describe how the strength of the body of evidence will be assessed (such as GRADE)	21

*** It is strongly recommended that this checklist be read in conjunction with the PRISMA-P Explanation and Elaboration (cite when available) for important clarification on the items. Amendments to a review protocol should be tracked and dated. The copyright for PRISMA-P (including checklist) is held by the PRISMA-P Group and is distributed under a Creative Commons Attribution Licence 4.0.**

From: Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart L, PRISMA-P Group. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and explanation. BMJ. 2015 Jan 2;349(jan02 1):g7647.

BMJ Open

Cannabinoids versus placebo for pain. Protocol for a systematic review with meta-analysis and Trial Sequential Analysis

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2019-031574.R1
Article Type:	Protocol
Date Submitted by the Author:	16-Jul-2019
Complete List of Authors:	Barakji, Jehad; The Copenhagen Trial Unit, Rigshospitalet Dept. 7812 Korang, Steven Kwasi; Rigshospitalet, Copenhagen Trial Unit; Holbaek Sygehus, Pediatric Dept. Feinberg, Joshua; Copenhagen Univ Hosp Maagard, Mathias; The Copenhagen Trial Unit, Rigshospitalet Dept. 7812 Gluud, Christian; Copenhagen Trial Unit (CTU), Center for Clinical Intervention Research Mathiesen, Ole; University of Copenhagen Jakobsen, Janus; Copenhagen Trial Unit, Centre for Clinical Intervention Research, Department 7812, Rigshospitalet, Copenhagen University Hospital
Primary Subject Heading:	Pharmacology and therapeutics
Secondary Subject Heading:	Anaesthesia, Evidence based practice, Complementary medicine
Keywords:	PAIN MANAGEMENT, Herbal medicine < THERAPEUTICS, Adverse events < THERAPEUTICS, CLINICAL PHARMACOLOGY, Health & safety < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

SCHOLARONE™
Manuscripts

Cannabinoids versus placebo for pain: Protocol for a systematic review with meta-analysis and Trial Sequential Analysis

Jehad A. Barakji¹, Steven Kwasi Korang¹, Joshua Rose-Hansen Feinberg¹, Mathias Maagaard¹, Christian Gluud¹, Ole Mathiesen^{2,3}, Janus C. Jakobsen^{1,4,5}

¹ The Copenhagen Trial Unit, Centre for Clinical Intervention Research, Department 7812, Rigshospitalet, Copenhagen University Hospital, Blegdamsvej 9, DK 2100 Copenhagen, Denmark

² Centre for Anaesthesiological Research, Department of Anaesthesiology, Zealand University Hospital, Koege, Denmark

³ Department of Clinical Medicine, Faculty of Health and Medical Sciences, Copenhagen University, Copenhagen, Denmark

⁴ Department of Cardiology, Holbæk Hospital, Holbæk, Denmark

⁵ Department of Regional Health Research, The Faculty of Health Sciences, University of Southern Denmark, Odense, Denmark

Corresponding author

Jehad A. Barakji

Tlf.: +45 21 52 07 80

Email: jehad.barakji@ctu.dk

Abstract

Introduction Pain is a frequent clinical symptom, and with significant impact on patient well-being. Therefore, sufficient pain management is of utmost importance. While cannabinoids have become a more popular alternative to traditional types of pain medication among patients, the quality of evidence supporting the use of cannabinoids has been questioned. The beneficial and harmful effects of cannabinoids in patients with pain is unknown. Accordingly, we aim to assess the efficacy, tolerability, and safety of cannabinoids (herbal, plant-derived extracts and synthetic) compared with placebo for any type of pain.

Methods and analysis We will conduct a systematic review of randomised clinical trials with meta-analysis and Trial Sequential Analysis to assess the beneficial and harmful effects of cannabinoids in any dose, formulation, and duration. We will accept placebo or no treatment as control interventions. We will include participants with any type of pain (acute and chronic pain, cancer-related pain, headache, neuropathic pain or any other types of pain). We will systematically search The Cochrane Library, MEDLINE, EMBASE, Science Citation Index, and BIOSIS for relevant literature. We will follow the recommendations by Cochrane and the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) statement. The risk of systematic errors (bias) and random errors (play of chance) will be assessed. The overall certainty of evidence will be evaluated using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach.

Ethics and dissemination Ethical approval is not a requirement since no primary data will be collected. The findings of this systematic review will be submitted for peer-reviewed publication and disseminated in national and international conferences.

Discussion Although cannabinoids are now being used to manage different pain conditions, the evidence for the clinical effects are unclear. The present review will systematically assess the current evidence for the benefits and harms of cannabinoids to inform practice and future research.

Strengths and limitations of this study

- Our methodology is based on the Cochrane Handbook for Systematic Reviews of Interventions, the PRISMA guideline, and a systematic eight step procedure for valid assessments of statistical and clinical significance
- We systemically plan to assess risks of random errors ('play of chance) and systematic errors ('bias')
- We have systematically predefined minimal important differences for all outcomes
- The certainty of the evidence will be assessed using the GRADE approach

Pain is the most commonly reported symptom in the general population and in a medical setting [1-3]. Persistent pain is a major international health problem [4], prompting the World Health Organization (WHO) to endorse a global campaign against pain [5]. Pain is the leading reason for use of alternative medicines (i.e. acupuncture, etc.) [6]. Pain has been associated with a low degree of health-related quality of life and may lead to psychosocial distress, insomnia, and depressive symptoms [7-15]. Pain is also among the most common reasons for temporary or permanent work disability [16]. Pain is always subjective and may be defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage" [17].

Cannabinoids have emerged as a potential alternative for the treatment of intractable pain [18]. Before the healthcare systems globally can endorse the applicability of cannabinoids for pain, the potential short-time and long-term adverse events encumbered with long-term use of cannabinoids must be investigated. This is of utmost importance because patients who consume cannabinoids to alleviate their chronic pain will most likely need to consume cannabinoids for the rest of their lifespan.

Description of pain

Pain may be caused by or be related to different clinical disorders and classified according to several different characteristics [19-22]. Below, we describe shortly some of these classifications.

Acute and chronic pain

Pain may be classified as 'acute pain' or 'chronic pain'.

- Acute pain usually has a well-defined onset and most often a readily identifiable cause (i.e. surgery, etc.). Acute pain is expected to run its course in a short time frame and management typically focuses on

1
2
3
4 symptomatic relief until this happens [23]. Acute pain is a common symptom, affecting between 37% to
5
6 84% of hospitalised patients [24] .
7

- 8
9
- 10 • Chronic pain is often characterised by an ill-defined onset and a prolonged, fluctuating course [23].
11 Chronic pain often persists past normal healing time and hence lacks the acute warning function of
12 physiological nociception [25]. Pain is usually regarded as chronic when it lasts or recurs for more than
13 three to six months [17, 26]. Chronic pain is a frequent condition, affecting an estimated 20% of people
14 worldwide [27-30] and accounting for 15% to 20% of physician visits according to European observational
15 studies [31, 32].
16
17
18
19
20

21 *Cancer-related pain*

22
23 Pain may also be classified based on whether it is cancer-related or non-cancer-related. Cancer-related pain is
24 pain caused by the cancer itself (primary tumour and metastases) or its treatment (i.e. radiation therapy, etc.)
25 [23, 33].
26
27
28

29 *Postoperative pain*

30
31 Postoperative pain includes pain from inflammation caused by tissue trauma (i.e. surgical incision, dissection,
32 burns, etc.) or direct nerve injury (e.g. nerve transection, stretching, or compression) [34]. Inflammation results
33 in activation and sensitisation of nociceptive pain pathways, resulting in primary and secondary hyperalgesia and
34 central sensitisation, which is characterized by clinically increased pain, allodynia, and increased sensitivity from
35 surrounding non-damaged anatomical areas [35].
36
37
38
39
40

41 *Other types of pain*

42
43 Pain in one or more anatomic regions where the aetiology is unknown is defined as idiopathic pain [36]. Examples
44 of idiopathic pain are chronic widespread pain, fibromyalgia, irritable bowel syndrome, and back pain that is not
45 diagnosed as musculoskeletal or as neuropathic pain [33].
46
47
48
49

50 *Pain types defined according to specific mechanism causing the pain*

51
52 Somatic nociceptive pain
53
54
55
56
57
58
59
60

1
2
3
4 Nociceptive pain is the most frequent type of pain. It results from activity in neural pathways caused by actual
5 tissue damage or potentially tissue-damaging stimuli [31, 37] originating from somatic nociceptors from skin,
6 bone, joints, or muscles [38].
7
8
9

10 11 Visceral nociceptive pain

12 The visceral nociceptive pain is pain resulting from viscera in the thoracic, pelvis, or abdominal organs [39-41].
13 Visceral pain is diffuse, less distinctive, and difficult to localise [41] and is often characterised by referred visceral
14 pain [42].
15
16
17
18

19 20 Neuropathic pain

21 The 2011 International Association for the Study of Pain definition of neuropathic pain is "pain caused by a lesion
22 or disease of the somatosensory system" [43].
23

24 Neuropathic pain may be classified as central neuropathic pain or peripheral neuropathic pain. Central
25 neuropathic pain conditions are mainly attributed to multiple sclerosis and post-stroke pain [44], while
26 peripheral neuropathic pain is largely due to post-herpetic neuralgia and diabetic neuropathy [45].
27
28
29
30
31
32

33 34 Description of the intervention

35 Cannabis (also called marijuana) is the most common illegally used psychoactive substance worldwide [46].
36 Cannabinoids refer to a heteromorphic group of molecules that demonstrate activity upon cannabinoid
37 receptors [47]. Cannabinoids may be classified into three groups: 1) endocannabinoids, 2) phytocannabinoids,
38 and 3) synthetic cannabinoids [47].
39
40
41
42
43

44 45 *Endocannabinoids*

46 Endocannabinoids are characterised by being the endogenously generated cannabinoids [48]. The primary types
47 of endocannabinoids are the lipid endocannabinoid arachidonoyl ethanolamide (named anandamide) [49] and
48 the endocannabinoid 2-arachidonoylglycerol (2-AG) [50, 51].
49
50
51

52 53 *Phytocannabinoids*

1
2
3
4 Phytocannabinoids are cannabinoids found in the cannabis plant [52]. The best characterised phytocannabinoids
5 are the psychotropic tetrahydrocannabinol (THC) and the primarily anti-inflammatory cannabidiol (CBD) [53].
6 Nabiximols (marketed as Sativex®) is a sublingually administered oromucosal spray based on a mixture of
7 tetrahydrocannabinol and cannabidiol [54].
8
9
10

11 12 *Synthetic cannabinoids*

13 Synthetic cannabinoids are analogues of the cannabinoids found in natural marijuana that are chemically
14 synthesised. The most commonly prescribed cannabinoid-based medicines are the synthetic cannabinoids
15 dronabinol (marketed as Marinol®) and nabilone (marketed as Cesamet®) [54].
16
17
18
19
20

21 **Endocannabinoid system**

22 All cannabinoids act on cannabinoid receptors. These cannabinoid receptors are located throughout the body
23 but are mostly located in the brain [55]. The cannabinoid receptors and endocannabinoids (see paragraph above)
24 are together named the endocannabinoid system [56].
25
26
27
28
29

30 *Cannabinoid receptors*

31 There are two types of cannabinoid receptors, type I and type II [57]. Cannabinoid receptor type I are most
32 abundant in the central nervous system, especially in areas promoting nociception, short-term memory, and in
33 the basal ganglia, but are also found in the peripheral nerves, uterus, testis, and bones [57].
34 Tetrahydrocannabinol activates cannabinoid type I receptors in the dopaminergic mesolimbic brain circuit,
35 resulting in enhanced release of dopamine [58]. Such activation of the so-called 'brain reward system' is
36 hypothesised to mediate the positive reinforcing and rewarding effects of almost all drugs of abuse [58].
37
38
39
40
41
42
43

44 In contrast, cannabinoid receptor type II, is mostly found in the periphery, often in conjunction with immune
45 cells, but may appear in the central nervous system particularly under conditions of inflammation in association
46 with microcytes [57]. The physiological responses that result from cannabinoid receptor activation are euphoria,
47 psychosis, impaired memory and cognition, reduced locomotor function, increased appetite, as well as anti-
48 emetic, pain-relieving, anti-spasticity, and sleep-promoting effects [59].
49
50
51
52
53

54 **Administration of cannabinoids**

1
2
3
4 Cannabis is most commonly consumed via smoked, inhaled vapor, or oral routes of administration [60].
5
6 Vaporising cannabis ('vaping') heats the material without burning which theoretically minimises potential
7
8 carcinogens compared to smoking and may produce less respiratory irritation [61, 62]. Sublingual administration
9
10 is used for some medical cannabis preparations (i.e. nabiximols, etc.).
11

12 13 **Why it is important to do this review**

14
15 We identified ten previous reviews with meta-analyses assessing the effects of cannabinoids on different types
16
17 of pain [63-72]. Bearing in mind that some of the previous reviews investigated more than one type of pain, eight
18
19 reviews assessed the effects of different cannabinoids on neuropathic pain [63-69, 72]; four reviews assessed
20
21 the effects of different cannabinoids on nociceptive pain (i.e. rheumatoid arthritis, etc.) [63, 64, 67, 68]; three
22
23 reviews assessed the effects of different cannabinoids on cancer-related pain [63, 67, 68]; four reviews assessed
24
25 the effects of different cannabinoids on fibromyalgia-related pain [63, 64, 67, 71]; and three reviews assessed
26
27 the effects of different cannabinoids on postoperative pain [63, 68, 70]. All the previous reviews included
28
29 randomised clinical trials, but only two of the ten reviews systematically assessed the risk of bias in the trials [65,
30
31 72], and none of the previous reviews took into account the risks of random errors [63-72]. Only two out of the
32
33 ten reviews used predefined Cochrane methodology [71, 72] and only four reviews used the GRADE approach
34
35 [65, 70-72].
36

37 Most of the reviews concluded that the assessed cannabinoids were effective against pain [63-67, 69, 72]. In
38
39 **Table 1 (Additional file 1)**, we have summarised the results and conclusions of the previous reviews. Five of the
40
41 reviews reported serious adverse events (i.e. agitation, impaired memory, abuse, dissociation, acute psychosis,
42
43 death, etc.) [63, 65-67, 72]. The reviews also showed that the most commonly reported adverse events were
44
45 sedation, dizziness, dry mouth, increased appetite, somnolence, confusion, nausea, and disturbances in
46
47 concentration [63-66, 68, 69, 71, 72].
48

49 A correlation between psychiatric disorders (i.e. schizophrenia and psychosis etc.) and increased cannabinoid
50
51 consumption have previously been hypothesised [73-79]. Di Forti et. al recently conducted a study indicating
52
53 that daily cannabis use was associated with increased odds of psychotic disorder compared with never users
54
55 (adjusted odds ratio [OR] 3.2, 95% CI 2.2–4.1), increasing to nearly five-times increased odds for daily use of high-
56
57 potency (THC \geq 10%) types of cannabis (adjusted odds ratio [OR] 4.8, 95% CI 2.5–6.3) [80].
58
59

1
2
3
4
5
6 Compared to previous systematic reviews on cannabinoids, we want to assess the effects of all types of
7 cannabinoid versus placebo or no intervention for all different forms of pain. This increases the power and
8 precision over the overall analysis and make it possible to conduct subgroup analyses and sensitivity analyses
9 that may identify pain areas where cannabinoid could be especially beneficial and cause the least harms. In
10 addition, we will implement a minimal clinically important threshold regarding analgesic efficacy based on
11 previously conducted methodological studies which ensures that analgesic efficacy is of a firm significance before
12 acceptance. Finally, by instigating all types of cannabinoids treated for any type of pain this systematic review
13 will aid trialist in optimising the design of future randomised clinical trials by illuminating any research pitfalls of
14 all previously conducted randomised clinical trials on this topic.
15
16
17
18
19
20
21
22

23 **Objective**

24
25 The objective of our systematic review is to assess the analgesic efficacy and adverse events encumbered with
26 the use of cannabinoids compared to placebo or no intervention in participants with any type of pain (acute and
27 chronic pain, cancer-related pain, headache, neuropathic pain, or any other types of pain). A secondary objective
28 of this systematic review is to assess the impact of cannabinoid use on the quality of sleep and quality of life
29 which is especially decreased in participants with chronic pain.
30
31
32
33
34
35

36 **Methods**

37
38 This systematic review protocol has been developed based on Preferred Reporting Items for Systematic
39 Reviews and Meta-Analysis Protocols (PRISMA-P) guidelines for reporting systematic reviews evaluating
40 healthcare interventions [81, 82]. A PRISMA-P checklist file is attached (**Additional file 2**).
41
42
43
44

45 **Criteria for considering studies for this review**

46 *Type of studies*

47
48 Randomised clinical trials irrespective of trial design, setting, publication status, publication year, and language.
49 If we identify quasi-randomised studies and observational studies during our searches for randomised clinical
50 trials, we will only include their reporting on harms in a narrative way. By not systematically searching for all
51 observational studies on harm, we run the risk of putting more focus on benefit than harm. We are aware that
52 this is a limitation of our review.
53
54
55
56
57
58
59
60

Types of participants

Participants with any type of pain, i.e. acute and chronic pain, cancer-related pain, headache, neuropathic pain, or any other types of pain (as defined by the trialists). Participants will be included irrespective of age, sex, and comorbidities.

Types of interventions

Experimental intervention

Any type of cannabinoids such as: herbal cannabis (hashish, marihuana), plant-based extracts (i.e. nabiximole, etc.), or synthetic cannabinoids (i.e. cannabidiol, dronabinol, levonantradol, nabilone, etc.). We will accept cannabinoids at any dose, by any route, administered for the relief of pain.

Control intervention

Placebo or no intervention.

Co-interventions

We will accept any co-intervention but only if this co-intervention is planned to be delivered similarly in both intervention groups. If this plan is not followed, then these trials will be assessed as a subgroup due to potential confounding.

Types of outcome measures

Primary outcomes

- All-cause mortality
- Pain assessment on visual analogue scale (VAS) or numerical rating scale (NRS)
- Proportion of participants with a serious adverse event defined as any untoward medical occurrence that resulted in death; was life threatening; was persistent; or led to significant disability, nephrotoxicity, superinfection, need for respiratory support, need for circulatory support, or prolonged hospitalisation [83]. As we expect the trialists' reporting of serious adverse events to be heterogeneous and not strictly according to the ICH-GCP recommendations, we will include the event as a serious adverse if the trialists either: 1) use the term 'serious adverse event' but not refer to ICH-GCP, or 2) report the proportion of

1
2
3
4 participants with an event we consider fulfils the ICH-GCP definition. If several of such events are reported
5 then we will choose the highest proportion reported in each trial.
6

- 7 • Quality of life measured on any valid continuous scale
8
9

10 11 *Secondary outcomes*

- 12 • Dependence (as defined by trialists)
- 13 • Psychosis (as defined by trialists)
- 14 • Proportion of participants with one or more adverse event not considered to be serious
- 15 • Quality of sleep measured on any valid continuous scale
16
17
18
19
20

21 *Exploratory outcomes*

- 22 • Each serious adverse event separately
- 23 • Each adverse event not considered serious separately.
- 24 • Twenty-four-hour morphine consumption (as defined by trialists)
- 25 • Physical function (as defined by trialists)
- 26 • Depressive symptoms (e.g. Hamilton Depression Rating Scale)
27
28
29
30
31
32

33 We will for all outcomes use the trial results reported at maximal follow-up except for acute pain. For acute
34 pain, we will use the trials' results reported at the time point closest to 24 hours after the intervention is given.
35
36
37

38 **Patient and Public Involvement**

39 We have had email correspondence with several relevant patient associations in Denmark to select the most
40 patient relevant outcomes. The patient associations we have been in contact with include: The Danish Diabetes
41 Association, Steno Diabetes Centre Copenhagen, The Danish Rheumatism Association, The Danish Multiple
42 Sclerosis Society, and Danish Cancer Society. Initially we presented our potential outcomes for the
43 aforementioned patient associations and requested for their opinion. Initially we had not included quality of
44 sleep as an outcome however this was mentioned by almost all patient associations and it was included as a
45 crucial secondary outcome. All-cause mortality was questioned by one of the patient associations however we
46 have chosen to keep this outcome because of potential increased risk of both acute coronary syndrome and
47 chronic cardiovascular disease associated with cannabis use [84]. We are very thankful for their input.
48
49
50
51
52
53
54
55
56
57
58
59
60

Search methods for identification of studies

Electronic searches

We will search the Cochrane Central Register of Controlled Trials (CENTRAL), Medical Literature Analysis and Retrieval System Online (MEDLINE), Excerpta Medica database (EMBASE), Latin American and Caribbean Health Sciences Literature (LILACS), Science Citation Index Expanded on Web of Science, and BIOSIS in order to identify relevant trials. The preliminary search strategy for CENTRAL, MEDLINE (Ovid), Embase (Ovid), LILACS, Web of Science and BIOSIS is given in **Additional file 3**.

We will search all databases from their inception to the 1st of October 2019.

Searching other resources

The reference lists of relevant publications will be checked for any unidentified randomised trials. We will contact authors of included studies, and major pharmaceutical companies, by email asking for unpublished randomised trials. Further, we will search for ongoing trials on:

- ClinicalTrials.gov (www.clinicaltrials.gov)
- Google Scholar (<https://scholar.google.dk/>)
- The Turning Research into Practice (TRIP) Database (<https://www.tripdatabase.com/>)
- European Medicines Agency (EMA) (<http://www.ema.europa.eu/ema/>)
- United States Food and Drug Administration (FDA) (www.fda.gov)
- China Food and Drug Administration (CFDA) (<http://eng.sfda.gov.cn/WS03/CL0755/>)
- Medicines and Healthcare products Regulatory Agency (<https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency>)
- The World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP) search portal (<http://apps.who.int/trialsearch/>)

We will also consider relevant for the review unpublished and grey literature trials, if we identify such trials.

Data collection and analysis

1
2
3
4 We will perform the review following the recommendations of Cochrane [85]. The analyses will be performed
5 using Review Manager 5 [86] and Trial Sequential Analysis [87]. In case of Review Manager statistical software
6 not being sufficient, we will use STATA 15 [88].
7
8
9

10 11 *Selection of studies*

12 Two authors (JB, SKK) will independently screen titles and abstracts. We will retrieve all relevant full-text study
13 reports/publications, and four review authors (JB, SKK, JRF, MM) will independently screen the full text and
14 identify and record reasons for exclusion of the ineligible studies. We will resolve any disagreement through
15 discussion or, if required, we will consult a fifth author (JCJ). Trial selection will be displayed in an adapted flow
16 diagram as per the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement
17 [89].
18
19
20
21
22
23

24 **Data extraction and management**

25 Four authors (JB, SKK, JRF, MM) will in pairs extract data independently from included trials. Disagreements will
26 be resolved by discussion with a fifth author (JCJ). We will assess duplicate publications and companion papers
27 of a trial together to evaluate all available data simultaneously (maximise data extraction, correct bias
28 assessment). We will contact the trial authors by email to specify any additional data, which may not have been
29 reported sufficiently or at all in the publication.
30
31
32
33
34
35

36 *Trial characteristics*

37 Bias risk components (as defined below); trial design (parallel, factorial, or crossover); number of intervention
38 arms; length of follow-up; estimation of sample size; inclusion and exclusion criteria.
39
40
41
42

43 *Participant characteristics and diagnosis*

44 Number of randomised participants; number of analysed participants; number of participants lost to follow-up/
45 withdrawals/crossover; compliance with medication; age range (mean or median) and sex ratio; type of pain
46 (acute and chronic pain, cancer-related pain, headache, neuropathic pain or any other types of pain); baseline
47 pain score; drug and dosing regimen; study design (placebo or active control); study duration and follow-up;
48 analgesic outcome measures and results; adverse events (participants experiencing any adverse event, or
49 serious adverse event).
50
51
52
53
54
55
56
57
58
59
60

Co-intervention characteristics

Type of co-intervention; dose of co-intervention; duration of co-intervention; and mode of administration.

Outcomes

All outcomes listed above will be extracted from each randomised clinical trial, and we will identify if outcomes are incomplete or selectively reported according to the criteria described later in 'incomplete outcome data' bias domain and 'selective outcome reporting' bias domain.

Notes

Funding of the trial and notable conflicts of interest of trial authors will be extracted, if available.

We will note in the 'Characteristics of included studies' table if outcome data were not reported in a usable way. Four review authors (JB, SKK, JRF, MM) will independently transfer data into the Review Manager file [86].

Disagreements will be resolved through discussion or, if required, we will consult with a fifth author (JCJ).

Assessment of risk of bias in included studies

We will use the instructions given in the Cochrane Handbook for Systematic Reviews of Interventions [85] in our evaluation of the methodology and hence the risk of bias of the included trials. We will evaluate the methodology in respect of:

- Random sequence generation
- Allocation concealment
- Blinding of participants and treatment providers
- Blinding of outcome assessment
- Incomplete outcome data
- Selective outcome reporting
- For-profit bias
- Overall risk of bias

These components enable classification of randomised trials as being at low risk of bias and at high risk of bias.

The latter trials tend to overestimate positive intervention effects and underestimate negative effects [90-96].

We will classify the trials according to the following criteria.

Random sequence generation

- 1
2
3
4 • Low risk: If sequence generation was achieved using computer random number generator or a random
5 number table. Drawing lots, tossing a coin, shuffling cards, and throwing dice were also considered
6 adequate if performed by an independent adjudicator.
7
8 • Unclear risk: If the method of randomisation was not specified, but the trial was still presented as being
9 randomised.
10
11 • High risk: If the method of sequence generation was inadequate e.g. alternate medical record numbers
12 or other non-random sequence generation.
13
14
15
16
17

18 *Allocation concealment*

- 19 • Low risk: If the allocation of patients was performed by a central independent unit, on-site locked
20 computer, identical-looking numbered sealed envelopes, drug bottles, or containers prepared by an
21 independent pharmacist or investigator.
22
23 • Uncertain risk: If the trial was classified as randomised but the allocation concealment process was not
24 described.
25
26 • High risk: If the allocation sequence was familiar to the investigators who assigned participants.
27
28
29
30

31 *Blinding of participants and treatment providers*

- 32 • Low risk: If the participants and the treatment providers were blinded to intervention allocation and
33 this was described.
34
35 • Uncertain risk: If the procedure of blinding was insufficiently described.
36
37 • High risk: If blinding of participants and the treatment providers was not performed.
38
39
40

41 *Blinding of outcome assessment*

- 42 • Low risk of bias: If it was mentioned that outcome assessors were blinded and this was described.
43
44 • Uncertain risk of bias: If it was not mentioned if the outcome assessors in the trial were blinded or the
45 extent of blinding was insufficiently described.
46
47 • High risk of bias: If no blinding or incomplete blinding of outcome assessors was performed.
48
49
50

51 *Incomplete outcome data*

- 52 • Low risk of bias: If missing data were unlikely to make treatment effects depart from plausible values.
53 This could be either (1) there were no drop-outs or withdrawals for all outcomes or (2) the numbers
54
55
56
57
58
59
60

1
2
3
4 and reasons for the withdrawals and drop-outs for all outcomes were clearly stated and could be
5 described as being similar to both groups. Generally, the trial is judged as at a low risk of bias due to
6 incomplete outcome data if drop-outs are less than 5%. However, the 5% cut-off is not definitive.
7

- 8
9 • Uncertain risk of bias: If there was insufficient information to assess whether missing data were likely
10 to induce bias on the results.
- 11
12 • High risk of bias: If the results were likely to be biased due to missing data either because the pattern
13 of drop-outs could be described as being different in the two intervention groups or the trial used
14 improper methods in dealing with the missing data (i.e. last observation carried forward, etc.).
15
16
17
18

19 *Selective outcome reporting*

- 20
21 • Low risk of bias: If a protocol was published before or at the time the trial was begun, and the
22 outcomes specified in the protocol were reported on. If there is no protocol or the protocol was
23 published after the trial has begun, reporting pain assessment on VAS or NRS and serious adverse
24 events will grant the trial a grade of low risk of bias.
25
26
- 27 • Uncertain risk of bias: If no protocol was published and the outcome pain assessment on VAS or NRS
28 and serious adverse events were not reported on.
29
30
- 31 • High risk of bias: If the outcomes in the protocol were not reported on.
32
33

34 *For-profit bias*

- 35
36 • Low risk of bias: If the trial appeared to be free of other components of for-profit bias.
- 37
38 • Unclear risk of bias: If it was unclear whether the trial was free of for-profit bias.
- 39
40 • High risk of bias: If there was a high risk of for-profit bias.
41
42

43 *Overall risk of bias*

- 44
45 • Low risk of bias: The trial will be classified at overall 'low risk of bias' only if all of the bias domains
46 described in the above paragraphs are classified at 'low risk of bias'.
47
- 48 • High risk of bias: The trial will be classified at 'high risk of bias' if any of the bias risk domains described
49 in the above are classified at 'unclear' or 'high risk of bias'.
50
51
52

53 We will assess the domains 'blinding of outcome assessment', 'incomplete outcome data', and 'selective
54 outcome reporting' for each outcome result. Thus, we can assess the bias risk for each outcome assessed in
55
56
57
58
59

1
2
3
4 addition to each trial. Our primary conclusions will be based on the results of our primary outcome results at
5 overall low risk of bias. Both our primary and secondary analyses will be presented in the summary of findings
6 tables.
7
8
9

10 **Differences between the protocol and the review**

11 We will conduct the review according to this published protocol and report any deviations from it in the
12 'Differences between the protocol and the review' section of the systematic review.
13
14
15

16 **Measures of treatment effect**

17 *Dichotomous outcomes*

18 We will calculate risk ratios (RRs) with 95% confidence interval (CI) for dichotomous outcomes, as well as the
19 Trial Sequential Analysis- adjusted CIs (see below).
20
21
22

23 *Continuous outcomes*

24 We will calculate the mean differences (MDs) and the standardised mean difference (SMD) with 95% CI for
25 continuous outcomes, as well as the Trial Sequential Analysis-adjusted CIs (see below).
26
27

28 *Dealing with missing data*

29 We will, as first option, contact all trial authors to obtain any relevant missing data (i.e. for data extraction and
30 for assessment of risk of bias, as specified above).
31
32

33 *Dichotomous outcomes*

34 We will not impute missing values for any outcomes in our primary analysis. In two of our sensitivity analyses
35 (see paragraph below), we will impute data.
36
37
38

39 *Continuous outcomes*

40 We will primarily analyse scores assessed at single time points. If only changes from baseline scores are
41 reported, we will analyse the results together with follow-up scores [85]. If standard deviations (SDs) are not
42 reported, we will calculate the SDs using trial data, if possible. We will not use intention-to-treat data if the
43 original report did not contain such data. We will not impute missing values for any outcomes in our primary
44 analysis. In our sensitivity analysis (see paragraph below) for continuous outcomes, we will impute data.
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Assessment of heterogeneity

We will primarily investigate forest plots to visually assess any sign of heterogeneity. We will secondly assess the presence of statistical heterogeneity by chi² test (threshold $P < 0.10$) and measure the quantities of heterogeneity by the I² statistic [97, 98]. We will investigate for heterogeneity through subgroup analyses. Ultimately, we may decide that a meta-analysis should be avoided [85].

Assessment of reporting biases

We will use a funnel plot to assess reporting bias if ten or more trials are included. We will visually inspect funnel plots to assess the risk of bias. We are aware of the limitations of a funnel plot (i.e. a funnel plot assesses bias due to small sample size, etc.). From this information, we assess possible reporting bias. For dichotomous outcomes, we will test asymmetry with the Harbord test [99] if τ^2 is less than 0.1 and with the R cker test if τ^2 is more than 0.1. For continuous outcomes, we will use the regression asymmetry test [100] and the adjusted rank correlation [101].

Unit of analysis issues

We will only include randomised clinical trials. For trials using crossover design, only data from the first period will be included [85, 102]. There will therefore not be any unit of analysis issues.

Minimal important difference

In clinical intervention research it is of utmost importance always to define minimal important differences (MID) and to define thresholds for clinical significance [103]. If a large number of trial participants are randomised, small and clinically irrelevant intervention effects may lead to statistically significant results and rejection of the null hypothesis [104]. Jaeschke et al. defined the minimal important difference as “the smallest difference in score in the domain of interest which patients perceive as beneficial” [105].

Estimations of minimal important differences should be used as arbitrary strict precise thresholds. However, to avoid erroneous conclusions minimal important differences need to be estimated and predefined when assessing the effects of interventions for pain. Olsen et al. have conducted two systematic reviews on this matter in order to gather the evidence and present an estimate of the minimal important difference [106, 107]. Olsen et al. conducted a systematic review on the minimal important difference in patients with acute pain and concluded

1
2
3
4 that the median of the studies' results was 17 mm on VAS (IQR 14 mm to 23 mm) [106]. Another systematic
5 review conducted by Olsen et al. was on the minimal important difference in patients with chronic pain and the
6 results showed a median of 23 mm on VAS (IQR 12 mm to 39 mm) when using the within-patient anchor-based
7 method, while the median in studies using the sensitivity- and specificity-based method was 20 mm on VAS (IQR
8 15 mm – 30 mm) [107]. We have described detailed considerations about minimal important differences in

12 **Appendix 1.**

13
14 Based on the previously conducted systematic reviews we will choose at minimal important difference
15 equivalent to 10 mm or 1 point on the visual analogue scale and the numerical rating scale, respectively,
16 regarding an analgesic effect.
17
18
19
20

21 **Data synthesis**

22 *Meta-analysis*

23
24 We will undertake this meta-analysis according to the recommendations stated in the Cochrane Handbook for
25 Systematic Reviews of Interventions [85], Keus et al. [108], and the eight-step assessment suggested by
26 Jakobsen et al. [103]. We will use the statistical software Review Manager 5.3 [86] provided by Cochrane to
27 analyse data. We will assess our intervention effects with both random-effects meta-analyses [109] and fixed-
28 effect meta-analyses [110]. We will use the more conservative point estimate of the two [103]. The more
29 conservative point estimate is the estimate closest to zero effect. If the two estimates are similar, we will use
30 the estimate with the highest P value [103]. We use four primary and four secondary outcomes, and therefore,
31 we will consider a P value of 0.02 as the threshold for statistical significance [103, 111]. We will investigate for
32 heterogeneity through subgroup analyses. Ultimately, we may decide that a meta-analysis should be avoided
33 [85]. We will use the eight-step procedure to assess if the thresholds for statistical and clinical significance are
34 crossed [103]. Our primary conclusion will be based on results with low risk of bias [103].
35
36
37
38
39
40
41
42
43

44
45 Where multiple trial intervention groups are reported in a single trial, we will include only the relevant groups.
46 If two comparisons are combined in the same meta-analysis, we will halve the control group to avoid double-
47 counting [85]. Trials with a factorial design will be included.
48
49

50
51 If quantitative synthesis is not appropriate, we will report the results in a narrative way.
52
53

54 *Trial Sequential Analysis*

1
2
3
4 Traditional meta-analysis runs the risk of random errors due to sparse data and repetitive testing of
5 accumulating data when updating reviews. We wish to control the risks of type I errors and type II errors. We
6 will therefore perform Trial Sequential Analysis on the outcomes, in order to calculate the required information
7 size (that is the number of participants needed in a meta-analysis to detect or reject a certain intervention
8 effect) and the cumulative Z-curve's breach of relevant trial sequential monitoring boundaries [87, 112-120]. A
9 more detailed description of Trial Sequential Analysis can be found in the Trial Sequential Analysis manual
10 [113] and at <http://www.ctu.dk/tsa/>. For dichotomous outcomes, we will estimate the required information
11 size based on the observed proportion of patients with an outcome in the control group (the cumulative
12 proportion of patients with an event in the control groups relative to all patients in the control groups), a
13 relative risk reduction of 20%, an alpha of 2.0% for our primary and secondary outcomes, a beta of 10%, and
14 diversity as suggested by the trials in the meta-analysis. For the outcome "pain assessment on visual analogue
15 scale (VAS) or numerical rating scale (NRS)", we will use a minimal important difference estimate based on
16 previously conducted systematic reviews [106, 107]. We will accept an analgesic effect equivalent to 10 mm or
17 1 point on the visual analogue scale and the numerical rating scale, respectively, or a consumption of at least 5
18 mg morphine.

19 For all remaining continuous outcome, we will in the Trial Sequential Analysis use the observed SD, a mean
20 difference of the observed SD/2, an alpha of 2.0% for our primary and secondary outcomes, and a beta of 10%.

21 22 23 24 25 26 27 28 29 30 31 32 33 34 **Subgroup analysis and investigation of heterogeneity**

35 *Subgroup analysis*

36 We will perform the following subgroup analysis when analysing the primary outcomes (All-cause mortality,
37 pain assessment on VAS or NRS, serious adverse event, and quality of life).

- 38 • Trials at high risk of bias compared to trials at low risk of bias
- 39 • Trials compared according to type of pain (acute pain, chronic pain and cancer pain)
- 40 • Trials compared according to type of chronic pain
- 41 • Trials compared according to type of cannabinoids used

42
43
44
45
46
47
48
49 We will use the formal test for subgroup interactions in Review Manager [86].

50 51 52 53 *Sensitivity analysis*

1
2
3
4 To assess the potential impact of the missing data for dichotomous outcomes, we will perform the two
5 following sensitivity analyses on both the primary and secondary outcomes.
6

- 7 • ‘Best-worst-case’ scenario: We will assume that all participants lost to follow-up in the cannabinoid
8 intervention group have survived and had no serious adverse event, and that all those participants lost
9 to follow-up in the placebo group have not survived, and had a serious adverse event.
10
- 11 • ‘Worst-best-case’ scenario: We will assume that all participants lost to follow-up in the cannabinoid
12 intervention group have not survived, and had a serious adverse event, and that all those participants
13 lost to follow-up in the placebo group have survived, and had no serious adverse event.
14
15
16
17

18
19 We will present results of both scenarios in our review.
20
21

22
23 For all continuous outcome when analysing a ‘beneficial outcome’ will be the group mean plus two standard
24 deviations (SDs) (we will secondly use one SD in another sensitivity analysis) of the group mean and a ‘harmful
25 outcome’ will be the group mean minus two SDs (we will secondly use one SD in another sensitivity analysis) of
26 the group mean [103].
27
28
29
30

31 To assess the potential impact of missing SDs for continuous outcomes, we will perform the following
32 sensitivity analysis.
33

- 34 • Where SDs are missing and it is not possible to calculate them, we will impute SDs from trials with
35 similar populations and low risk of bias. If we find no such trials, we will impute SDs from trials with a
36 similar population. As the final option, we will impute SDs from all trials.
37
38

39 We will present results of this scenario in our review. Other post hoc sensitivity analyses might be warranted if
40 unexpected clinical or statistical heterogeneity is identified during the analysis of the review results [103].
41
42
43

44 *Summary of Findings*

45
46 We will create a Summary of Findings table using each of the primary outcomes (all-cause mortality, pain
47 assessment on VAS or NRS, serious adverse event, and quality of life). We will use the five GRADE
48 considerations (bias risk of the trials, consistency of effect, imprecision, indirectness, and publication bias) to
49 assess the quality of a body of evidence as it relates to the studies which contribute data to the meta-analyses
50 for the prespecified outcomes [103, 121-123]. We will use methods and recommendations described in
51 Chapter 8 (Section 8.5) and Chapter 12 of the Cochrane Handbook for Systematic Reviews of Interventions [85]
52
53
54
55
56
57
58
59
60

1
2
3
4 using GRADEpro software. We will justify all decisions to downgrade the quality of studies using footnotes, and
5 we will make comments to aid the reader's understanding of the review where necessary. Firstly, we will
6 present our results in the Summary of Findings table based on the results from the trials with low risk of bias,
7 and secondly, we will present the results based on all trials.
8
9
10

11 12 **Ethics and Dissemination**

13
14 Ethical approval is not a requirement since no primary data will be collected. The findings of this systematic
15 review will be submitted for peer-reviewed publication and disseminated in national and international
16 conferences and is expected to inform healthcare workers and providers about the occurrence of serious and
17 non-serious adverse events following cannabinoid consumption. It is expected that the findings of this systematic
18 review will identify some research gaps for future trials.
19
20
21
22

23 24 **Discussion**

25
26 This protocol aims at investigating the beneficial and harmful effects of cannabinoids in patients with any type
27 of pain condition. The outcomes will be all-cause mortality, pain assessment on VAS or NRS, serious adverse
28 events, quality of life, dependence, psychosis, non-serious adverse events, and sleep quality.
29
30
31
32

33
34 This protocol has several strengths. The predefined methodology is based on the Cochrane Handbook for
35 Systematic Reviews of Interventions [85], the eight-step assessment suggested by Jakobsen et al. [103], Trial
36 Sequential Analysis [84], and GRADE assessment [121-123]. Hence, this protocol takes into account both the risk
37 of random error and the risk of systematic error. We predefined evidence-based estimations of minimal
38 important differences which will limit the risk of focusing on statistically significant results with questionable
39 clinical importance. This threshold of minimal important difference is based on the estimations of several
40 previously conducted studies and reviews [106, 107]. Moreover, we are including all types of cannabinoids and
41 all types of pain which will increase the statistical power and make it possible to perform essential subgroup
42 analyses. We have been in contact with several relevant patient associations which has assisted us in choosing
43 the most clinically relevant outcomes.
44
45
46
47
48
49
50

51
52 Our protocol also has several limitations. One of the potential limitations is that we include participants with all
53 types of pain; cannabinoids might have different effects on different types of pain. It might e.g. be problematic
54
55
56
57
58
59
60

1
2
3
4 to combine trials assessing the effects of cannabinoids on acute pain and chronic pain because of different
5 underlying pathophysiological mechanisms [124]. On the other hand, the effects of cannabinoids on acute pain
6 and chronic pain might be comparable and hence it might be valid to combine trials assessing the effects of
7 cannabinoids on acute pain and chronic pain in meta-analysis, which would increase the statistical power. The
8 results of the subgroup analysis comparing trials including participants with acute pain to participants with
9 chronic pain will therefore be highlighted when reporting our review results. Moreover, we only intend to assess
10 cannabinoids versus placebo or no intervention. Further systematic reviews with meta-analyses and Trial
11 Sequential Analyses need to assess the benefits and harms of cannabinoids versus other pain killers, provided
12 that cannabinoids show more benefit than harm in the present systematic review.
13
14
15
16
17
18
19
20

21 Furthermore, more than one active cannabinoid agent is often combined in the different intervention options
22 provided to the patients with a pain condition, thereby making difficult to explore the analgesic effect and
23 adverse event associated with a single cannabinoid agent. Hence, if we show a difference between the
24 intervention options, it will be difficult to conclude what exactly caused the difference in effect. To minimise
25 these limitations, we have planned a careful assessment of statistical and clinical heterogeneity as well as several
26 subgroup analyses and sensitivity analyses. Another limitation is the large number of comparisons which increase
27 the risk of type 1 error. We have adjusted our thresholds for significance according to the number of primary
28 outcomes, but, as mentioned, we have also included multiple subgroup analyses. This large risk of type 1 error
29 will be taken into account when interpreting the review results.
30
31
32
33
34
35
36
37
38

39 **Acknowledgements**

40 We hugely appreciate the contribution of The Danish Diabetes Association, Steno Diabetes Centre Copenhagen,
41 The Danish Rheumatism Association, The Danish Multiple Sclerosis Society, and Danish Cancer Society in guiding
42 us to select the most patient relevant outcomes.
43
44

45 The expert help from Sarah Louise Klingenberg (Information Specialist, The Cochrane Hepato-Biliary Group,
46 Copenhagen Trial Unit, Copenhagen, Denmark) in making the search strategy is hugely appreciated.
47
48
49

50 **Funding statement**

51 This research received no specific grant from any funding agency in the public, commercial or not-for-profit
52 sectors.
53
54
55
56
57
58
59
60

Authors' contributions

JB drafted the protocol. JCJ, SKK, OM, CG, JRF and MM amended the protocol. All authors read and approved the final manuscript.

Competing interests

None declared

Ethics approval and consent to participate

Not applicable.

Word Count

10835 words, including the full references.

References

1. Verhaak P, Kerssens J, Dekker J, Sorbi M, and Bensing J, *Prevalence of chronic benign pain disorder among adults: a review of the literature*. PAIN, 1998. **77**(3): p. 231-9.
2. Kroenke K, *Patients presenting with somatic complaints: epidemiology, psychiatric comorbidity and management*. Int J Methods Psychiatr Res, 2003. **12**(1): p. 34-43.
3. Sternbach RA, *Survey of pain in the United States: The nuprin pain report*. The Clinical Journal of Pain, 1986. **2**(1): p. 49-53.
4. Gureje O, Von Korff M, Simon G, and Gater R, *Persistent pain and well-being: a World Health Organization Study in Primary Care*. Jama, 1998. **280**(2): p. 147-51.
5. Breivik H, *International association for the study of pain: update on WHO-IASP activities*. J Pain Symptom Manage, 2002. **24**(2): p. 97-101.
6. Astin J, *Why patients use alternative medicine: Results of a national study*. JAMA, 1998. **279**(19): p. 1548-1553.
7. Davison SN, Jhangri GS, and Johnson JA, *Cross-sectional validity of a modified Edmonton symptom assessment system in dialysis patients: a simple assessment of symptom burden*. Kidney Int, 2006. **69**(9): p. 1621-5.
8. Davison SN, Jhangri GS, and Johnson JA, *Longitudinal validation of a modified Edmonton symptom assessment system (ESAS) in haemodialysis patients*. Nephrol Dial Transplant, 2006. **21**(11): p. 3189-95.
9. Davison SN and Jhangri GS, *Impact of pain and symptom burden on the health-related quality of life of hemodialysis patients*. J Pain Symptom Manage, 2010. **39**(3): p. 477-85.

10. Davison S, *Chronic pain in end-stage renal disease*. *Adv Chronic Kidney Dis*, 2005. **12**(3): p. 326-34.
11. Kimmel PL, Emont SL, Newmann JM, Danko H, and Moss AH, *ESRD patient quality of life: symptoms, spiritual beliefs, psychosocial factors, and ethnicity*. *Am J Kidney Dis*, 2003. **42**(4): p. 713-21.
12. Leinau L, Murphy TE, Bradley E, and Fried T, *Relationship between conditions addressed by hemodialysis guidelines and non-ESRD-specific conditions affecting quality of life*. *Clin J Am Soc Nephrol*, 2009. **4**(3): p. 572-8.
13. Weisbord SD, Carmody SS, Bruns FJ, Rotondi AJ, Cohen LM, Zeidel ML, et al., *Symptom burden, quality of life, advance care planning and the potential value of palliative care in severely ill haemodialysis patients*. *Nephrol Dial Transplant*, 2003. **18**(7): p. 1345-52.
14. Weisbord SD, Fried LF, Arnold RM, Fine MJ, Levenson DJ, Peterson RA, et al., *Prevalence, severity, and importance of physical and emotional symptoms in chronic hemodialysis patients*. *J Am Soc Nephrol*, 2005. **16**(8): p. 2487-94.
15. Gamondi C, Galli N, Schonholzer C, Marone C, Zwahlen H, Gabutti L, et al., *Frequency and severity of pain and symptom distress among patients with chronic kidney disease receiving dialysis*. *Swiss Med Wkly*, 2013. **143**: p. w13750.
16. Smith BH, Elliott AM, Chambers WA, Smith WC, Hannaford PC, and Penny K, *The impact of chronic pain in the community*. *Fam Pract*, 2001. **18**(3): p. 292-9.
17. Merskey H, Lindblom U, Mumford JM, Nathan PW, and Sunderland S, *Part III: Pain terms—a current list with definitions and notes on usage with definitions and notes on usage.. In: Merskey H, Bogduk N editor(s). Classification of Chronic Pain, IASP Task Force on Taxonomy*. IASP Press, 1994(2nd Edition): p. 209-14.
18. Vuckovic S, Srebro D, Vujovic K S, Vucetic C, and Prostran M, *Cannabinoids and Pain: New Insights From Old Molecules*. *Frontiers in pharmacology*, 2018. **9**: p. 1259.
19. Carr DB and Goudas LC, *Acute pain*. *The Lancet*, 1999. **353**(9169): p. 2051-2058.
20. Ashburn MA and Staats PS, *Management of chronic pain*. *The Lancet*, 1999. **353**(9167): p. 1865-1869.
21. Kanner R, *Pain Management*. *JAMA*, 1986. **256**(15): p. 2112-2114.
22. Loeser J, Melzack R, *Pain: an overview*. *The Lancet*, 1999. **353**(9164): p. 1607-1609.
23. Portenoy R and Dhingra L. *Assessment of cancer pain*. 2017 [cited 18/04 2018].
24. Gregory J and McGowan L, *An examination of the prevalence of acute pain for hospitalised adult patients: a systematic review*. *J Clin Nurs*, 2016. **25**(5-6): p. 583-98.
25. Treede R, *Entstehung der schmerzchronifizierung. Rückenschmerzen und nackenschmerzen*. 2016: Springer, Berlin, Heidelberg.
26. American Geriatrics Society Panel *Pharmacological management of persistent pain in older persons*. *J Am Geriatr Soc*, 2009. **57**: p. 1331-46.
27. Breivik H, Collett B, Ventafridda V, Cohen R, and Gallacher D, *Survey of chronic pain in Europe: prevalence, impact on daily life, and treatment*. *Eur J Pain*, 2006. **10**(4): p. 287-333.
28. Goldberg DS and McGee SJ, *Pain as a global public health priority*. *BMC Public Health*, 2011. **11**: p. 770.

- 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10
 - 11
 - 12
 - 13
 - 14
 - 15
 - 16
 - 17
 - 18
 - 19
 - 20
 - 21
 - 22
 - 23
 - 24
 - 25
 - 26
 - 27
 - 28
 - 29
 - 30
 - 31
 - 32
 - 33
 - 34
 - 35
 - 36
 - 37
 - 38
 - 39
 - 40
 - 41
 - 42
 - 43
 - 44
 - 45
 - 46
 - 47
 - 48
 - 49
 - 50
 - 51
 - 52
 - 53
 - 54
 - 55
 - 56
 - 57
 - 58
 - 59
 - 60
29. Gureje O, Von Korff M, Kola L, Demyttenaere K, He Y, Posada-Villa J, et al., *The relation between multiple pains and mental disorders: results from the World Mental Health Surveys*. PAIN, 2008. **135**(1-2): p. 82-91.
30. Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education, *Relieving pain in America: A blueprint for transforming prevention, care, education, and research*. National Academies Press 2011.
31. Koleva D, *Pain in primary care: an Italian survey*. Eur J Public Health, 2005. **15**: p. 475–79.
32. Mantyselka P, Kumpusalo E, Ahonen R, Kumpusalo A, Kauhanen J, Viinamaki H, et al., *Pain as a reason to visit the doctor: a study in Finnish primary health care*. PAIN, 2001. **89**(2-3): p. 175-80.
33. Treede RD, Rief W, Barke A, Aziz Q, Bennett MI, Benoliel R, et al., *A classification of chronic pain for ICD-11*. PAIN, 2015. **156**(6): p. 1003-7.
34. Kelly DJ, Ahmad M, and Brull SJ, *Preemptive analgesia I: physiological pathways and pharmacological modalities*. Canadian Journal of Anaesthesia, 2001. **48**(10): p. 1000-1010.
35. Pogatzki-Zahn EM, Segelcke D, and Schug SA, *Postoperative pain—from mechanisms to treatment*. Pain Rep, 2017. **2**(2): p. e588.
36. Lipowski Z, *Chronic idiopathic pain syndrome*. Annals of Medicine, 1990. **22**(4): p. 213-217.
37. Goucke C, *The management of persistent pain*. Med J Aust, 2003. **178**(9): p. 444-7.
38. Chang V. *Approach to symptom assessment in palliative care*. 2018 [cited 2018].
39. Knowles CH and Aziz Q, *Basic and clinical aspects of gastrointestinal pain*. Pain, 2009. **141**(3): p. 191-209.
40. Stein S L, *Chronic pelvic pain*. Gastroenterol Clin North Am, 2013. **42**(4): p. 785-800.
41. Schwartz ES and Gebhart GF, *Visceral pain*. Curr Top Behav Neurosci, 2014. **20**: p. 171-97.
42. Giamberardino M, Affaitati G, and Costantini R, *Chapter 24 Referred pain from internal organs*. Handb Clin Neurol, 2006. **81**: p. 343-61.
43. Jensen TS, Baron R, Haanpaa M, Kalso E, Loeser JD, Rice AS, et al., *A new definition of neuropathic pain*. Pain, 2011. **152**(10): p. 2204-5.
44. Headache Classification Committee of the International Headache Society, *The International Classification of Headache Disorders, 3rd edition (beta version)*. Cephalalgia, 2013. **33**: p. 629-808.
45. Institute for clinical systems improvement, *Health care guideline: Assessment and management of chronic pain*. 2009.
46. United Nations office on drugs and crime, *World Drug Report, United Nations*. 2016.
47. Russo E, *Cannabinoids in the management of difficult to treat pain*. Ther Clin Risk Manag, 2008. **4**(1): p. 245-59.
48. Ueda N, Tsuboi K, and Uyama T, *Metabolic enzymes for endocannabinoids and endocannabinoid-like mediators*. 2015, Boston: Academic Press.
49. Devane WA, Hanus L, Breuer A, Pertwee RG, Stevenson LA, Griffin G, et al., *Isolation and structure of a brain constituent that binds to the cannabinoid receptor*. Science, 1992. **258**(5090): p. 1946-9.
50. Mechoulam R, Ben-Shabat S, Hanus L, Ligumsky M, Kaminski NE, Schatz AR, et al., *Identification of an endogenous 2-monoglyceride, present in canine gut, that binds to cannabinoid receptors*. Biochem Pharmacol, 1995. **50**(1): p. 83-90.

- 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10
 - 11
 - 12
 - 13
 - 14
 - 15
 - 16
 - 17
 - 18
 - 19
 - 20
 - 21
 - 22
 - 23
 - 24
 - 25
 - 26
 - 27
 - 28
 - 29
 - 30
 - 31
 - 32
 - 33
 - 34
 - 35
 - 36
 - 37
 - 38
 - 39
 - 40
 - 41
 - 42
 - 43
 - 44
 - 45
 - 46
 - 47
 - 48
 - 49
 - 50
 - 51
 - 52
 - 53
 - 54
 - 55
 - 56
 - 57
 - 58
 - 59
 - 60
 - 61
 - 62
 - 63
 - 64
 - 65
 - 66
51. Sugiura T, Kondo S, Sukagawa A, Nakane S, Shinoda A, Itoh K, et al., *2-Arachidonoylglycerol: a possible endogenous cannabinoid receptor ligand in brain*. *Biochem Biophys Res Commun*, 1995. **215**(1): p. 89-97.
52. Fisar Z, *Phytocannabinoids and endocannabinoids*. *Curr Drug Abuse Rev*, 2009. **2**(1): p. 51-75.
53. Häuser W, Fitzcharles M, Radbruch L, and Petzke F, *Cannabinoids in pain management and palliative medicine*. *Deutsches Arzteblatt international*, 2017. **114**(38): p. 627-634.
54. Hazekamp A, Ware MA, Muller-Vahl KR, Abrams D, and Grotenhermen F, *The medicinal use of cannabis and cannabinoids—An international cross-sectional survey on administration forms*. *Journal of Psychoactive Drugs*, 2013. **45**(3): p. 199-210.
55. Watson SJ, Benson JA, and Joy JE, *Marijuana and medicine: assessing the science base: a summary of the 1999 Institute of Medicine report*. *Arch Gen Psychiatry*, 2000. **57**(6): p. 547-52.
56. Brenneisen R, *Chemistry and analysis of phytocannabinoids and other cannabis constituents*, in *Marijuana and the Cannabinoids*, ElSohly M A, Editor. 2007, Humana Press: Totowa, NJ. p. 17-49.
57. Pertwee R, *Cannabis and cannabinoids: Pharmacology and rationale for clinical use*. *Pharmacy and Pharmacology Communications*, 1997. **3**(11): p. 539-545.
58. Solinas M, Goldberg SR, and Piomelli D, *The endocannabinoid system in brain reward processes*. *Br J Pharmacol*, 2008. **154**(2): p. 369-83.
59. Koppel BS, Brust J, Fife T, Bronstein J, Youssof S, Gronseth G, et al., *Systematic review: efficacy and safety of medical marijuana in selected neurologic disorders: report of the Guideline Development Subcommittee of the American Academy of Neurology*. *Neurology*, 2014. **82**(17): p. 1556-63.
60. Gorelick D, Saxon A, and Hermann R *Cannabis use and disorder: Pathogenesis and pharmacology*. UpToDate Cannabis use and disorder: Pathogenesis and pharmacology, 2018.[cited Access 2018 Access Date].
61. Morean ME, Kong G, Camenga DR, Cavallo DA, and Krishnan-Sarin S, *High school students' use of electronic cigarettes to vaporize cannabis*. *Pediatrics*, 2015. **136**(4): p. 611-616.
62. Loflin M and Earleywine M, *No smoke, no fire: What the initial literature suggests regarding vapourized cannabis and respiratory risk*. *Canadian journal of respiratory therapy*, 2015. **51**(1): p. 7-9.
63. Aviram J and Samuelly-Leichtag G, *Efficacy of Cannabis-Based Medicines for Pain Management: A Systematic Review and Meta-Analysis of Randomized Controlled Trials*. *Pain Physician*, 2017. **20**(6): p. E755-e796.
64. Lynch M, Campbell, F, *Cannabinoids for treatment of chronic non-cancer pain; a systematic review of randomized trials*. *Br J Clin Pharmacol*, 2011. **72**(5): p. 735-44.
65. Meng H, Johnston B, Englesakis M, Moulin DE, and Bhatia A, *Selective Cannabinoids for Chronic Neuropathic Pain: A Systematic Review and Meta-analysis*. *Anesth Analg*, 2017. **125**(5): p. 1638-1652.
66. Boychuk DG, Goddard G, Mauro G, and Orellana MF, *The effectiveness of cannabinoids in the management of chronic nonmalignant neuropathic pain: a systematic review*. *J Oral Facial Pain Headache*, 2015. **29**(1): p. 7-14.

- 1
- 2
- 3
- 4
- 5 67. Martin-Sanchez E, Furukawa TA, Taylor J, and Martin JL, *Systematic review and meta-analysis of cannabis treatment for chronic pain*. Pain Med, 2009. **10**(8): p. 1353-68.
- 6
- 7 68. Campbell FA, Tramèr MR, Carroll D, Reynolds DJ, Moore RA, and McQuay HJ, *Are cannabinoids an effective and safe treatment option in the management of pain? A qualitative systematic review*. BMJ (Clinical research ed.), 2001. **323**(7303): p. 13-16.
- 8
- 9
- 10 69. Deshpande A, Mailis-Gagnon A, Zoheiry N, and Lakha SF, *Efficacy and adverse effects of medical marijuana for chronic noncancer pain: Systematic review of randomized controlled trials*. Can Fam Physician, 2015. **61**(8): p. e372-81.
- 11
- 12
- 13
- 14 70. Stevens AJ and Higgins MD, *A systematic review of the analgesic efficacy of cannabinoid medications in the management of acute pain*. Acta Anaesthesiol Scand, 2017. **61**(3): p. 268-280.
- 15
- 16
- 17
- 18 71. Walitt B, Klose P, Fitzcharles MA, Phillips T, and Hauser W, *Cannabinoids for fibromyalgia*. Cochrane Database Syst Rev, 2016. **7**: p. Cd011694.
- 19
- 20 72. Mucke M, Phillips T, Radbruch L, Petzke F, and Hauser W, *Cannabis-based medicines for chronic neuropathic pain in adults*. Cochrane Database Syst Rev, 2018. **3**: p. Cd012182.
- 21
- 22 73. Boydell J, Van Os J, Caspi A, Kennedy N, Giouroukou E, Fearon P, et al., *Trends in cannabis use prior to first presentation with schizophrenia, in South-East London between 1965 and 1999*. Psychological Medicine, 2006. **36**(10): p. 1441-1446.
- 23
- 24
- 25 74. Andreasson S, Allebeck P, Engstrom A, and Rydberg U, *Cannabis and schizophrenia. A longitudinal study of Swedish conscripts*. Lancet, 1987. **2**(8574): p. 1483-6.
- 26
- 27 75. Arseneault L, Cannon M, Poulton R, Murray R, Caspi A, and Moffitt TE, *Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study*. Bmj, 2002. **325**(7374): p. 1212-3.
- 28
- 29
- 30
- 31
- 32 76. van Os J, Bak M, Hanssen M, Bijl R V, de Graaf R, and Verdoux H, *Cannabis use and psychosis: a longitudinal population-based study*. Am J Epidemiol, 2002. **156**(4): p. 319-27.
- 33
- 34 77. Zammit S, Allebeck P, Andreasson S, Lundberg I, and Lewis G, *Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study*. Bmj, 2002. **325**(7374): p. 1199.
- 35
- 36
- 37
- 38 78. Fergusson DM, Horwood LJ, and Ridder EM, *Tests of causal linkages between cannabis use and psychotic symptoms*. Addiction, 2005. **100**(3): p. 354-66.
- 39
- 40 79. Henquet C, Krabbendam L, Spauwen J, Kaplan C, Lieb R, Wittchen HU, et al., *Prospective cohort study of cannabis use, predisposition for psychosis, and psychotic symptoms in young people*. Bmj, 2005. **330**(7481): p. 11.
- 41
- 42
- 43
- 44 80. Di Forti M, Quattrone D, Freeman TP, Tripoli G, Gayer-Anderson C, Quigley H, et al., *The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe (EU-GEI): a multicentre case-control study*. Lancet Psychiatry, 2019. **6**(5): p. 427-436.
- 45
- 46
- 47 81. Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, et al., *Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and explanation*. Bmj, 2015. **350**: p. g7647.
- 48
- 49
- 50
- 51 82. Moher D, Shamseer L, Clarke M, Ghersi D, Liberati A, Petticrew M, et al., *Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement*. Syst Rev, 2015. **4**: p. 1.
- 52
- 53
- 54
- 55
- 56
- 57
- 58
- 59
- 60

- 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10
 - 11
 - 12
 - 13
 - 14
 - 15
 - 16
 - 17
 - 18
 - 19
 - 20
 - 21
 - 22
 - 23
 - 24
 - 25
 - 26
 - 27
 - 28
 - 29
 - 30
 - 31
 - 32
 - 33
 - 34
 - 35
 - 36
 - 37
 - 38
 - 39
 - 40
 - 41
 - 42
 - 43
 - 44
 - 45
 - 46
 - 47
 - 48
 - 49
 - 50
 - 51
 - 52
 - 53
 - 54
 - 55
 - 56
 - 57
 - 58
 - 59
 - 60
83. *International conference on harmonisation of technical requirements for registration of pharmaceuticals for human use (ICH) adopts consolidated guideline on good clinical practice in the conduct of clinical trials on medicinal products for human use*. *Int Dig Health Legis*, 1997. **48**(2): p. 231-4.
84. Richards J R, Bing M L, Moulin A K, Elder J W, Rominski R T, Summers P J, et al., *Cannabis use and acute coronary syndrome*. *Clinical toxicology (Philadelphia, Pa.)*, 2019: p. 1-11.
85. Higgins J and Green S. *Cochrane handbook for systematic reviews of interventions version 5.1.0*. www.handbook.cochrane.org. 2011.
86. *Review Manager (RevMan)*. 2014, Copenhagen: the Nordic Cochrane Centre, The Cochrane Collaboration.
87. *TSA—trial sequential analysis*. Copenhagen Trial Unit.
88. *StataCorp: Stata: Release 14*. 2014, College Station, TX: StataCorp LP.
89. Moher D, Liberati A, Tetzlaff J, and Altman DG, *Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement*. *PLOS Medicine*, 2009. **6**(7): p. e1000097.
90. Gluud LL, *Bias in clinical intervention research*. *Am J Epidemiol*, 2006. **163**(6): p. 493-501.
91. Kjaergard LL, Villumsen J, and Gluud C, *Reported methodologic quality and discrepancies between large and small randomized trials in meta-analyses*. *Ann Intern Med*, 2001. **135**(11): p. 982-9.
92. Lundh A, Sismondo, S, Lexchin, J, Busuioac, OA, Bero, L, *Industry sponsorship and research outcome*. *Cochrane Database Syst Rev*, 2012. **12**: p. Mr000033.
93. Moher D, Pham, B, Jones, A, Cook, DJ, Jadad, AR, Moher, M et al., *Does quality of reports of randomised trials affect estimates of intervention efficacy reported in meta-analyses?* *Lancet*, 1998. **352**(9128): p. 609-13.
94. Schulz KF, Chalmers I, Hayes RJ, and Altman DG, *Empirical evidence of bias. Dimensions of methodological quality associated with estimates of treatment effects in controlled trials*. *JAMA*, 1995. **273**(5): p. 408-12.
95. Wood L, Egger M, Gluud L, Schulz K, Jüni P, Altman D, et al., *Empirical evidence of bias in treatment effect estimates in controlled trials with different interventions and outcomes: meta-epidemiological study*. *BMJ*, 2008. **336**(7644): p. 601-605.
96. Savovic J, Jones H, Altman D, Harris R, Juni P, Pildal J, et al., *Influence of reported study design characteristics on intervention effect estimates from randomised controlled trials: combined analysis of meta-epidemiological studies*. *Health Technol Assess*, 2012. **16**(35): p. 1-82.
97. Higgins JP and Thompson SG, *Quantifying heterogeneity in a meta-analysis*. *Stat Med*, 2002. **21**(11): p. 1539-58.
98. Higgins JP, Thompson SG, Deeks JJ, and Altman DG, *Measuring inconsistency in meta-analyses*. *BMJ*, 2003. **327**(7414): p. 557-60.
99. Harbord RM, Egger M, and Sterne JA, *A modified test for small-study effects in meta-analyses of controlled trials with binary endpoints*. *Stat Med*, 2006. **25**(20): p. 3443-57.
100. Egger M, Davey Smith G, Schneider M, and Minder C, *Bias in meta-analysis detected by a simple, graphical test*. *BMJ*, 1997. **315**(7109): p. 629-34.
101. Begg CB and Mazumdar M, *Operating characteristics of a rank correlation test for publication bias*. *Biometrics*, 1994. **50**(4): p. 1088-101.

102. Elbourne D, Altman D, Higgins J, Curtin F, Worthington H, and Vail A, *Meta-analyses involving cross-over trials: methodological issues*. International Journal of Epidemiology, 2002. **31**(1): p. 140-149.
103. Jakobsen JC, Wetterslev J, Winkel P, Lange T, and Gluud C, *Thresholds for statistical and clinical significance in systematic reviews with meta-analytic methods*. BMC Med Res Methodol, 2014. **14**: p. 120.
104. Hagg O, Fritzell P, and Nordwall A, *The clinical importance of changes in outcome scores after treatment for chronic low back pain*. Eur Spine J, 2003. **12**(1): p. 12-20.
105. Jaeschke R, Singer J, and Guyatt GH, *Measurement of health status. Ascertaining the minimal clinically important difference*. Control Clin Trials, 1989. **10**(4): p. 407-15.
106. Olsen MF, Bjerre E, Hansen MD, Hilden J, Landler NE, Tendal B, et al., *Pain relief that matters to patients: systematic review of empirical studies assessing the minimum clinically important difference in acute pain*. BMC Med, 2017. **15**(1): p. 35.
107. Olsen MF, Bjerre E, Hansen MD, Tendal B, Hilden J, and Hrobjartsson A, *Minimum clinically important differences in chronic pain vary considerably by baseline pain and methodological factors: systematic review of empirical studies*. J Clin Epidemiol, 2018. **101**: p. 87-106.e2.
108. Keus F, Wetterslev J, Gluud C, and van Laarhoven CJ, *Evidence at a glance: error matrix approach for overiewing available evidence*. BMC Med Res Methodol, 2010. **10**: p. 90.
109. DerSimonian R and Laird N, *Meta-analysis in clinical trials*. Control Clin Trials, 1986. **7**(3): p. 177-88.
110. Demets DL, *Methods for combining randomized clinical trials: strengths and limitations*. Stat Med, 1987. **6**(3): p. 341-50.
111. Jakobsen J C, Wetterslev J, Lange T, and Gluud C, *Viewpoint: taking into account risks of random errors when analysing multiple outcomes in systematic reviews*. Cochrane Database of Systematic Reviews, 2016(3).
112. Wetterslev J, Thorlund K, Brok J, and Gluud C, *Trial sequential analysis may establish when firm evidence is reached in cumulative meta-analysis*. J Clin Epidemiol, 2008. **61**(1): p. 64-75.
113. Thorlund K W J, Brok J, Imberger G, Gluud C, *User manual for trial sequential analysis (TSA)*. 2011.
114. Brok J, Thorlund K, Gluud C, and Wetterslev J, *Trial sequential analysis reveals insufficient information size and potentially false positive results in many meta-analyses*. J Clin Epidemiol, 2008. **61**(8): p. 763-9.
115. Brok J, Thorlund K, Wetterslev J, and Gluud C, *Apparently conclusive meta-analyses may be inconclusive--Trial sequential analysis adjustment of random error risk due to repetitive testing of accumulating data in apparently conclusive neonatal meta-analyses*. Int J Epidemiol, 2009. **38**(1): p. 287-98.
116. Thorlund K, Devereaux PJ, Wetterslev J, Guyatt G, Ioannidis JP, Thabane L, et al., *Can trial sequential monitoring boundaries reduce spurious inferences from meta-analyses?* Int J Epidemiol, 2009. **38**(1): p. 276-86.
117. Wetterslev J, Thorlund K, Brok J, and Gluud C, *Estimating required information size by quantifying diversity in random-effects model meta-analyses*. BMC Med Res Methodol, 2009. **9**: p. 86.

- 1
2
3
4 118. Thorlund K, Anema A, and Mills E, *Interpreting meta-analysis according to the adequacy of*
5 *sample size. An example using isoniazid chemoprophylaxis for tuberculosis in purified protein*
6 *derivative negative HIV-infected individuals.* Clin Epidemiol, 2010. **2**: p. 57-66.
7
8 119. Imberger G, Gluud C, Boylan J, and Wetterslev J, *Systematic reviews of anesthesiologic*
9 *interventions reported as statistically significant: problems with power, precision, and type 1*
10 *error protection.* Anesth Analg, 2015. **121**(6): p. 1611-22.
11
12 120. Imberger G, Thorlund K, Gluud C, and Wetterslev J, *False-positive findings in Cochrane meta-*
13 *analyses with and without application of trial sequential analysis: an empirical review.* BMJ
14 Open, 2016. **6**(8).
15
16 121. Guyatt G, Oxman A, Vist G, Kunz R, Falck-Ytter Y, Alonso-Coello P, et al., *GRADE: an emerging*
17 *consensus on rating quality of evidence and strength of recommendations.* BMJ, 2008.
18 **336**(7650): p. 924-926.
19
20 122. Guyatt GH, Oxman AD, Schunemann HJ, Tugwell P, and Knottnerus A, *GRADE guidelines: a new*
21 *series of articles in the Journal of Clinical Epidemiology.* J Clin Epidemiol, 2011. **64**(4): p. 380-2.
22
23 123. Schunemann HJ, Best D, Vist G, and Oxman AD, *Letters, numbers, symbols and words: how to*
24 *communicate grades of evidence and recommendations.* Cmaj, 2003. **169**(7): p. 677-80.
25
26 124. Voscopoulos C and Lema M, *When does acute pain become chronic?* Br J Anaesth, 2010. **105**
27 **Suppl 1**: p. i69-85.
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Appendix

Minimal important difference

For the determination of minimal important differences in clinical trials two types of methods are available; anchor-based methods and distributional-based methods [1].

Anchor-based methods

Anchor-based methods relate the change in on a person reported outcome score, (e.g. a score on the visual analog scale (VAS)) to a subjective global assessment rating (e.g. scores from the Clinical Global Impressions-Improvement (CGI-I)) which is used as an 'anchor' [1]. Ideally, there needs to be an established association between the person reported outcome score and the 'anchor' to make any meaningful inference about a minimal important difference [2].

There are two subtypes of anchor-based methods, i.e., the '*within-patient score*' and the '*between-patients score*' [1].

- Within-patient score defines minimal important difference as the average minimal change in a given person's reported outcome score that leads to a clinically observable change in the subjective global assessment rating (the latter is used as an anchor) [1]. For example, to ascertain the minimal important difference regarding depression management, Moncrieff et. al describes the linking of within-patient scores (change from baseline) scores on the Hamilton Depression Rating Scale (the most commonly used depression rating scale) to scores on the Clinical Global Impressions-Improvement (CGI-I) scale, a scale which rates improvement on a scale of 1 (very much improved from baseline) through 4 (no change from baseline) to 7 (very much worse from baseline) [3]. Moncrieff et. al conclude that seven points on the Hamilton Depression Rating Scale correspond to a minimal important difference when using within-patient scores [3].
- The between-patients score method, also known as 'the group difference' method, compare the reported outcome scores between a group of people with no clinically observable change (based on a subjective global assessment rating (used as an anchor)) to a group of people with clinically observable change (based on a subjective global assessment rating (used as an anchor)). The minimal important difference is then estimated as the mean difference between these two groups [4]. For example, Musoro et. al defines the minimal important difference (MID) as the group difference in terms of quality of life assessed by HRQOL scores [5]. Participants were assigned to distinct subgroups reflecting various levels of change (e.g. no change, small positive changes, large positive changes, small negative changes or large negative changes). The group difference was identified by the

1
2
3
4 comparison of the average of the HRQOL scores of the group of participants with at 'small change'
5 to the HRQOL scores of the group of participants with 'no change' [5].
6
7
8

9 There are also other anchor-based methods (e.g. the sensitivity- and specificity-based method and the social
10 comparison method) [1]. The sensitivity- and specificity-based method aims to identify the minimal
11 important difference that allows for the best discrimination between groups of patients (i.e., the score that
12 produces the greatest sensitivity and specificity) [1]. For example, an outcome measure (e.g. NRS score) is
13 considered a 'diagnostic test' and the anchor (e.g. Global Perceived Effect) is used as gold standard and hence
14 standard methods may be used to estimate sensitivity and specificity. Sensitivity is the proportion of patients
15 who report an improvement on the external criterion (anchor) and whose person reported outcome scores
16 are above the threshold minimal important difference value [1]. Specificity is the proportion of patients who
17 do not report an improvement on the external criterion (anchor) and whose person reported outcome scores
18 are below the threshold minimal important difference value [1]. Receiver operating characteristic (ROC)
19 curves are then used to identify the person reported outcome score with the greatest sensitivity and
20 specificity [6-8].
21
22
23
24
25
26
27
28
29
30

31 *The distributional-based methods*

32 Distribution-based methods are based on the statistical characteristics of the obtained sample [9]. Crosby et.
33 al [9] have identified two general types of distribution-based methods for estimations of minimal important
34 differences:
35
36

- 37 • The first type of distribution-based method evaluate change in relation to sample variation [9].
38 Different types of variation can be used: effect size, standardised response mean, and
39 responsiveness statistic [9]. The effect size represents individual change in relation to the number of
40 pre-test standard deviations (SDs) [9]. Cohen et. al has suggested benchmarks to better interpret the
41 effect sizes: .20 for "small" effects, .50 for "moderate" effects, and .80 for "large" effects [10].
42 Whereas the effect size is the ratio of individual change to the baseline standard deviation of the
43 sample, standardised response mean is the ratio of individual change to the standard deviation of
44 that change [11]. A large standardised response mean indicates that the change is large in
45 comparison to the background variability in the measurements [9]. Guyatt et. al has proposed a
46 responsiveness statistic as a variation of standardised response mean; calculated by dividing the
47 difference between pre-test and post-test by the standard deviation of change observed for a group
48 of stable participants [12].
49
50
51
52
53
54
55
56
57
58
59
60

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
- The second type distribution-based method is based on the measurement precision of the instrument [9]. This method include the standard error of the mean (SEM) and evaluate the change in relation to variation of the instrument as opposed to variation in the sample [9]. Standard error of the mean (SEM) is a measure of the precision of a test instrument and considered an attribute of the measure and not a characteristic of the sample per se [13]. The standard error of the mean (SEM) for a given measure is likely to vary across samples depending upon the method used to estimate reliability and the presence of extreme scores [9]. Different thresholds for a minimal important difference have been suggested, i.e., values of 1 SEM [14], 1.96 SEM [15], and 2.77 SEM [13, 15].

19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38

In conclusion, different methods for estimating minimal important differences exist, but no single method has been shown to be the optimal method. The question of whether to use anchor-based or distribution-based methods for determining clinically meaningful change has received considerable attention and debate [9]. Dworkin et. al defined the clinical importance of patient improvement as the clinically important changes in individuals that can be identified using either within-patient anchor-based method or distributional-based method [16, 17], while the clinical importance of group differences could be the clinical difference between a treatment group and a placebo group or between two different treatment groups [18]. Dworkin et. al claim that the clinical important difference identified in individuals cannot be directly extrapolated to the evaluation of group differences [17, 19-22]. The U.S. Food and Drug Administration also states in their web site “When defining meaningful change on an individual patient basis, that definition is generally larger than the minimum important difference for application to group mean comparisons” [22].

39
40
41
42
43
44
45

While it is claimed that the within-patient differences are larger the between-group difference [22], based on the studies included in our review we are not able to find a significant difference between the minimal important difference estimated by the two different methods.

46 47

Previously conducted reviews on this subject

- 48
49
50
51
52
53
54
55
56
57
58
59
60
- Lynch & Campbell and Boychuk et. al both concluded that cannabinoids are a modestly effective and a safe treatment option for neuropathic pain [23, 24]. Lynch & Campbell and Boychuk et. al did not publish a protocol on beforehand [23, 24].
 - Meng et. al concluded that there is moderate quality evidence to suggest that nabiximols (phytocannabinoid mixture) is effective in reducing neuropathic pain [25].

- Mücke et. al concluded that there is no high-quality evidence for the efficacy of any cannabis-based medicine in any condition with chronic neuropathic pain [26]. Mücke et. al further concluded that some adverse events may limit the clinical usefulness of cannabis-based medicines [26].
- Deshpande et. al concluded that current evidence suggests that very low-dose medical marijuana (< 34 mg/d) is associated with an improvement in refractory neuropathic pain of moderate severity in adults using concurrent analgesics. Deshpande et. al did not publish a protocol on beforehand [27].
- Martín-Sánchez et. al concluded that treatment of chronic pain based on cannabinoid compounds would entail more risk of adverse events than benefit [28]. Martín-Sánchez et. al included trials randomising participants with either neuropathic pain, cancer pain, fibromyalgia related pain and nociceptive pain [28]. Martín-Sánchez et. al did not publish a protocol on beforehand [28].
- Aviram et. al concluded that cannabinoid-based medicines were not effective for postoperative pain, however further investigation is advised [29]. Aviram et. al also concluded that evidence suggests a moderate to good treatment effect on neuropathic pain [29]. Furthermore, neuropathic pain patients should be advised that the inhalation of cannabinoids showed relatively better pain reduction effects than other routes of administration [29]. Aviram et. al stated that the total number of adverse events that were accumulated in the meta-analysis indicated that cannabinoid-based medicines should be used with caution [29]. Aviram et. al did not publish a protocol on beforehand [29].
- Campbell et. al concluded that levonantradol (synthetic cannabinoid analogue) was superior to placebo on postoperative pain but no more effective than codeine [30]. Campbell et. al also stated that there are suggestions of efficacy in spasticity and in neuropathic pain and that increasing the cannabinoid dose to increase the analgesia will increase adverse effects [30]. Campbell et. al did not publish a protocol on beforehand [30].
- Stevens et. al concluded that cannabinoids have no role in the management of acute pain, but cannabinoids were found to be well-tolerated, with most reported adverse effects only mild to moderate in severity [31].
- Walitt et. al concluded that no convincing, unbiased evidence suggests that nabilone (synthetic cannabinoid analog) is of value in treating people with fibromyalgia [32]. The tolerability of nabilone was low and adverse events (particularly somnolence, dizziness, vertigo) may limit its clinical usefulness [32].

TABEL 1

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
First author	Title	Year of publication	Design	Type of cannabinoid	Types of participants	Information sources	No. of trials	No. of participants	Published protocols	Outcomes	Assessment of adverse events	Assessment of risk of bias	Accounts for random error	Use of the GRADE	Conclusion																																												
Lynch & Campbell [23]	Cannabinoids for treatment of chronic non-cancer pain; a systematic review of random	2011	Systematic Review	Phytocannabinoids ; Smoked cannabis, oromucosal extracts of cannabis-based medicine, and synthetic cannabinoids ; nabilone, dronabin	Neuropathic pain, fibromyalgia, rheumatoid arthritis, and mixed chronic pain.	PubMed, EMBASE, CINAHL (EBSCO), PsycInfo (EBSCO), The Cochrane Library, ISI Web of Science, ABI Inform (Proquest), Dissertation Abstracts (Proquest), Academic Search	18	766	No	The primary outcome was pain in subjects with chronic non-cancer pain. The secondary outcomes were sleep, function, and quality of life.	Yes	Yes, except for reporting bias, publication bias and for-profit bias	No	No	Overall there is evidence that cannabinoids are safe and modestly effective in neuropathic pain with preliminary evidence of efficacy																																												

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

	mi ze d tria ls			ol and a nove l THC anal ogue .		Premie r (EBSCO)), Clinical Trials.g ov, TrialsC entral. org, individ ual pharm aceutic al compa ny trials sites for Eli Lilly and GlaxoS mithKli ne, OAlste r (OCLC) and Google Scholar .									in fibro myal gia and rheu mato id arthr itis. Did not pool data for meta - analy sis but data was descr ibed quali tativ ely.
Me ng et. al [25]	Sel ect ive Cann abino ids for Chro	20 17	Sys tema tic Re vie w and Meta-	Dron abin ol, nabil one and nabi ximo ls	Ne urop athic pai n	Medlin e, Embas e, Cochra ne Library , PROSP ERO, clinical	11 (1 0 trials com pa rin g th	12 19	No	The primar y outco me was intensi ty of pain record ed	Yes	Yes	Bon ferr oni adju stm ent for mul tipl e testi	Yes	Selec tive cann abin oids provi de a small analgesic bene

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

	nic Ne ur op ath ic Pai n: A Sys te ma tic Re vie w an d Me ta- an aly sis		an aly sis			trials.g ov, and Google Scholar . Pain societi es (Ameri can Society of Anesth esiolog ists, Europe an Society of Anaest hesiolo gy, Intern ation al Associ ation for the Study of Pain, Americ an Society of Region al Anesth esia and Pain Medici ne, Europe an	e int er ve nti on wi th pla ce bo)			after a minim um of 2 weeks followi ng initiati on of selecti ve cannab inoid and placeb o/com parato r admini stratio n, expres sed on an NRS (0—no pain to 10— worst possibl e pain). Second ary outco mes were presen ce or absenc e of analge sia define d as			ng was not perf orm ed as per rec om me nda tion s in the Coc hra ne Han dbo ok.		fit in patie nts with chro nic neur opat hic pain.
--	--	--	------------------	--	--	---	---	--	--	--	--	--	--	--	---

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

						<p>Society of Regional Anesthesia and Pain Therapy, and World Institute of Pain) in the last 2 years were also searched.</p>			<p>reduction in pain scores (NRS/VAS) by $\geq 30\%$ at 2 weeks or more after initiation of intervention, quality of life (QoL), physical function, psychological function, sleep, overall patient satisfaction, and the incidence of adverse effects of selective cannabinoids.</p>					
--	--	--	--	--	--	--	--	--	---	--	--	--	--	--

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
Martín-Sánchez et al [28]	Systematic Review and Meta-analysis of Cannabinoids Treatment for Chronic Pain	2009	Meta-analysis	Phytocannabinoids and synthetic derivatives of THC, such as dronabinol, nabilone, or benzopyranoperidine (a synthetic nitrogen analog of THC)	Chronic pain of a pathological or traumatic origin	Medline/Pubmed, Embase, and The Cochrane Controlled Trials Register (CENTRAL)	18	?	No	The primary outcome was intensity of pain as scored by numerical rating scales. The Secondary outcomes were CNS related events	Yes	Yes, except for reporting bias, detection bias and for-profit bias	No	No	Currently available evidence suggests that cannabis treatment is moderately efficacious for treatment of chronic pain, but beneficial effects may be partially (or completely) offset by potentially serious																																												

															us harm s.
Boy chu k et. al [24]	The Eff ect ive ness of Cann abis noids in the Man age ment of Chro nic Non mali gnant Neur opath ic Pain: A Syste matic Re	20 15	Syste matic Re vie w	Phyt ocan nabi noid s ; smoked cann abis, cann abis- base d medi cinal extra cts (CB ME) in the form of oro muc osal spra ys (nabi ximo ls), vapo rized cann abis, and synt hetic cann abin oids ; dron	Neur opath ic pain	PubMe d, Embas e, Web of Scienc e, and all eviden ce- based medici ne review s and databa ses (Cochr ane Databa se of System atic Review s, ASP Journal Club, Databa se of Abstra cts of Review s of Effects [DARE] , and Cochra ne Contro lled	13	77 1	No	Outco mes consid ered were reducti on in pain intensi ty and advers e events.	Yes	Yes, exce pt for, repor ting bias, publi cations bias and for- profit bias	No	No	Cann abis- base d medi cinal extra cts used in diffe rent popu lations of chro nic non- mali gnant neur opath ic pain patie nts may provi de effec tive analge sia in cond ition s that are refra ctory

	view			abinol, nabiximol, and CT-3		Trials Register [CCTR])									to other treatments.
Mücke et al [26]	Cannabis products for adults with chronic neuropathic pain	2018	Cochrane Review	Phytocannabinoid ; oromucosal spray containing THC or THC/CBD mix, smoked cannabis containing THC, THC and CBD as extract of cannabis sativa L., and synt	Neuropathic pain	Cochrane Library, MEDLINE and EMBASE. Following clinical trials databases were searched for additional data including unpublished data: US National Institutes of Health clinical trial register (www.ClinicalTrials.gov)	16 (15 of the trials compared)	1750	Yes	Primary outcomes: Participant-reported pain relief of 50% or greater. We preferred composite neuropathic pain scores over single-scale generic pain scores if both measures were used by studies;	Yes	Yes	No	Yes	The potential benefits of cannabis-based medicine (herbal cannabis, plant-derived or synthetic THC, THC/CBD oromucosal spray) in chronic neuropathic pain might be

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

				<p>hetic cann abin oids; nabil one, dron abin ol</p>	<p>Trials.g ov), Europe an Union Clinical Trials Registe r (www. clinical trialsre gister. eu), World Health Organi zation (WHO) Interna tional Clinical Trials Registr y Platfor m (ICTRP) (apps. who.in t/trials earch/) , and Interna tional Associ ation for Canna binoid Medici nes (IACM) databa nk</p>	<p>PGIC (Patien t Global Impres sion of Chang e) much or very much improv ed;</p> <p>Withdr awals due to advers e events (tolera bility);</p> <p>Seriou s advers e events (safety). Seriou s advers e events typicall y include any untow ard medica l occurr ence</p>	<p>outw eigh ed by their pote ntial harm s.</p>
--	--	--	--	---	--	---	---

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

						www.cannabis-med.org/studies/study.php)				or effect that at any dose results in death, is life-threatening, requires hospitalisation or prolongation of existing hospitalisation, results in persistent or significant disability or incapacity, is a congenital anomaly or birth defect, is an 'important medical				
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

										I event' that may jeopar dise the person , or may requir e an interve ntion to preven t one of the above charac teristic s/cons equen ces.					
Avi ra m et. al [29]	Effi cac y of Cann abi s- Ba se d Me dic ine s for Pai n Ma na ge	20 17	Me ta- An aly sis	Phyt ocan nabi noid s; Sativ ex/n abixi mol, cann abidi ol, cann abin oid cigar ettes /vap orize r,	Ch ro nic (ca nc er an d no n- ca nc er) pai n an d ac ute po sto	MEDLI NE/Pu bmed and in Google Scholar using Medic al Subjec t Headin g (MeSH) terms	43 tri als com par ing the int er ve nti on wi th bo th 'ac tiv	24 37	No	The outco me measu re that was chosen was the variabl e "pain intensi ty", as scored by the numeri cal rating scale (NRS- 11),	Yes	Yes, ex cept for, re po rtin g bi as, pu bli ca tio n bi as an	No	No	The curre nt syste mati c revie w sugg ests that cann abin oid- base d medi cines migh t be effec

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

	ment: A Systematic Review and Meta-Analysis of Randomized Controlled Trials		and synthetic cannabinoids; dronabinol and nabilone, CT-3, ajulemic acid, synthetic nitrogen analog of tetrahydrocannabinol (NIB), fatty acid amide hydrolase-1 (FAAH1) inhibitor (PF-04457845) (bloc	perative pain		drug and placebo			numerical 11-point box (BS-11), visual analog scale (VAS), and the VAS section of the questionnaire short form McGill Pain Questionnaire.		d for-profit bias		tive for chronic pain treatment, based on limited evidence, primarily for neuropathic pain patients.
--	---	--	---	---------------	--	------------------	--	--	---	--	-------------------	--	--

				king degradation of endocannabinoids), benzopyranoperidine (BPP), and levonantadol												
29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60	Ca mp bell et. al [30]	Ar e cann abi noids an eff ect ive and saf e tre at me nt opt ion in the ma na	20 01	Sys te ma tic Re vie w	Oral THC, an oral synt hetic nitro gen anal ogue of THC (NIB) , oral benz opyr anop eridi ne (BPP), and intra mus cular	Ac ute , chr oni c non -ma lig na nt pai n, and canc er pai n	MEDLI NE, EMBAS E, Oxford Pain Databa se, and Cochra ne Library	9	22 2	No	Outco me measu res for pain intensi ty; pain relief; the use of supple menta ry analge sia; patient s' prefer ences; and advers e effects .	Yes	Yes, ex cept for, re po rti ng bi as, pu bli ca tio n bi as and for pr	No	No	Cann abin oids are no more effec tive than code ine in contr ollin g pain and have depr essa nt effec ts on the centr

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

	gement of pain? A qualitative systematic review			levonantadol								ofit bias			al nervous system that limit their use. Their widespread introduction into clinical practice for pain management is therefore undesirable. In acute post operative pain they should not be used.
Des hpa	Effi cac	20 15	Sys te	Cigar ettes	Ne ur	MEDLI NE,	6 tri	22 6	N o	For outco	Ye s	Ye s,	No	N o	Ther e is

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

nd e et. al [27]	y an d ad ver se eff ect s of me dic al mari ju an a for chro nic non can cer pai n		ma tic Re vie w	or vapo rizer cont ainin g delta -9- THC	op ath ic pai n	EMBAS E, and the Interna tional Pharm aceutic al Abstra cts	als co m pa rin g int er ve nti on wi th pla ce bo . Pla ce bo bei ng cigar ett es or va po riz er co nt ain ing 0% del ta- 9- TH C or wi th ca			mes, pain scores were extract ed using the visual analog ue scale (VAS) or an alterna tive numeri cal pain rating tool. If pain scores were not report ed, surrog ate measu res of effecti veness were include d (sleep, functio n, and quality of life). Freque ncy of serious and		ex ce pt fo r, re po rti ng bi as, pu bli ca tio n bi as and for pro fit bi as		evid ence for the use of low- dose medi cal mari juana in refra ctory neur opat hic pain in conj uncti on with tradi tiona l anal gesics. How ever, trials were limit ed by short dura tion, varia bility in dosi ng and
----------------------------------	---	--	-----------------------------	--	-----------------------------	--	--	--	--	---	--	---	--	--

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

							nn abi no id re m ov al			most comm only report ed advers e effects was collect ed.					stren gh of delta -9- tetra hydr ocan nabi nol, and lack of funct ional outc ome s. Altho ugh well toler ated in the short term , the long- term effec ts of psyc hoac tive and neur ocog nitiv e effec ts of medi cal marij
--	--	--	--	--	--	--	--	--	--	---	--	--	--	--	--

															una rema in unkn own.
11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60	Steven et. al [31]	20 17	Systematic Review	Levonant radol , nabilone, AZD 1940 , GW8 4216 6, dronabinol, Δ-9-T HC	Acute postoperative pain	MEDLINE, EMBASE, Cochrane Library , and the World Health Organization International Clinical Trials Registry Platform	7 trials comparing interve ntion with placebo , Ketoprofen , Pethidine , Naproxen , and Ibuprofen	61 1	Yes	The primary outcome was the qualitative analysis of the analgesic efficacy of cannabinoids in the management of acute pain compared to placebo or active comparator. The secondary outcome was the qualitative	Yes	Yes, except for, publication bias and for-profit bias	No	Yes	Based on the available randomized controlled trial evidence, cannabinoids have no role in the management of acute pain.

							rof en			analysi s of the report ed advers e effects .					
Wa litt et. al [32]	Ca nn abinoids for fibro myalgia	20 16	Co chr ane Re vie w	Nabil one	Fibro myalgia	Cochra ne Library , MEDLI NE and EMBAS E	2 tri als com pa rin g the int er ve nti on wi th eit he r (1) pla ce bo or (1) a mi tri pt yline	72 (4 0)	Y es	Primar y outco mes: Partici pant-r eporte d pain relief of 50% or greate r. PGIC (Patien t Global Impres sion of Chang e) much or very much improv ed. Withdr awal due to advers e events	Ye s	Ye s, ex ce pt for pu bli ca tion bi as.	No	Y es	We foun d no convi ncing , unbi ased, high quali ty evid ence sugg estin g that nabil one is of value in treat ing peop le with fibro myal gia. The toler abilit y of nabil one

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

										<p>(tolerability).</p> <p>Serious adverse events (safety).</p> <p>Serious adverse events typically include any untoward medical occurrence or effect that at any dose results in death, is life-threatening, requires hospitalisation or prolongation of</p>							<p>was low in people with fibromyalgia.</p>
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	---

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

										existin g hospit alisatio n, results in persist ent or signific ant disabili ty or incapa city, is a conge nital anoma ly or birth defect, is an 'impor tant medica l event' that may jeopar dise the person , or may requir e an interve ntion to preven t one of the above						
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

										charac teristic s/cons equen ces.									
--	--	--	--	--	--	--	--	--	--	---	--	--	--	--	--	--	--	--	--

References

1. Copay AG, Subach BR, Glassman SD, Polly DW, and Schuler TC, *Understanding the minimum clinically important difference: a review of concepts and methods*. Spine J, 2007. **7**(5): p. 541-6.
2. Guyatt GH, Osoba D, Wu AW, Wyrwich KW, and Norman GR, *Methods to Explain the Clinical Significance of Health Status Measures*. Mayo Clinic Proceedings, 2002. **77**(4): p. 371-383.
3. Moncrieff J and Kirsch I, *Empirically derived criteria cast doubt on the clinical significance of antidepressant-placebo differences*. Contemp Clin Trials, 2015. **43**: p. 60-2.
4. Hagg O, Fritzell P, and Nordwall A, *The clinical importance of changes in outcome scores after treatment for chronic low back pain*. Eur Spine J, 2003. **12**(1): p. 12-20.
5. Musoro ZJ, Hamel J, Ediebah DE, Cocks K, King MT, Groenvold M, et al., *Establishing anchor-based minimally important differences (MID) with the EORTC quality-of-life measures: a meta-analysis protocol*. BMJ Open, 2018. **8**(1).
6. Stratford PW, Binkley JM, Riddle DL, and Guyatt GH, *Sensitivity to change of the Roland-Morris Back Pain Questionnaire: part 1*. Phys Ther, 1998. **78**(11): p. 1186-96.
7. Riddle DL, Stratford PW, and Binkley JM, *Sensitivity to change of the Roland-Morris Back Pain Questionnaire: part 2*. Phys Ther, 1998. **78**(11): p. 1197-207.
8. Van der Roer N, Ostelo RW, Bekkering GE, van Tulder MW, and de Vet HC, *Minimal clinically important change for pain intensity, functional status, and general health status in patients with nonspecific low back pain*. Spine (Phila Pa 1976), 2006. **31**(5): p. 578-82.
9. Crosby RD, Kolotkin RL, and Williams GR, *Defining clinically meaningful change in health-related quality of life*. J Clin Epidemiol, 2003. **56**(5): p. 395-407.
10. Cohen J, *CHAPTER 1 - The Concepts of Power Analysis*, in *Statistical Power Analysis for the Behavioral Sciences*, Cohen J, Editor. 1977, Academic Press. p. 1-17.
11. Fayers PM and Machin D, *Quality of life: assessment, analysis and interpretation*. John Wiley & Sons, 2000.
12. Guyatt GH, Bombardier C, and Tugwell PX, *Measuring disease-specific quality of life in clinical trials*. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne, 1986. **134**(8): p. 889-895.
13. Wyrwich KW, Tierney WM, and Wolinsky FD, *Further evidence supporting an SEM-based criterion for identifying meaningful intra-individual changes in health-related quality of life*. J Clin Epidemiol, 1999. **52**(9): p. 861-73.
14. Wolinsky FD, Wan GJ, and Tierney WM, *Changes in the SF-36 in 12 months in a clinical sample of disadvantaged older adults*. Med Care, 1998. **36**(11): p. 1589-98.
15. McHorney CA and Tarlov AR, *Individual-patient monitoring in clinical practice: are available health status surveys adequate?* Qual Life Res, 1995. **4**(4): p. 293-307.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

16. Lydick E and Epstein RS, *Interpretation of quality of life changes*. Qual Life Res, 1993. **2**(3): p. 221-6.
17. Beaton DE, Bombardier C, Katz JN, Wright JG, Wells G, Boers M, et al., *Looking for important change/differences in studies of responsiveness. OMERACT MCID Working Group. Outcome Measures in Rheumatology. Minimal Clinically Important Difference*. J Rheumatol, 2001. **28**(2): p. 400-5.
18. Dworkin RH, Turk DC, McDermott MP, Peirce-Sandner S, Burke LB, Cowan P, et al., *Interpreting the clinical importance of group differences in chronic pain clinical trials: IMMPACT recommendations*. Pain, 2009. **146**(3): p. 238-44.
19. Cella D, Bullinger M, Scott C, and Barofsky I, *Group vs individual approaches to understanding the clinical significance of differences or changes in quality of life*. Mayo Clin Proc, 2002. **77**(4): p. 384-92.
20. Guyatt GH, *Making sense of quality-of-life data*. Med Care, 2000. **38**(9 Suppl): p. li175-9.
21. Testa MA, *Interpretation of quality-of-life outcomes: issues that affect magnitude and meaning*. Med Care, 2000. **38**(9 Suppl): p. li166-74.
22. U.S. Department of Health Human Services FDA Center for Drug Evaluation Research, U.S. Department of Health Human Services FDA Center for Biologics Evaluation Research, U.S. Department of Health Human Services FDA Center for Devices Radiological Health, *Guidance for industry: patient-reported outcome measures: use in medical product development to support labeling claims: draft guidance*. 2006. **4**: p. 79.
23. Lynch M E and Campbell F, *Cannabinoids for treatment of chronic non-cancer pain; a systematic review of randomized trials*. Br J Clin Pharmacol, 2011. **72**(5): p. 735-44.
24. Boychuk D G, Goddard G, Mauro G, and Orellana M F, *The effectiveness of cannabinoids in the management of chronic nonmalignant neuropathic pain: a systematic review*. J Oral Facial Pain Headache, 2015. **29**(1): p. 7-14.
25. Meng H, Johnston B, Englesakis M, Moulin D E, and Bhatia A, *Selective Cannabinoids for Chronic Neuropathic Pain: A Systematic Review and Meta-analysis*. Anesth Analg, 2017. **125**(5): p. 1638-1652.
26. Mücke M, Phillips T, Radbruch L, Petzke F, and Häuser W, *Cannabis-based medicines for chronic neuropathic pain in adults*. Cochrane Database of Systematic Reviews, 2018(3).
27. Deshpande A, Mailis-Gagnon A, Zoheiry N, and Lakha S F, *Efficacy and adverse effects of medical marijuana for chronic noncancer pain: Systematic review of randomized controlled trials*. Can Fam Physician, 2015. **61**(8): p. e372-81.
28. Martin-Sanchez E, Furukawa T A, Taylor J, and Martin J L, *Systematic review and meta-analysis of cannabis treatment for chronic pain*. Pain Med, 2009. **10**(8): p. 1353-68.
29. Aviram J and Samuelly-Leichtag G, *Efficacy of Cannabis-Based Medicines for Pain Management: A Systematic Review and Meta-Analysis of Randomized Controlled Trials*. Pain Physician, 2017. **20**(6): p. E755-e796.
30. Campbell F A, Tramèr M R, Carroll D, Reynolds D J M, Moore R A, and McQuay H J, *Are cannabinoids an effective and safe treatment option in the management of pain? A qualitative systematic review*. Bmj, 2001. **323**(7303): p. 13.
31. Stevens A J and Higgins M D, *A systematic review of the analgesic efficacy of cannabinoid medications in the management of acute pain*. Acta Anaesthesiol Scand, 2017. **61**(3): p. 268-280.

- 1
2
3
4 32. Walitt B, Klose P, Fitzcharles M A, Phillips T, and Hauser W, *Cannabinoids for fibromyalgia*.
5 Cochrane Database Syst Rev, 2016. **7**: p. Cd011694.
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

First author	Year of publication	Design	Type of cannabinoid preparation	Types of participants	Information sources	No. of trials	No. of participants or events	Published protocol	Outcomes	Assessment of adverse events	Assessment of bias	Accounts for random error	Use of the GRADE	Conclusion
Lynch & Campbell	2011	Systematic Review	Physician nabiximols; smoked cannabis; oromucosal phatomatol extracts of arbutin, and mixed cannabinoid medicine, and synthetic cannabinoid id; dronabinol and a novel THC analog.	Neuropathic pain, fibromyalgia, chronic pain, rheumatoid arthritis, and mixed chronic pain.	PubMed, EMBASE, CINAH, EBSCO, Cochrane Library, ISI PsychInfo, The Cochrane Library, Web of Science, AD Inform (Proquest), Dissertation Abstracts (Proquest), Academic Search Premier (EBSCO), Clinical Trials.gov, TrialCentral.org, Individual pharmaceutical company trials sites for Eli Lilly and GlaxoSmithKline, Olaner (DCLC) and Google Scholar.	3	13	No	Primary outcome was pain in subjects with chronic non-cancer pain. The secondary outcomes were sleep, function, and quality of life.	Yes	Yes, except for reporting bias, publication bias and for-profit bias	No	Overall there is evidence that cannabinoids are safe and modestly effective in neuropathic pain with preliminary evidence of efficacy in fibromyalgia and rheumatoid arthritis. Did not pool data for meta-analysis but data was described qualitatively.	
Meng et al	2017	Selective Review and Meta-analysis	gabapentin, nabilone and nabiximols	Chronic pain	Medline, Embase, PROSPERO, Cochrane Library, ISI ClinicalTrials.gov, and Google Scholar, Pain societies (American Society of Anesthesiologists, European Society of Anaesthesiology, International Association for the Study of Pain, American Society of Regional Anesthesia and Pain Medicine, European Society of Regional Anesthesia and Pain Therapy, and World Federation of Pain) in the last 2 years were also searched.	11	1219	No	The primary outcome was intensity of pain recorded after a minimum of 2 weeks following initiation of selective cannabinoid or placebo/comparator administration, expressed on an NRS (0=no pain to 10=worst possible pain). Secondary outcomes were presence or absence of analgesia defined as reduction in pain scores (NRS/VAS) by ≥30% at 2 weeks or more after initiation of intervention, quality of life (QoL), physical function, psychological function, sleep, overall patient satisfaction, and the incidence of adverse effects of selective cannabinoids.	Yes	Yes	Bonferroni adjustment for multiple testing was not performed as per recommendations in the Cochrane Handbook.	Selective cannabinoids provide a small analgesic benefit in patients with chronic neuropathic pain.	
Martin-Sanchez et al	2009	Systematic Review and Meta-analysis	Physician nabiximols; dronabinol, nabilone, or benpropyriperidine (a synthetic tetrahydrocannabinol analog of THC)	Chronic pain of a pathological or traumatic origin	Medline, Embase, and The Cochrane Controlled Trials Register (CENTRAL)	18	7	No	The primary outcome was intensity of pain as scored by numerical rating scales. The secondary outcomes were CNS related events	Yes	Yes, except for reporting bias, detection bias and for-profit bias	No	Currently available evidence suggests that cannabis treatment is moderately efficacious for treatment of chronic pain, but beneficial effects may be partially (or completely) offset by potentially serious harms.	
Boychuk et al	2015	Systematic Review	Physician nabiximols; cannabis, cannabis-based medicinal extracts (CBME) in the form of oromucosal sprays (nabilonol), vaporized cannabis, and synthetic cannabinoid id; dronabinol, nabilone, and CT-3	Chronic pain	PubMed, Embase, Web of Science, and all evidence-based medicine reviews and databases (Cochrane Database of Systematic Reviews, ASP Journal Club, Database of Abstracts of Reviews of Effects [DARE], and Cochrane Controlled Trials Register [CCTR])	13	771	No	Outcomes considered were reduction in pain intensity and adverse events.	Yes	Yes, except for reporting bias, publication bias and for-profit bias	No	Cannabis-based medicinal extracts used in different populations of chronic non-malignant neuropathic pain patients may provide effective analgesia in conditions that are refractory to other treatments.	
Milick et al	2018	Cochrane Review	Physician nabiximols; oromucosal spray containing THC or THC/ CBD mix, smoked cannabis containing THC, THC and CBD, an extract of cannabis sativa L, and synthetic cannabinoid id; dronabinol, nabilone, and CT-3	Chronic pain	Cochrane Library, MEDLINE and EMBASE.	16	1750	Yes	Primary outcomes: Participant-reported pain relief of 50% or greater. We preferred composite neurophysiologic pain scores over single-scale generic pain scores if both measures were used by studies; RIG (Patient Global Impression of Change) much or very much improved. Withdrawals due to adverse events (tolerability); Serious adverse events (safety). Serious adverse events typically include any untoward medical occurrence or effect that at any dose results in	Yes	Yes	No	Yes	The potential benefits of cannabis-based medicines (herbal cannabis, plant-derived or synthetic THC, THCCBD oromucosal spray) in chronic neuropathic pain they might be outweighed by their potential harms.
Avram et al	2017	Meta-Analysis	Physician nabiximols; Sativex (a non-nabilone, nabilone, and benpropyriperidine) and synthetic cannabinoid id; dronabinol, nabilone, and CT-3	Chronic non-malignant neuropathic pain	PubMed and Medical Subject Heading (MeSH) terms	43	2437	No	The outcome measure that was chosen was the variable "pain intensity," as scored by the numerical rating scale (NRS-11), numerical 11-point box (0-10), visual analog scale (VAS), and the VAS section of the questionnaire short form McGill Pain Questionnaire	Yes	Yes, except for reporting bias, publication bias and for-profit bias	No	No	The current systematic review suggests that cannabis-based medicines might be effective for chronic pain treatment, based on limited evidence, primarily for neuropathic pain patients.
Campbell et al	2001	Systematic Review	Oral THC, synthetic non-nabilone, nabilone, and benpropyriperidine (BPP), and tetrahydrocannabinol	Acute non-malignant cancer pain	MEDLINE, EMBASE, and Cochrane Database, and Cochrane Library	9	222	No	Outcome measures for pain intensity, pain relief, the use of supplementary analgesics, patients' preferences; and adverse effects.	Yes	Yes, except for reporting bias, publication bias and for-profit bias	No	No	Cannabinoids are no more effective than codeine in controlling pain and have depressant effects on the central nervous system that limit their use. The widespread introduction into clinical practice for pain management is therefore undesirable. In acute postoperative pain they should not be used.
Desbande et al	2015	Systematic Review	Cigarettes or vaporizer containing delta-9-THC	Neuropathic pain	MEDLINE, EMBASE, and the International Pharmaceutical Abstracts	6	226	No	For outcomes, pain scores were extracted using the visual analogue scale (VAS) or an alternative numerical pain rating tool. If pain scores were not reported, surrogate measures of effectiveness were included (sleep, function, and quality of life). Frequency of various and most commonly reported adverse effects was collected.	Yes	Yes, except for reporting bias, publication bias and for-profit bias	No	No	There is evidence for the use of low-dose medical marijuana in refractory neuropathic pain in conjunction with traditional analgesics. However, trials were limited by short duration, variability in dosing and strength of delta-9-tetrahydrocannabinol, and lack of functional outcomes. Although well tolerated in the short term, the long-term effects of psychoactive and neurocognitive effects of medical marijuana remain unknown.
Stevens et al	2017	Systematic Review	Leonatrol, nabiximols, dronabinol, and -9-THC	Acute postoperative pain	MEDLINE, EMBASE, Cochrane Library, and the World Health Organization International Clinical Trials Registry Platform	7	611	Yes	The primary outcome was the qualitative analysis of the analgesic efficacy of cannabinoids in the management of acute pain compared to placebo or active comparator. The secondary outcome was the qualitative analysis of the reported adverse effects	Yes	Yes, except for reporting bias and for-profit bias	No	Yes	Based on the available randomized controlled trial evidence, cannabinoids have no role in the management of acute pain.
Walsh et al	2016	Cochrane Review	Nabilone	Fibromyalgia	Cochrane Library, MEDLINE and EMBASE	2	140	Yes	Primary outcomes: Participant-reported pain relief of 50% or greater; RIG (Patient Global Impression of Change) much or very much improved. Withdrawal due to adverse events (tolerability); Serious adverse events (safety). Serious adverse events typically include any untoward medical occurrence or effect that at any dose results in death, is life-threatening, requires hospitalization or prolongation of existing hospitalization, results in persistent or significant disability or	Yes	Yes, except for reporting bias.	No	Yes	We found no convincing, unbiased, high quality evidence suggesting that nabilone is of value in treating people with fibromyalgia. The tolerability of nabilone was low in people with fibromyalgia.

PRISMA-P (Preferred Reporting Items for Systematic review and Meta-Analysis Protocols) 2015 checklist: recommended items to address in a systematic review protocol*

Section and topic	Item No	Checklist item	(Page No.#)
ADMINISTRATIVE INFORMATION			
Title:			
Identification	1a	Identify the report as a protocol of a systematic review	1
Update	1b	If the protocol is for an update of a previous systematic review, identify as such	
Registration	2	If registered, provide the name of the registry (such as PROSPERO) and registration number	
Authors:			
Contact	3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author	1
Contributions	3b	Describe contributions of protocol authors and identify the guarantor of the review	25-26
Amendments	4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments	
Support:			
Sources	5a	Indicate sources of financial or other support for the review	25
Sponsor	5b	Provide name for the review funder and/or sponsor	
Role of sponsor or funder	5c	Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol	
INTRODUCTION			
Rationale	6	Describe the rationale for the review in the context of what is already known	3-9
Objectives	7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)	9
METHODS			
Eligibility criteria	8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review	10-12
Information sources	9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage	12-13
Search strategy	10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated	

Study records:			
Data management	11a	Describe the mechanism(s) that will be used to manage records and data throughout the review	13-14
Selection process	11b	State the process that will be used for selecting studies (such as two independent reviewers) through each phase of the review (that is, screening, eligibility and inclusion in meta-analysis)	13
Data collection process	11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators	13-14
Data items	12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications	14
Outcomes and prioritization	13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale	11-12
Risk of bias in individual studies	14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis	15-17
Data synthesis	15a	Describe criteria under which study data will be quantitatively synthesised	16
	15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I ² , Kendall's τ)	19-21
	15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)	22-23
	15d	If quantitative synthesis is not appropriate, describe the type of summary planned	21
Meta-bias(es)	16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)	17
Confidence in cumulative evidence	17	Describe how the strength of the body of evidence will be assessed (such as GRADE)	21

*** It is strongly recommended that this checklist be read in conjunction with the PRISMA-P Explanation and Elaboration (cite when available) for important clarification on the items. Amendments to a review protocol should be tracked and dated. The copyright for PRISMA-P (including checklist) is held by the PRISMA-P Group and is distributed under a Creative Commons Attribution Licence 4.0.**

From: Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart L, PRISMA-P Group. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and explanation. BMJ. 2015 Jan 2;349(jan02 1):g7647.

**Search strategies for
'Cannabinoids versus placebo for pain'
(J Barakji)**

Preliminary searches performed 1 July 2019

Total number of records identified	4106 records
Number of duplicates removed	1079 records
Number of records in final list	3027 records

The Cochrane Central Register of Controlled Trials (CENTRAL) in the Cochrane Library (2019, Issue 6) (961 hits)

- #1 MeSH descriptor: [Cannabis] explode all trees
- #2 MeSH descriptor: [Cannabinoids] explode all trees
- #3 (cannabi* or mari*uana or nabixmol* or dronabinol* or marinol* or nabilon* or cesamet* or hash* or hemp* or levonantradol* or anandamid*)
- #4 #1 or #2 or #3
- #5 MeSH descriptor: [Pain] explode all trees
- #6 (pain* or ache* or migraine*)
- #7 #5 or #6
- #8 #4 and #7

MEDLINE Ovid (1946 to July 2019) (465 hits)

- 1. exp Cannabis/
- 2. exp Cannabinoids/
- 3. (cannabi* or mari*uana or nabixmol* or dronabinol* or marinol* or nabilon* or cesamet* or hash* or hemp* or levonantradol* or anandamid* or 2-AG).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 4. 1 or 2 or 3
- 5. exp Pain/
- 6. (pain* or ache* or migraine*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 7. 5 or 6
- 8. 4 and 7
- 9. (random* or blind* or placebo* or meta-analys*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 10. 8 and 9

Embase Ovid (1974 to July 2019) (1829 hits)

- 1. exp cannabis/
- 2. exp cannabinoid/
- 3. (cannabi* or mari*uana or nabixmol* or dronabinol* or marinol* or nabilon* or cesamet* or hash* or hemp* or levonantradol* or anandamid* or 2-AG).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word, candidate term word]
- 4. 1 or 2 or 3
- 5. exp pain/
- 6. (pain* or ache* or migraine*).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word, candidate term word]
- 7. 5 or 6
- 8. 4 and 7
- 9. (random* or blind* or placebo* or meta-analys*).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word, candidate term word]
- 10. 8 and 9

LILACS (Bireme; 1982 to July 2019) (51 hits)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

(cannabi\$ or mari\$uana or nabixmol\$ or dronabinol\$ or marinol\$ or nabilon\$ or cesamet\$ or hash\$ or hemp\$ or levonantradol\$ or anandamid\$ or 2-AG) [Words] and (pain\$ or ache\$ or migraine\$) [Words]

Science Citation Index Expanded (1900 to July 2019) and Conference Proceedings Citation Index – Science (1990 to July 2019) (Web of Science) (623 hits)

#5 #4 AND #3

#4 TS=(random* or blind* or placebo* or meta-analys*)

#3 #2 AND #1

#2 TS=(pain* or ache* or migraine*)

#1 TS=(cannabi* or mari*uana or nabixmol* or dronabinol* or marinol* or nabilon* or cesamet* or hash* or hemp* or levonantradol* or anandamid* or 2-AG)

Biosis (1969 to July 2019; Web of Science) (177 hits)

#5 #4 AND #3

#4 TS=(random* or blind* or placebo* or meta-analys*)

#3 #2 AND #1

#2 TS=(pain* or ache* or migraine*)

#1 TS=(cannabi* or mari*uana or nabixmol* or dronabinol* or marinol* or nabilon* or cesamet* or hash* or hemp* or levonantradol* or anandamid* or 2-AG)

BMJ Open

Cannabinoids versus placebo or no intervention for pain. Protocol for a systematic review with meta-analysis and Trial Sequential Analysis

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2019-031574.R2
Article Type:	Protocol
Date Submitted by the Author:	07-Sep-2019
Complete List of Authors:	Barakji, Jehad; The Copenhagen Trial Unit, Rigshospitalet Dept. 7812 Korang, Steven Kwasi; Rigshospitalet, Copenhagen Trial Unit; Holbaek Sygehus, Pediatric Dept. Feinberg, Joshua; Copenhagen Univ Hosp Maagard, Mathias; The Copenhagen Trial Unit, Rigshospitalet Dept. 7812 Gluud, Christian; Copenhagen Trial Unit (CTU), Center for Clinical Intervention Research Mathiesen, Ole; University of Copenhagen Jakobsen, Janus; Copenhagen Trial Unit, Centre for Clinical Intervention Research, Department 7812, Rigshospitalet, Copenhagen University Hospital
Primary Subject Heading:	Pharmacology and therapeutics
Secondary Subject Heading:	Anaesthesia, Evidence based practice, Complementary medicine
Keywords:	PAIN MANAGEMENT, Herbal medicine < THERAPEUTICS, Adverse events < THERAPEUTICS, CLINICAL PHARMACOLOGY, Health & safety < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

SCHOLARONE™
Manuscripts

Cannabinoids versus placebo or no intervention for pain: Protocol for a systematic review with meta-analysis and Trial Sequential Analysis

Jehad A. Barakji¹, Steven Kwasi Korang¹, Joshua Rose-Hansen Feinberg¹, Mathias Maagaard¹, Christian Gluud¹, Ole Mathiesen^{2,3}, Janus C. Jakobsen^{1,4,5}

¹ The Copenhagen Trial Unit, Centre for Clinical Intervention Research, Department 7812, Rigshospitalet, Copenhagen University Hospital, Blegdamsvej 9, DK 2100 Copenhagen, Denmark

² Centre for Anaesthesiological Research, Department of Anaesthesiology, Zealand University Hospital, Køge, Denmark

³ Department of Clinical Medicine, Faculty of Health and Medical Sciences, Copenhagen University, Copenhagen, Denmark

⁴ Department of Cardiology, Holbæk Hospital, Holbæk, Denmark

⁵ Department of Regional Health Research, The Faculty of Health Sciences, University of Southern Denmark, Odense, Denmark

Corresponding author

Jehad A. Barakji

Tlf.: +45 21 52 07 80

Email: jehad.barakji@ctu.dk

Abstract

Introduction Pain is a frequent clinical symptom with significant impact on the patient's well-being. Therefore, adequate pain management is of utmost importance. While cannabinoids have become a more popular alternative to traditional types of pain medication among patients, the quality of evidence supporting the use of cannabinoids has been questioned. The beneficial and harmful effects of cannabinoids in patients with pain is unknown. Accordingly, we aim to assess the efficacy, tolerability, and safety of cannabinoids (herbal, plant-derived extracts and synthetic) compared with placebo or no intervention for any type of pain.

Methods and analyses We will conduct a systematic review of randomised clinical trials with meta-analysis and Trial Sequential Analysis to assess the beneficial and harmful effects of cannabinoids in any dose, formulation, and duration. We will accept placebo or no treatment as control interventions. We will include participants with any type of pain (acute and chronic pain, cancer-related pain, headache, neuropathic pain, or any other types of pain). We will systematically search The Cochrane Library, MEDLINE, EMBASE, Science Citation Index, and BIOSIS for relevant literature. We will follow the recommendations by Cochrane and the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) statement. The risk of systematic errors (bias) and random errors (play of chance) will be assessed. The overall certainty of evidence will be evaluated using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach.

Ethics and dissemination Ethical approval is not a requirement since no primary data will be collected. The findings of this systematic review will be submitted for peer-reviewed publication and disseminated in national and international conferences.

Discussion Although cannabinoids are now being used to manage different pain conditions, the evidence for the clinical effects are unclear. The present review will systematically assess the current evidence for the benefits and harms of cannabinoids to inform practice and future research.

Strengths and limitations of this study

- Our methodology is based on the Cochrane Handbook for Systematic Reviews of Interventions, the PRISMA guideline, and a systematic eight step procedure for valid assessments of statistical and clinical significance
- We systemically plan to assess risks of random errors ('play of chance') and systematic errors ('bias')
- We have systematically predefined minimal important differences for all outcomes
- The certainty of the evidence will be assessed using the GRADE approach

Pain is the most commonly reported symptom in the general population and in a medical setting [1-3]. Persistent pain is a major international health problem [4], prompting the World Health Organization (WHO) to endorse a global campaign against pain [5]. Pain is the leading reason for use of alternative medicines (i.e. acupuncture, etc.) [6]. Pain has been associated with a low degree of health-related quality of life and may lead to psychosocial distress, insomnia, and depressive symptoms [7-15]. Pain is also among the most common reasons for temporary or permanent work disability [16]. Pain is always subjective and may be defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage" [17].

Cannabinoids have emerged as a potential alternative to other painkillers for the treatment of intractable pain [18]. Before the healthcare systems globally can endorse the applicability of cannabinoids for pain, the potential short-time and long-term benefits and harms with use of cannabinoids must be investigated. This is of utmost importance because patients who consume cannabinoids to alleviate their chronic pain will most likely need to consume cannabinoids for the rest of their lifespan.

Description of pain

Pain may be caused by or be related to different clinical disorders and classified according to several different characteristics [19-22]. Below, we describe shortly some of these classifications.

Acute and chronic pain

Pain may be classified as 'acute pain' or 'chronic pain'.

- Acute pain usually has a well-defined onset and most often a readily identifiable cause (i.e. surgery, etc.). Acute pain is expected to run its course in a short time frame and management typically focuses on symptomatic relief until this happens [23]. Acute pain is a common symptom, affecting between 37% to 84% of hospitalised patients [24].
- Chronic pain is often characterised by an ill-defined onset and a prolonged, fluctuating course [23]. Chronic pain often persists past normal healing time and hence lacks the acute warning function of physiological nociception [25]. Pain is usually regarded as chronic when it lasts or recurs for more than three to six months [17, 26]. Chronic pain is a frequent condition, affecting an estimated 20% of people worldwide [27-30] and accounting for 15% to 20% of physician visits according to European observational studies [31, 32].

Cancer-related pain

Pain may also be classified based on whether it is cancer-related or non-cancer-related. Cancer-related pain is pain caused by the cancer itself (primary tumour and metastases) or its treatment (i.e. radiation therapy, etc.) [23, 33].

Postoperative pain

Postoperative pain includes pain from inflammation caused by tissue trauma (i.e. surgical incision, dissection, burns, etc.) or direct nerve injury (e.g. nerve transection, stretching, or compression) [34]. Inflammation results in activation and sensitisation of nociceptive pain pathways, resulting in primary and secondary hyperalgesia and central sensitisation, which is characterized by clinically increased pain, allodynia, and increased sensitivity from surrounding non-damaged anatomical areas [35].

Other types of pain

Pain in one or more anatomic regions where the aetiology is unknown is defined as idiopathic pain [36]. Examples of idiopathic pain are chronic widespread pain, fibromyalgia, irritable bowel syndrome, and back pain that is not diagnosed as musculoskeletal or as neuropathic pain [33].

Pain types defined according to specific mechanism causing the pain

Somatic nociceptive pain

Nociceptive pain is the most frequent type of pain. It results from activity in neural pathways caused by actual tissue damage or potentially tissue-damaging stimuli [31, 37] originating from somatic nociceptors from skin, bone, joints, or muscles [38].

Visceral nociceptive pain

The visceral nociceptive pain is pain resulting from viscera in the thoracic, pelvis, or abdominal organs [39-41]. Visceral pain is diffuse, less distinctive, and difficult to localise [41] and is often characterised by referred visceral pain [42].

Neuropathic pain

The 2011 International Association for the Study of Pain definition of neuropathic pain is "pain caused by a lesion or disease of the somatosensory system" [43]. Neuropathic pain may be classified as central neuropathic pain or peripheral neuropathic pain. Central neuropathic pain conditions are mainly attributed to multiple sclerosis and post-stroke pain [44], while peripheral neuropathic pain is largely due to post-herpetic neuralgia and diabetic neuropathy [45].

Description of the intervention

Cannabis (also called marijuana) is the most common illegally used psychoactive substance worldwide [46]. Cannabinoids refer to a heteromorphic group of molecules that demonstrate activity upon cannabinoid receptors [47]. Cannabinoids may be classified into three groups: 1) endocannabinoids, 2) phytocannabinoids, and 3) synthetic cannabinoids [47].

Endocannabinoids

Endocannabinoids are characterised by being the endogenously generated cannabinoids [48]. The primary types of endocannabinoids are the lipid endocannabinoid arachidonoyl ethanolamide (named anandamide) [49] and the endocannabinoid 2-arachidonoylglycerol (2-AG) [50, 51].

Phytocannabinoids

1
2
3
4 Phytocannabinoids are cannabinoids found in the cannabis plant [52]. The best characterised phytocannabinoids
5 are the psychotropic tetrahydrocannabinol (THC) and the primarily anti-inflammatory cannabidiol (CBD) [53].
6 Nabiximols (marketed as Sativex®) is a sublingually administered oromucosal spray based on a mixture of
7 tetrahydrocannabinol and cannabidiol [54].
8
9
10

11 12 13 *Synthetic cannabinoids*

14 Synthetic cannabinoids are analogues of the cannabinoids found in natural marijuana that are chemically
15 synthesised. The most commonly prescribed cannabinoid-based medicines are the synthetic cannabinoids
16 dronabinol (marketed as Marinol®) and nabilone (marketed as Cesamet®) [54].
17
18
19
20

21 **Endocannabinoid system**

22 All cannabinoids act on cannabinoid receptors. These cannabinoid receptors are located throughout the body
23 but are mostly located in the brain [55]. The cannabinoid receptors and endocannabinoids (see paragraph above)
24 are together named the endocannabinoid system [56].
25
26
27
28
29

30 *Cannabinoid receptors*

31 There are two types of cannabinoid receptors, type I and type II [57]. Cannabinoid receptor type I are most
32 abundant in the central nervous system, especially in areas promoting nociception, short-term memory, and in
33 the basal ganglia, but are also found in the peripheral nerves, uterus, testis, and bones [57].
34 Tetrahydrocannabinol activates cannabinoid type I receptors in the dopaminergic mesolimbic brain circuit,
35 resulting in enhanced release of dopamine [58]. Such activation of the so-called 'brain reward system' is
36 hypothesised to mediate the positive reinforcing and rewarding effects of almost all drugs of abuse [58].
37
38
39
40
41
42
43

44 In contrast, cannabinoid receptor type II, is mostly found in the periphery, often in conjunction with immune
45 cells, but may appear in the central nervous system particularly under conditions of inflammation in association
46 with microcytes [57]. The physiological responses that result from cannabinoid receptor activation are euphoria,
47 psychosis, impaired memory and cognition, reduced locomotor function, increased appetite, as well as anti-
48 emetic, pain-relieving, anti-spasticity, and sleep-promoting effects [59].
49
50
51
52
53

54 **Administration of cannabinoids**

55
56
57
58
59
60

1
2
3
4 Cannabis is most commonly consumed via smoked, inhaled vapor, or oral routes of administration [60].
5
6 Vaporising cannabis ('vaping') heats the material without burning which theoretically minimises potential
7
8 carcinogens compared to smoking and may produce less respiratory irritation [61, 62]. Sublingual administration
9
10 is used for some medical cannabis preparations (i.e. nabiximols, etc.).
11

12 13 **Why it is important to do this review** 14

15 We identified ten previous reviews with meta-analyses assessing the effects of cannabinoids on different types
16
17 of pain [63-72]. Bearing in mind that some of the previous reviews investigated more than one type of pain, eight
18
19 reviews assessed the effects of different cannabinoids on neuropathic pain [63-69, 72]; four reviews assessed
20
21 the effects of different cannabinoids on nociceptive pain (i.e. rheumatoid arthritis, etc.) [63, 64, 67, 68]; three
22
23 reviews assessed the effects of different cannabinoids on cancer-related pain [63, 67, 68]; four reviews assessed
24
25 the effects of different cannabinoids on fibromyalgia-related pain [63, 64, 67, 71]; and three reviews assessed
26
27 the effects of different cannabinoids on postoperative pain [63, 68, 70]. All the previous reviews included
28
29 randomised clinical trials, but only two of the ten reviews systematically assessed the risk of bias in the trials [65,
30
31 72], and none of the previous reviews took into account the risks of random errors [63-72]. Only two out of the
32
33 ten reviews used predefined Cochrane methodology [71, 72] and only four reviews used the GRADE approach
34
35 [65, 70-72].
36

37 Most of the reviews concluded that the assessed cannabinoids were effective against pain [63-67, 69, 72]. In
38
39 **Table 1 (Additional file 1)**, we have summarised the results and conclusions of the previous reviews. Five of the
40
41 reviews reported serious adverse events (i.e. agitation, impaired memory, abuse, dissociation, acute psychosis,
42
43 death, etc.) [63, 65-67, 72]. The reviews also showed that the most commonly reported adverse events were
44
45 sedation, dizziness, dry mouth, increased appetite, somnolence, confusion, nausea, and disturbances in
46
47 concentration [63-66, 68, 69, 71, 72].
48

49 A correlation between psychiatric disorders (schizophrenia, psychosis, etc.) and increased cannabinoid
50
51 consumption has previously been hypothesised [73-79]. Di Forti et al. recently conducted a study indicating that
52
53 daily cannabis use was associated with increased odds of psychotic disorders compared with never users
54
55 (adjusted odds ratio [OR] 3.2, 95% confidence interval (CI) 2.2 to 4.1), increasing to nearly five-times increased
56
57 odds for daily use of high-potency (THC \geq 10%) types of cannabis (adjusted OR 4.8, 95% CI 2.5 to 6.3) [80].
58
59

1
2
3
4
5
6 Compared to previous systematic reviews on cannabinoids, we want to assess the effects of all types of
7 cannabinoid versus placebo or no intervention for all different forms of pain. Depending on the data results
8 provided by the included trials this could increase the power and precision of the overall analysis and make it
9 possible to conduct subgroup analyses and sensitivity analyses that may identify pain areas where cannabinoid
10 could be especially beneficial and cause the least harms. In addition, we will implement a minimal clinically
11 important threshold regarding analgesic efficacy based on previously conducted methodological studies which
12 ensures that analgesic efficacy is of a firm significance before acceptance. Finally, by instigating all types of
13 cannabinoids treated for any type of pain this systematic review will aid trialist in optimising the design of future
14 randomised clinical trials by illuminating any research pitfalls of all previously conducted randomised clinical
15 trials on this topic.
16
17
18
19
20
21
22
23
24

25 **Objective**

26
27 The objective of our systematic review is to assess the analgesic efficacy and adverse events encumbered with
28 the use of cannabinoids compared with placebo or no intervention in participants with any type of pain (acute
29 and chronic pain, cancer-related pain, headache, neuropathic pain, or any other types of pain). A secondary
30 objective of this systematic review is to assess the impact of cannabinoid use on the quality of sleep and quality
31 of life which is especially decreased in participants with chronic pain.
32
33
34
35
36

37 **Methods**

38
39 This systematic review protocol has been developed based on Preferred Reporting Items for Systematic
40 Reviews and Meta-Analysis Protocols (PRISMA-P) guidelines for reporting systematic reviews evaluating
41 healthcare interventions [81, 82]. A PRISMA-P checklist file is attached (**Additional file 2**).
42
43
44
45

46 **Criteria for considering studies for this review**

47 *Type of studies*

48
49 Randomised clinical trials irrespective of trial design, setting, publication status, publication year, and language.
50 If we identify quasi-randomised studies and observational studies during our searches for randomised clinical
51 trials, we will only include their reporting on harms in a narrative way. By not systematically searching for all
52
53
54
55
56
57
58
59
60

1
2
3
4 observational studies on harm, we run the risk of putting more focus on benefit than harm. We are aware that
5 this is a limitation of our review.
6
7

8 9 *Types of participants*

10 Participants with any type of pain, i.e. acute and chronic pain, cancer-related pain, headache, neuropathic pain,
11 or any other types of pain (as defined by the trialists). Participants will be included irrespective of age, sex, and
12 comorbidities.
13
14
15

16 17 **Types of interventions**

18 19 *Experimental intervention*

20 Any type of cannabinoids such as: herbal cannabis (hashish, marihuana), plant-based extracts (i.e. nabiximols,
21 etc.), or synthetic cannabinoids (i.e. cannabidiol, dronabinol, levonantradol, nabilone, etc.). We will accept
22 cannabinoids at any dose, by any route, administered for the relief of pain.
23
24
25
26

27 28 *Control intervention*

29 Placebo or no intervention.
30
31

32 33 *Co-interventions*

34 We will accept any co-intervention but only if this co-intervention is planned to be delivered similarly in both
35 intervention groups. If this plan is not followed, then these trials will be assessed as a subgroup due to
36 potential confounding.
37
38
39
40

41 42 **Types of outcome measures**

43 44 *Primary outcomes*

- 45 • All-cause mortality
- 46 • Pain assessment on visual analogue scale (VAS) or numerical rating scale (NRS)
- 47 • Proportion of participants with a serious adverse event defined as any untoward medical occurrence that
48 resulted in death; was life threatening; was persistent; or led to significant disability, nephrotoxicity,
49 superinfection, need for respiratory support, need for circulatory support, or prolonged hospitalisation
50 [83]. As we expect the trialists' reporting of serious adverse events to be heterogeneous and not strictly
51
52
53
54
55
56
57
58
59
60

1
2
3
4 according to the ICH-GCP recommendations, we will include the event as a serious adverse if the trialists
5 either: 1) use the term 'serious adverse event' but not refer to ICH-GCP, or 2) report the proportion of
6 participants with an event we consider fulfils the ICH-GCP definition. If several of such events are reported
7 then we will choose the highest proportion reported in each trial.
8
9

- 10 • Quality of life measured on any valid continuous scale
11
12
13

14 *Secondary outcomes*

- 15 • Dependence (as defined by trialists)
- 16 • Psychosis (as defined by trialists)
- 17 • Proportion of participants with one or more adverse event not considered to be serious
- 18 • Quality of sleep measured on any valid continuous scale
19
20
21
22
23

24 *Exploratory outcomes*

- 25 • Each serious adverse event separately
- 26 • Each adverse event not considered serious separately
- 27 • Twenty-four-hour morphine consumption (as defined by trialists)
- 28 • Physical function (as defined by trialists)
- 29 • Depressive symptoms (e.g. Hamilton Depression Rating Scale)
30
31
32
33
34
35

36 We will for all outcomes use the trial results reported at maximal follow-up except for acute pain. For acute
37 pain, we will use the trials' results reported at the time point closest to 24 hours after the intervention is given.
38
39
40

41 **Patient and public involvement**

42 We have had email correspondence with several relevant patient associations in Denmark to select the most
43 patient-relevant outcomes. The patient associations we have been in contact with included: The Danish
44 Diabetes Association, Steno Diabetes Centre Copenhagen, The Danish Rheumatism Association, The Danish
45 Multiple Sclerosis Society, and Danish Cancer Society. Initially we presented our potential outcomes for the
46 patient associations and requested for their opinion. We had not included quality of sleep as an outcome,
47 however, this was mentioned by almost all patient associations and it was included as a crucial secondary
48 outcome. All-cause mortality was questioned by one of the patient associations, however, we want to keep this
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3
4 outcome because of potential increased risk of both acute coronary syndrome and chronic cardiovascular
5 disease associated with cannabis use [84].
6
7
8
9
10

11 **Search methods for identification of studies**

12 *Electronic searches*

13
14 We will search the Cochrane Central Register of Controlled Trials (CENTRAL), Medical Literature Analysis and
15 Retrieval System Online (MEDLINE), Excerpta Medica database (EMBASE), Latin American and Caribbean Health
16 Sciences Literature (LILACS), Science Citation Index Expanded on Web of Science, and BIOSIS in order to identify
17 relevant trials. The preliminary search strategy for CENTRAL, MEDLINE (Ovid), Embase (Ovid), LILACS, Web of
18 Science and BIOSIS is given in **Additional file 3**.
19
20
21
22

23
24 We will search all databases from their inception to the 1st of October 2019.
25
26
27

28 *Searching other resources*

29
30 The reference lists of relevant publications will be checked for any unidentified randomised trials. We will
31 contact authors of included studies, and major pharmaceutical companies, by email asking for unpublished
32 randomised trials. Further, we will search for ongoing trials on:
33

- 34 • ClinicalTrials.gov (www.clinicaltrials.gov)
- 35 • Google Scholar (<https://scholar.google.dk/>)
- 36 • The Turning Research into Practice (TRIP) Database (<https://www.tripdatabase.com/>)
- 37 • European Medicines Agency (EMA) (<http://www.ema.europa.eu/ema/>)
- 38 • United States Food and Drug Administration (FDA) (www.fda.gov)
- 39 • China Food and Drug Administration (CFDA) (<http://eng.sfda.gov.cn/WS03/CL0755/>)
- 40 • Medicines and Healthcare products Regulatory Agency
41 ([https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-](https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency)
42 [agency](https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency))
- 43 • The World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP) search
44 portal (<http://apps.who.int/trialsearch/>)
45
46
47
48
49
50
51
52
53

54 We will also consider relevant for the review unpublished and grey literature trials, if we identify such trials.
55
56
57
58
59
60

Data collection and analysis

We will perform the review following the recommendations of Cochrane [85]. The analyses will be performed using Review Manager 5 [86] and Trial Sequential Analysis [87]. In case of Review Manager statistical software is not being sufficient, we will use STATA 15 [88].

Selection of studies

Two authors (JB, SKK) will independently screen titles and abstracts. We will retrieve all relevant full-text study reports/publications, and four review authors (JB, SKK, JRF, MM) will independently screen the full texts and identify and record reasons for exclusion of the ineligible studies. We will resolve any disagreement through discussion or, if required, we will consult a fifth author (JCJ). Trial selection will be displayed in an adapted flow diagram as per the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement [89].

Data extraction and management

Four authors (JB, SKK, JRF, MM) will in pairs extract data independently from included trials. Disagreements will be resolved by discussion with a fifth author (JCJ). We will assess duplicate publications and companion papers of a trial together to evaluate all available data simultaneously (maximise data extraction, correct bias assessment). We will contact the trial authors by email to specify any additional data, which may not have been reported sufficiently or at all in the publication.

Trial characteristics

Bias risk components (as defined below); trial design (parallel, factorial, or crossover); number of intervention arms; length of follow-up; estimation of sample size; inclusion and exclusion criteria.

Participant characteristics and diagnosis

Number of randomised participants; number of analysed participants; number of participants lost to follow-up/withdrawals/crossover; compliance with medication; age range (mean or median) and sex ratio; type of pain (acute and chronic pain, cancer-related pain, headache, neuropathic pain or any other types of pain); baseline pain score; drug and dosing regimen; study design (placebo or active control); study duration and follow-up;

1
2
3
4 analgesic outcome measures and results; adverse events (participants experiencing any adverse event, or
5 serious adverse event).
6
7

8 9 *Co-intervention characteristics*

10 Type of co-intervention; dose of co-intervention; duration of co-intervention; and mode of administration.
11
12
13

14 *Outcomes*

15 All outcomes listed above will be extracted from each randomised clinical trial, and we will identify if outcomes
16 are incomplete or selectively reported according to the criteria described later in 'incomplete outcome data'
17 bias domain and 'selective outcome reporting' bias domain.
18
19
20
21

22 *Notes*

23 Funding of the trial and notable conflicts of interest of trial authors will be extracted, if available.
24 We will note in the 'Characteristics of included studies' table if outcome data were not reported in a usable
25 way. Four review authors (JB, SKK, JRF, MM) will independently transfer data into the Review Manager file [86].
26 Disagreements will be resolved through discussion or, if required, we will consult with a fifth author (JCJ).
27
28
29
30
31

32 **Assessment of risk of bias in included studies**

33 We will use the instructions given in the Cochrane Handbook for Systematic Reviews of Interventions [85] in
34 our evaluation of the methodology and hence the risk of bias of the included trials. We will evaluate the
35 methodology in respect of:
36
37
38

- 39 • Random sequence generation
 - 40 • Allocation concealment
 - 41 • Blinding of participants and treatment providers
 - 42 • Blinding of outcome assessment
 - 43 • Incomplete outcome data
 - 44 • Selective outcome reporting
 - 45 • For-profit bias
 - 46 • Overall risk of bias
- 47
48
49
50
51
52

53 These components enable classification of randomised trials as being at low risk of bias and at high risk of bias.
54 The latter trials tend to overestimate positive intervention effects and underestimate negative effects [90-96].
55
56
57
58
59
60

1
2
3
4 We will classify the trials according to the following criteria.
5
6

7
8 *Random sequence generation*

- 9
10
11
12
13
14
15
16
17
18
19
20
21
22
- Low risk: If sequence generation was achieved using computer random number generator or a random number table. Drawing lots, tossing a coin, shuffling cards, and throwing dice were also considered adequate if performed by an independent adjudicator.
 - Unclear risk: If the method of randomisation was not specified, but the trial was still presented as being randomised.
 - High risk: If the method of sequence generation was inadequate e.g. alternate medical record numbers or other non-random sequence generation.

23
24
25
26
27
28
29
30
31
32
33
34
35

36 *Allocation concealment*

- 37
38
39
40
41
42
43
44
45
- Low risk: If the allocation of patients was performed by a central independent unit, on-site locked computer, identical-looking numbered sealed envelopes, drug bottles, or containers prepared by an independent pharmacist or investigator.
 - Uncertain risk: If the trial was classified as randomised but the allocation concealment process was not described.
 - High risk: If the allocation sequence was familiar to the investigators who assigned participants.

46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

46 *Blinding of participants and treatment providers*

- 47
48
49
50
51
52
53
54
55
56
57
58
59
60
- Low risk: If the participants and the treatment providers were blinded to intervention allocation and this was described.
 - Uncertain risk: If the procedure of blinding was insufficiently described.
 - High risk: If blinding of participants and the treatment providers was not performed.

46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

46 *Blinding of outcome assessment*

- 47
48
49
50
51
52
53
54
55
56
57
58
59
60
- Low risk of bias: If it was mentioned that outcome assessors were blinded and this was described.
 - Uncertain risk of bias: If it was not mentioned if the outcome assessors in the trial were blinded or the extent of blinding was insufficiently described.
 - High risk of bias: If no blinding or incomplete blinding of outcome assessors was performed.

Incomplete outcome data

- Low risk of bias: If missing data were unlikely to make treatment effects depart from plausible values. This could be either (1) there were no drop-outs or withdrawals for all outcomes or (2) the numbers and reasons for the withdrawals and drop-outs for all outcomes were clearly stated and could be described as being similar to both groups. Generally, the trial is judged as at a low risk of bias due to incomplete outcome data if drop-outs are less than 5%. However, the 5% cut-off is not definitive.
- Uncertain risk of bias: If there was insufficient information to assess whether missing data were likely to induce bias on the results.
- High risk of bias: If the results were likely to be biased due to missing data either because the pattern of drop-outs could be described as being different in the two intervention groups or the trial used improper methods in dealing with the missing data (i.e. last observation carried forward, etc.).

Selective outcome reporting

- Low risk of bias: If a protocol was published before or at the time the trial was begun, and the outcomes specified in the protocol were reported on. If there is no protocol or the protocol was published after the trial has begun, reporting pain assessment on VAS or NRS and serious adverse events will grant the trial a grade of low risk of bias.
- Uncertain risk of bias: If no protocol was published and the outcome pain assessment on VAS or NRS and serious adverse events were not reported on.
- High risk of bias: If the outcomes in the protocol were not reported on.

For-profit bias

- Low risk of bias: If the trial appeared to be free of other components of for-profit bias.
- Unclear risk of bias: If it was unclear whether the trial was free of for-profit bias.
- High risk of bias: If there was a high risk of for-profit bias.

Overall risk of bias

- Low risk of bias: The trial will be classified at overall 'low risk of bias' only if all of the bias domains described in the above paragraphs are classified at 'low risk of bias'.

- High risk of bias: The trial will be classified at 'high risk of bias' if any of the bias risk domains described in the above are classified at 'unclear' or 'high risk of bias'.

We will assess the domains 'blinding of outcome assessment', 'incomplete outcome data', and 'selective outcome reporting' for each outcome result. Thus, we can assess the bias risk for each outcome assessed in addition to each trial. Our primary conclusions will be based on the results of our primary outcome results at overall low risk of bias. Both our primary and secondary analyses will be presented in the summary of findings tables.

Differences between the protocol and the review

We will conduct the review according to this published protocol and report any deviations from it in the 'Differences between the protocol and the review' section of the systematic review.

Measures of treatment effect

Dichotomous outcomes

We will calculate risk ratios (RRs) with 95% confidence interval (CI) for dichotomous outcomes, as well as the Trial Sequential Analysis- adjusted CIs (see below).

Continuous outcomes

We will calculate the mean differences (MDs) and the standardised mean difference (SMD) with 95% CI for continuous outcomes, as well as the Trial Sequential Analysis-adjusted CIs (see below).

Dealing with missing data

We will, as first option, contact all trial authors to obtain any relevant missing data (i.e. for data extraction and for assessment of risk of bias, as specified above).

Dichotomous outcomes

We will not impute missing values for any outcomes in our primary analysis. In two of our sensitivity analyses (see paragraph below), we will impute data.

Continuous outcomes

1
2
3
4 We will primarily analyse scores assessed at single time points. If only changes from baseline scores are
5 reported, we will analyse the results together with follow-up scores [85]. If standard deviations (SDs) are not
6 reported, we will calculate the SDs using trial data, if possible. We will not use intention-to-treat data if the
7 original report did not contain such data. We will not impute missing values for any outcomes in our primary
8 analysis. In our sensitivity analysis (see paragraph below) for continuous outcomes, we will impute data.
9
10
11
12

13 14 *Assessment of heterogeneity*

15 We will primarily investigate forest plots to visually assess any sign of heterogeneity. We will secondly assess
16 the presence of statistical heterogeneity by χ^2 test (threshold $P < 0.10$) and measure the quantities of
17 heterogeneity by the I^2 statistic [97, 98]. We will investigate for heterogeneity through subgroup analyses.
18 Ultimately, we may decide that a meta-analysis should be avoided [85].
19
20
21
22

23 24 *Assessment of reporting biases*

25 We will use a funnel plot to assess reporting bias if ten or more trials are included. We will visually inspect
26 funnel plots to assess the risk of bias. We are aware of the limitations of a funnel plot (i.e. a funnel plot
27 assesses bias due to small sample size, etc.). From this information, we assess possible reporting bias. For
28 dichotomous outcomes, we will test asymmetry with the Harbord test [99] if τ^2 is less than 0.1 and with the
29 R ucker test if τ^2 is more than 0.1. For continuous outcomes, we will use the regression asymmetry test [100]
30 and the adjusted rank correlation [101].
31
32
33
34
35
36
37

38 39 *Unit of analysis issues*

40 We will only include randomised clinical trials. For trials using crossover design, only data from the first period
41 will be included [85, 102]. There will therefore not be any unit of analysis issues.
42
43
44

45 46 *Minimal important difference*

47 In clinical intervention research it is of utmost importance always to define minimal important differences (MID)
48 and to define thresholds for clinical significance [103]. If a large number of trial participants are randomised,
49 small and clinically irrelevant intervention effects may lead to statistically significant results and rejection of the
50 null hypothesis [104]. Jaeschke et al. defined the minimal important difference as “the smallest difference in
51 score in the domain of interest which patients perceive as beneficial” [105].
52
53
54
55
56
57
58
59
60

1
2
3
4 Estimations of minimal important differences should be used as arbitrary strict precise thresholds. However, to
5 avoid erroneous conclusions minimal important differences need to be estimated and predefined when assessing
6 the effects of interventions for pain. Olsen et al. have conducted two systematic reviews on this matter in order
7 to gather the evidence and present an estimate of the minimal important difference [106, 107]. Olsen et al.
8 conducted a systematic review on the minimal important difference in patients with acute pain and concluded
9 that the median of the studies' results was 17 mm on VAS (IQR 14 mm to 23 mm) [106]. Another systematic
10 review conducted by Olsen et al. was on the minimal important difference in patients with chronic pain and the
11 results showed a median of 23 mm on VAS (IQR 12 mm to 39 mm) when using the within-patient anchor-based
12 method, while the median in studies using the sensitivity- and specificity-based method was 20 mm on VAS (IQR
13 15 mm – 30 mm) [107]. We have described detailed considerations about minimal important differences in
14 **Appendix 1.**

15
16
17
18
19
20
21
22
23
24 Based on the previously conducted systematic reviews we will choose at minimal important difference
25 equivalent to 10 mm or 1 point on the visual analogue scale and the numerical rating scale, respectively,
26 regarding an analgesic effect.
27
28
29

30 31 **Data synthesis**

32 *Meta-analysis*

33
34 We will undertake this meta-analysis according to the recommendations stated in the Cochrane Handbook for
35 Systematic Reviews of Interventions [85], Keus et al. [108], and the eight-step assessment suggested by
36 Jakobsen et al. [103]. We will use the statistical software Review Manager 5.3 [86] provided by Cochrane to
37 analyse data. We will assess our intervention effects with both random-effects meta-analyses [109] and fixed-
38 effect meta-analyses [110]. We will use the more conservative point estimate of the two [103]. The more
39 conservative point estimate is the estimate closest to zero effect. If the two estimates are similar, we will use
40 the estimate with the highest P value [103]. We use four primary and four secondary outcomes, and therefore,
41 we will consider a P value of 0.02 as the threshold for statistical significance [103, 111]. We will investigate for
42 heterogeneity through subgroup analyses. Ultimately, we may decide that a meta-analysis should be avoided
43 [85]. We will use the eight-step procedure to assess if the thresholds for statistical and clinical significance are
44 crossed [103]. Our primary conclusion will be based on results with low risk of bias [103].
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3
4 Where multiple trial intervention groups are reported in a single trial, we will include only the relevant groups.
5
6 If two comparisons are combined in the same meta-analysis, we will halve the control group to avoid double-
7
8 counting [85]. Trials with a factorial design will be included.
9

10
11 If quantitative synthesis is not appropriate, we will report the results in a narrative way.
12
13

14 *Trial Sequential Analysis*

15
16 Traditional meta-analysis runs the risk of random errors due to sparse data and repetitive testing of
17
18 accumulating data when updating reviews. We wish to control the risks of type I errors and type II errors. We
19
20 will therefore perform Trial Sequential Analysis on the outcomes, in order to calculate the required information
21
22 size (that is the number of participants needed in a meta-analysis to detect or reject a certain intervention
23
24 effect) and the cumulative Z-curve's breach of relevant trial sequential monitoring boundaries [87, 112-120]. A
25
26 more detailed description of Trial Sequential Analysis can be found in the Trial Sequential Analysis manual
27
28 [113] and at <http://www.ctu.dk/tsa/>. For dichotomous outcomes, we will estimate the required information
29
30 size based on the observed proportion of patients with an outcome in the control group (the cumulative
31
32 proportion of patients with an event in the control groups relative to all patients in the control groups), a
33
34 relative risk reduction of 20%, an alpha of 2.0% for our primary and secondary outcomes, a beta of 10%, and
35
36 diversity as suggested by the trials in the meta-analysis. For the outcome "pain assessment on visual analogue
37
38 scale (VAS) or numerical rating scale (NRS)", we will use a minimal important difference estimate based on
39
40 previously conducted systematic reviews [106, 107]. We will accept an analgesic effect equivalent to 10 mm or
41
42 1 point on the visual analogue scale and the numerical rating scale, respectively, or a consumption of at least 5
43
44 mg morphine.
45
46

47
48 For all remaining continuous outcome, we will in the Trial Sequential Analysis use the observed SD, a mean
49
50 difference of the observed SD/2, an alpha of 2.0% for our primary and secondary outcomes, and a beta of 10%.

51 **Subgroup analysis and investigation of heterogeneity**

52 *Subgroup analysis*

53 We will perform the following subgroup analysis when analysing the primary outcomes (All-cause mortality,
54
55 pain assessment on VAS or NRS, serious adverse event, and quality of life).

- 56 • Trials at high risk of bias compared to trials at low risk of bias
- 57
58
59
60

- Trials at risk of vested interests compared to trial with no risk of vested interests
- Trials compared according to type of pain (acute pain, chronic pain, and cancer pain)
- Trials compared according to type of chronic pain
- Trials compared according to type of cannabinoids used

We will use the formal test for subgroup interactions in Review Manager [86].

Sensitivity analysis

To assess the potential impact of the missing data for dichotomous outcomes, we will perform the two following sensitivity analyses on both the primary and secondary outcomes.

- ‘Best-worst-case’ scenario: We will assume that all participants lost to follow-up in the cannabinoid intervention group have survived and had no serious adverse event, and that all those participants lost to follow-up in the placebo group have not survived, and had a serious adverse event.
- ‘Worst-best-case’ scenario: We will assume that all participants lost to follow-up in the cannabinoid intervention group have not survived, and had a serious adverse event, and that all those participants lost to follow-up in the placebo group have survived, and had no serious adverse event.

We will present results of both scenarios in our review.

For all continuous outcome when analysing a ‘beneficial outcome’ will be the group mean plus two standard deviations (SDs) (we will secondly use one SD in another sensitivity analysis) of the group mean and a ‘harmful outcome’ will be the group mean minus two SDs (we will secondly use one SD in another sensitivity analysis) of the group mean [103].

To assess the potential impact of missing SDs for continuous outcomes, we will perform the following sensitivity analysis.

- Where SDs are missing and it is not possible to calculate them, we will impute SDs from trials with similar populations and low risk of bias. If we find no such trials, we will impute SDs from trials with a similar population. As the final option, we will impute SDs from all trials.

1
2
3
4 We will present results of this scenario in our review. Other post hoc sensitivity analyses might be warranted if
5 unexpected clinical or statistical heterogeneity is identified during the analysis of the review results [103].
6
7

8 9 *Summary of Findings*

10 We will create a Summary of Findings table using each of the primary outcomes (all-cause mortality, pain
11 assessment on VAS or NRS, serious adverse event, and quality of life). We will use the five GRADE
12 considerations (bias risk of the trials, consistency of effect, imprecision, indirectness, and publication bias) to
13 assess the quality of a body of evidence as it relates to the studies which contribute data to the meta-analyses
14 for the prespecified outcomes [103, 121-123]. We will use methods and recommendations described in
15 Chapter 8 (Section 8.5) and Chapter 12 of the Cochrane Handbook for Systematic Reviews of Interventions [85]
16 using GRADEpro software. We will justify all decisions to downgrade the quality of studies using footnotes, and
17 we will make comments to aid the reader's understanding of the review where necessary. Firstly, we will
18 present our results in the Summary of Findings table based on the results from the trials with low risk of bias,
19 and secondly, we will present the results based on all trials.
20
21
22
23
24
25
26
27
28

29 **Ethics and dissemination**

30
31 Ethical approval is not a requirement since no primary data will be collected. The findings of this systematic
32 review will be submitted for peer-reviewed publication and disseminated in national and international
33 conferences and is expected to inform healthcare workers and providers about the occurrence of serious and
34 non-serious adverse events following cannabinoid consumption. It is expected that the findings of this systematic
35 review will identify some research gaps for future trials.
36
37
38
39
40
41

42 **Discussion**

43
44 This protocol aims at investigating the beneficial and harmful effects of cannabinoids in patients with any type
45 of pain condition. The outcomes will be all-cause mortality, pain assessment on VAS or NRS, serious adverse
46 events, quality of life, dependence, psychosis, non-serious adverse events, and sleep quality.
47
48
49

50 This protocol has several strengths. The predefined methodology is based on the Cochrane Handbook for
51 Systematic Reviews of Interventions [85], the eight-step assessment suggested by Jakobsen et al. [103], Trial
52 Sequential Analysis [84], and GRADE assessment [121-123]. Hence, this protocol takes both the risk of random
53
54
55
56
57
58
59

1
2
3
4 error and the risk of systematic error into account. We predefined evidence-based estimations of minimal
5 important differences which will limit the risk of focusing on statistically significant results with questionable
6 clinical importance. This threshold of minimal important difference is based on the estimations of several
7 previously conducted studies and reviews [106, 107]. Moreover, we are including all types of cannabinoids and
8 all types of pain which will increase the statistical power and make it possible to perform essential subgroup
9 analyses. We have been in contact with several relevant patient associations which has assisted us in choosing
10 the most clinically relevant outcomes.
11
12
13
14
15
16

17
18 Our protocol also has several limitations. One of the potential limitations is that we include participants with all
19 types of pain; cannabinoids might have different effects on different types of pain. It might, e.g. be problematic
20 to combine trials assessing the effects of cannabinoids on acute pain and chronic pain because of different
21 underlying pathophysiological mechanisms [124]. On the other hand, the effects of cannabinoids on acute pain
22 and chronic pain might be comparable and hence it might be valid to combine trials assessing the effects of
23 cannabinoids on acute pain and chronic pain in meta-analysis, which would increase the statistical power. The
24 results of the subgroup analysis comparing trials including participants with acute pain to participants with
25 chronic pain will therefore be highlighted when reporting our review results. Moreover, we only intend to assess
26 cannabinoids versus placebo or versus no intervention. Further systematic reviews with meta-analyses and Trial
27 Sequential Analyses need to assess the benefits and harms of cannabinoids versus other pain killers, provided
28 that cannabinoids show more benefit than harm in the present systematic review.
29
30
31
32
33
34
35
36

37
38 Furthermore, more than one active cannabinoid agent is often combined in the different intervention options
39 provided to the patients with a pain condition, thereby making difficult to explore the analgesic effect and
40 adverse event associated with a single cannabinoid agent. Hence, if we show a difference between the
41 intervention options, it will be difficult to conclude what exactly caused the difference in effect. To minimise
42 these limitations, we have planned a careful assessment of statistical and clinical heterogeneity as well as several
43 subgroup analyses and sensitivity analyses. Another limitation is the large number of comparisons which increase
44 the risk of type 1 error. We have adjusted our thresholds for significance according to the number of primary
45 outcomes, but, as mentioned, we have also included multiple subgroup analyses. This large risk of type 1 error
46 will be taken into account when interpreting the review results.
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Acknowledgements

We hugely appreciate the contribution of The Danish Diabetes Association, Steno Diabetes Centre Copenhagen, The Danish Rheumatism Association, The Danish Multiple Sclerosis Society, and Danish Cancer Society in guiding us to select the most patient relevant outcomes.

The expert help from Sarah Louise Klingenberg (Information Specialist, The Cochrane Hepato-Biliary Group, Copenhagen Trial Unit, Copenhagen, Denmark) in making the search strategy is hugely appreciated.

Funding statement

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Authors' contributions

JB drafted the protocol. JCJ, SKK, OM, CG, JRF, and MM amended the protocol. All authors read and approved the final manuscript.

Competing interests

None declared

Ethics approval and consent to participate

Not applicable.

Word Count

10191 words, including the full references.

References

1. Verhaak P, Kerssens J, Dekker J, Sorbi M, and Bensing J, *Prevalence of chronic benign pain disorder among adults: a review of the literature*. PAIN, 1998. **77**(3): p. 231-9.
2. Kroenke K, *Patients presenting with somatic complaints: epidemiology, psychiatric comorbidity and management*. Int J Methods Psychiatr Res, 2003. **12**(1): p. 34-43.
3. Sternbach RA, *Survey of pain in the United States: The nuprin pain report*. The Clinical Journal of Pain, 1986. **2**(1): p. 49-53.

4. Gureje O, Von Korff M, Simon G, and Gater R, *Persistent pain and well-being: a World Health Organization Study in Primary Care*. *Jama*, 1998. **280**(2): p. 147-51.
5. Breivik H, *International association for the study of pain: update on WHO-IASP activities*. *J Pain Symptom Manage*, 2002. **24**(2): p. 97-101.
6. Astin J, *Why patients use alternative medicine: Results of a national study*. *JAMA*, 1998. **279**(19): p. 1548-1553.
7. Davison SN, Jhangri GS, and Johnson JA, *Cross-sectional validity of a modified Edmonton symptom assessment system in dialysis patients: a simple assessment of symptom burden*. *Kidney Int*, 2006. **69**(9): p. 1621-5.
8. Davison SN, Jhangri GS, and Johnson JA, *Longitudinal validation of a modified Edmonton symptom assessment system (ESAS) in haemodialysis patients*. *Nephrol Dial Transplant*, 2006. **21**(11): p. 3189-95.
9. Davison SN and Jhangri GS, *Impact of pain and symptom burden on the health-related quality of life of hemodialysis patients*. *J Pain Symptom Manage*, 2010. **39**(3): p. 477-85.
10. Davison S, *Chronic pain in end-stage renal disease*. *Adv Chronic Kidney Dis*, 2005. **12**(3): p. 326-34.
11. Kimmel PL, Emont SL, Newmann JM, Danko H, and Moss AH, *ESRD patient quality of life: symptoms, spiritual beliefs, psychosocial factors, and ethnicity*. *Am J Kidney Dis*, 2003. **42**(4): p. 713-21.
12. Leinau L, Murphy TE, Bradley E, and Fried T, *Relationship between conditions addressed by hemodialysis guidelines and non-ESRD-specific conditions affecting quality of life*. *Clin J Am Soc Nephrol*, 2009. **4**(3): p. 572-8.
13. Weisbord SD, Carmody SS, Bruns FJ, Rotondi AJ, Cohen LM, Zeidel ML, et al., *Symptom burden, quality of life, advance care planning and the potential value of palliative care in severely ill haemodialysis patients*. *Nephrol Dial Transplant*, 2003. **18**(7): p. 1345-52.
14. Weisbord SD, Fried LF, Arnold RM, Fine MJ, Levenson DJ, Peterson RA, et al., *Prevalence, severity, and importance of physical and emotional symptoms in chronic hemodialysis patients*. *J Am Soc Nephrol*, 2005. **16**(8): p. 2487-94.
15. Gamondi C, Galli N, Schonholzer C, Marone C, Zwahlen H, Gabutti L, et al., *Frequency and severity of pain and symptom distress among patients with chronic kidney disease receiving dialysis*. *Swiss Med Wkly*, 2013. **143**: p. w13750.
16. Smith BH, Elliott AM, Chambers WA, Smith WC, Hannaford PC, and Penny K, *The impact of chronic pain in the community*. *Fam Pract*, 2001. **18**(3): p. 292-9.
17. Merskey H, Lindblom U, Mumford JM, Nathan PW, and Sunderland S, *Part III: Pain terms—a current list with definitions and notes on usage with definitions and notes on usage.. In: Merskey H, Bogduk N editor(s). Classification of Chronic Pain, IASP Task Force on Taxonomy*. IASP Press, 1994(2nd Edition): p. 209-14.
18. Vuckovic S, Srebro D, Vujovic K S, Vucetic C, and Prostran M, *Cannabinoids and Pain: New Insights From Old Molecules*. *Frontiers in pharmacology*, 2018. **9**: p. 1259.
19. Carr DB and Goudas LC, *Acute pain*. *The Lancet*, 1999. **353**(9169): p. 2051-2058.
20. Ashburn MA and Staats PS, *Management of chronic pain*. *The Lancet*, 1999. **353**(9167): p. 1865-1869.

21. Kanner R, *Pain Management*. JAMA, 1986. **256**(15): p. 2112-2114.
22. Loeser J, Melzack R, *Pain: an overview*. The Lancet, 1999. **353**(9164): p. 1607-1609.
23. Portenoy R and Dhingra L. *Assessment of cancer pain*. 2017 [cited 18/04 2018].
24. Gregory J and McGowan L, *An examination of the prevalence of acute pain for hospitalised adult patients: a systematic review*. J Clin Nurs, 2016. **25**(5-6): p. 583-98.
25. Treede R, *Entstehung der schmerzchronifizierung. Rückenschmerzen und nackenschmerzen*. 2016: Springer, Berlin, Heidelberg.
26. American Geriatrics Society Panel *Pharmacological management of persistent pain in older persons*. J Am Geriatr Soc, 2009. **57**: p. 1331-46.
27. Breivik H, Collett B, Ventafridda V, Cohen R, and Gallacher D, *Survey of chronic pain in Europe: prevalence, impact on daily life, and treatment*. Eur J Pain, 2006. **10**(4): p. 287-333.
28. Goldberg DS and McGee SJ, *Pain as a global public health priority*. BMC Public Health, 2011. **11**: p. 770.
29. Gureje O, Von Korff M, Kola L, Demyttenaere K, He Y, Posada-Villa J, et al., *The relation between multiple pains and mental disorders: results from the World Mental Health Surveys*. PAIN, 2008. **135**(1-2): p. 82-91.
30. Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education, *Relieving pain in America: A blueprint for transforming prevention, care, education, and research*. National Academies Press 2011.
31. Koleva D, *Pain in primary care: an Italian survey*. Eur J Public Health, 2005. **15**: p. 475-79.
32. Mantyselka P, Kumpusalo E, Ahonen R, Kumpusalo A, Kauhanen J, Viinamaki H, et al., *Pain as a reason to visit the doctor: a study in Finnish primary health care*. PAIN, 2001. **89**(2-3): p. 175-80.
33. Treede RD, Rief W, Barke A, Aziz Q, Bennett MI, Benoliel R, et al., *A classification of chronic pain for ICD-11*. PAIN, 2015. **156**(6): p. 1003-7.
34. Kelly DJ, Ahmad M, and Brull SJ, *Preemptive analgesia I: physiological pathways and pharmacological modalities*. Canadian Journal of Anaesthesia, 2001. **48**(10): p. 1000-1010.
35. Pogatzki-Zahn EM, Segelcke D, and Schug SA, *Postoperative pain-from mechanisms to treatment*. Pain Rep, 2017. **2**(2): p. e588.
36. Lipowski Z, *Chronic idiopathic pain syndrome*. Annals of Medicine, 1990. **22**(4): p. 213-217.
37. Goucke C, *The management of persistent pain*. Med J Aust, 2003. **178**(9): p. 444-7.
38. Chang V. *Approach to symptom assessment in palliative care*. 2018 [cited 2018].
39. Knowles CH and Aziz Q, *Basic and clinical aspects of gastrointestinal pain*. Pain, 2009. **141**(3): p. 191-209.
40. Stein S L, *Chronic pelvic pain*. Gastroenterol Clin North Am, 2013. **42**(4): p. 785-800.
41. Schwartz ES and Gebhart GF, *Visceral pain*. Curr Top Behav Neurosci, 2014. **20**: p. 171-97.
42. Giamberardino M, Affaitati G, and Costantini R, *Chapter 24 Referred pain from internal organs*. Handb Clin Neurol, 2006. **81**: p. 343-61.
43. Jensen TS, Baron R, Haanpaa M, Kalso E, Loeser JD, Rice AS, et al., *A new definition of neuropathic pain*. Pain, 2011. **152**(10): p. 2204-5.
44. Headache Classification Committee of the International Headache Society, *The International Classification of Headache Disorders, 3rd edition (beta version)*. Cephalalgia, 2013. **33**: p. 629-808.

- 1
- 2
- 3
- 4 45. Institute for clinical systems improvement, *Health care guideline: Assessment and management*
- 5 *of chronic pain*. 2009.
- 6
- 7 46. United Nations office on drugs and crime, *World Drug Report, United Nations*. 2016.
- 8 47. Russo E, *Cannabinoids in the management of difficult to treat pain*. Ther Clin Risk Manag, 2008.
- 9 **4(1)**: p. 245-59.
- 10 48. Ueda N, Tsuboi K, and Uyama T, *Metabolic enzymes for endocannabinoids and*
- 11 *endocannabinoid-like mediators*. 2015, Boston: Academic Press.
- 12 49. Devane WA, Hanus L, Breuer A, Pertwee RG, Stevenson LA, Griffin G, et al., *Isolation and*
- 13 *structure of a brain constituent that binds to the cannabinoid receptor*. Science, 1992.
- 14 **258(5090)**: p. 1946-9.
- 15 50. Mechoulam R, Ben-Shabat S, Hanus L, Ligumsky M, Kaminski NE, Schatz AR, et al., *Identification*
- 16 *of an endogenous 2-monoglyceride, present in canine gut, that binds to cannabinoid receptors*.
- 17 *Biochem Pharmacol*, 1995. **50(1)**: p. 83-90.
- 18 51. Sugiura T, Kondo S, Sukagawa A, Nakane S, Shinoda A, Itoh K, et al., *2-Arachidonoylglycerol: a*
- 19 *possible endogenous cannabinoid receptor ligand in brain*. *Biochem Biophys Res Commun*, 1995.
- 20 **215(1)**: p. 89-97.
- 21 52. Fisar Z, *Phytocannabinoids and endocannabinoids*. *Curr Drug Abuse Rev*, 2009. **2(1)**: p. 51-75.
- 22 53. Häuser W, Fitzcharles M, Radbruch L, and Petzke F, *Cannabinoids in pain management and*
- 23 *palliative medicine*. *Deutsches Arzteblatt international*, 2017. **114(38)**: p. 627-634.
- 24 54. Hazekamp A, Ware MA, Muller-Vahl KR, Abrams D, and Grotenhermen F, *The medicinal use of*
- 25 *cannabis and cannabinoids—An international cross-sectional survey on administration forms*.
- 26 *Journal of Psychoactive Drugs*, 2013. **45(3)**: p. 199-210.
- 27 55. Watson SJ, Benson JA, and Joy JE, *Marijuana and medicine: assessing the science base: a*
- 28 *summary of the 1999 Institute of Medicine report*. *Arch Gen Psychiatry*, 2000. **57(6)**: p. 547-52.
- 29 56. Brenneisen R, *Chemistry and analysis of phytocannabinoids and other cannabis constituents*, in
- 30 *Marijuana and the Cannabinoids*, ElSohly M A, Editor. 2007, Humana Press: Totowa, NJ. p. 17-
- 31 49.
- 32 57. Pertwee R, *Cannabis and cannabinoids: Pharmacology and rationale for clinical use*. *Pharmacy*
- 33 *and Pharmacology Communications*, 1997. **3(11)**: p. 539-545.
- 34 58. Solinas M, Goldberg SR, and Piomelli D, *The endocannabinoid system in brain reward processes*.
- 35 *Br J Pharmacol*, 2008. **154(2)**: p. 369-83.
- 36 59. Koppel BS, Brust J, Fife T, Bronstein J, Youssof S, Gronseth G, et al., *Systematic review: efficacy*
- 37 *and safety of medical marijuana in selected neurologic disorders: report of the Guideline*
- 38 *Development Subcommittee of the American Academy of Neurology*. *Neurology*, 2014. **82(17)**:
- 39 p. 1556-63.
- 40 60. Gorelick D, Saxon A, and Hermann R *Cannabis use and disorder: Pathogenesis and*
- 41 *pharmacology*. UpToDate Cannabis use and disorder: Pathogenesis and pharmacology,
- 42 2018.[cited Access 2018 Access Date].
- 43 61. Morean ME, Kong G, Camenga DR, Cavallo DA, and Krishnan-Sarin S, *High school students' use*
- 44 *of electronic cigarettes to vaporize cannabis*. *Pediatrics*, 2015. **136(4)**: p. 611-616.
- 45
- 46
- 47
- 48
- 49
- 50
- 51
- 52
- 53
- 54
- 55
- 56
- 57
- 58
- 59
- 60

- 1
2
3
4 62. Loflin M and Earleywine M, *No smoke, no fire: What the initial literature suggests regarding*
5 *vapourized cannabis and respiratory risk*. Canadian journal of respiratory therapy, 2015. **51**(1):
6 p. 7-9.
7
8 63. Aviram J and Samuelly-Leichtag G, *Efficacy of Cannabis-Based Medicines for Pain Management:*
9 *A Systematic Review and Meta-Analysis of Randomized Controlled Trials*. Pain Physician, 2017.
10 **20**(6): p. E755-e796.
11
12 64. Lynch M, Campbell, F, *Cannabinoids for treatment of chronic non-cancer pain; a systematic*
13 *review of randomized trials*. Br J Clin Pharmacol, 2011. **72**(5): p. 735-44.
14
15 65. Meng H, Johnston B, Englesakis M, Moulin DE, and Bhatia A, *Selective Cannabinoids for Chronic*
16 *Neuropathic Pain: A Systematic Review and Meta-analysis*. Anesth Analg, 2017. **125**(5): p. 1638-
17 1652.
18
19 66. Boychuk DG, Goddard G, Mauro G, and Orellana MF, *The effectiveness of cannabinoids in the*
20 *management of chronic nonmalignant neuropathic pain: a systematic review*. J Oral Facial Pain
21 Headache, 2015. **29**(1): p. 7-14.
22
23 67. Martin-Sanchez E, Furukawa TA, Taylor J, and Martin JL, *Systematic review and meta-analysis of*
24 *cannabis treatment for chronic pain*. Pain Med, 2009. **10**(8): p. 1353-68.
25
26 68. Campbell FA, Tramèr MR, Carroll D, Reynolds DJ, Moore RA, and McQuay HJ, *Are cannabinoids*
27 *an effective and safe treatment option in the management of pain? A qualitative systematic*
28 *review*. BMJ (Clinical research ed.), 2001. **323**(7303): p. 13-16.
29
30 69. Deshpande A, Mailis-Gagnon A, Zoheiry N, and Lakha SF, *Efficacy and adverse effects of medical*
31 *marijuana for chronic noncancer pain: Systematic review of randomized controlled trials*. Can
32 Fam Physician, 2015. **61**(8): p. e372-81.
33
34 70. Stevens AJ and Higgins MD, *A systematic review of the analgesic efficacy of cannabinoid*
35 *medications in the management of acute pain*. Acta Anaesthesiol Scand, 2017. **61**(3): p. 268-
36 280.
37
38 71. Walitt B, Klose P, Fitzcharles MA, Phillips T, and Hauser W, *Cannabinoids for fibromyalgia*.
39 Cochrane Database Syst Rev, 2016. **7**: p. Cd011694.
40
41 72. Mucke M, Phillips T, Radbruch L, Petzke F, and Hauser W, *Cannabis-based medicines for chronic*
42 *neuropathic pain in adults*. Cochrane Database Syst Rev, 2018. **3**: p. Cd012182.
43
44 73. Boydell J, Van Os J, Caspi A, Kennedy N, Giouroukou E, Fearon P, et al., *Trends in cannabis use*
45 *prior to first presentation with schizophrenia, in South-East London between 1965 and 1999*.
46 Psychological Medicine, 2006. **36**(10): p. 1441-1446.
47
48 74. Andreasson S, Allebeck P, Engstrom A, and Rydberg U, *Cannabis and schizophrenia. A*
49 *longitudinal study of Swedish conscripts*. Lancet, 1987. **2**(8574): p. 1483-6.
50
51 75. Arseneault L, Cannon M, Poulton R, Murray R, Caspi A, and Moffitt TE, *Cannabis use in*
52 *adolescence and risk for adult psychosis: longitudinal prospective study*. Bmj, 2002. **325**(7374):
53 p. 1212-3.
54
55 76. van Os J, Bak M, Hanssen M, Bijl R V, de Graaf R, and Verdoux H, *Cannabis use and psychosis: a*
56 *longitudinal population-based study*. Am J Epidemiol, 2002. **156**(4): p. 319-27.
57
58 77. Zammit S, Allebeck P, Andreasson S, Lundberg I, and Lewis G, *Self reported cannabis use as a*
59 *risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study*. Bmj, 2002.
60 **325**(7374): p. 1199.

- 1
- 2
- 3
- 4 78. Fergusson DM, Horwood LJ, and Ridder EM, *Tests of causal linkages between cannabis use and*
- 5 *psychotic symptoms*. *Addiction*, 2005. **100**(3): p. 354-66.
- 6
- 7 79. Henquet C, Krabbendam L, Spauwen J, Kaplan C, Lieb R, Wittchen HU, et al., *Prospective cohort*
- 8 *study of cannabis use, predisposition for psychosis, and psychotic symptoms in young people*.
- 9 *Bmj*, 2005. **330**(7481): p. 11.
- 10
- 11 80. Di Forti M, Quattrone D, Freeman TP, Tripoli G, Gayer-Anderson C, Quigley H, et al., *The*
- 12 *contribution of cannabis use to variation in the incidence of psychotic disorder across Europe*
- 13 *(EU-GEI): a multicentre case-control study*. *Lancet Psychiatry*, 2019. **6**(5): p. 427-436.
- 14
- 15 81. Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, et al., *Preferred reporting*
- 16 *items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and*
- 17 *explanation*. *Bmj*, 2015. **350**: p. g7647.
- 18
- 19 82. Moher D, Shamseer L, Clarke M, Ghersi D, Liberati A, Petticrew M, et al., *Preferred reporting*
- 20 *items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement*. *Syst Rev*,
- 21 **4**: p. 1.
- 22
- 23 83. *International conference on harmonisation of technical requirements for registration of*
- 24 *pharmaceuticals for human use (ICH) adopts consolidated guideline on good clinical practice in*
- 25 *the conduct of clinical trials on medicinal products for human use*. *Int Dig Health Legis*, 1997.
- 26 **48**(2): p. 231-4.
- 27
- 28 84. Richards J R, Bing M L, Moulin A K, Elder J W, Rominski R T, Summers P J, et al., *Cannabis use*
- 29 *and acute coronary syndrome*. *Clinical toxicology (Philadelphia, Pa.)*, 2019: p. 1-11.
- 30
- 31 85. Higgins J and Green S. *Cochrane handbook for systematic reviews of interventions version 5.1.0*.
- 32 *www.handbook.cochrane.org*. 2011.
- 33
- 34 86. *Review Manager (RevMan)*. 2014, Copenhagen: the Nordic Cochrane Centre, The Cochrane
- 35 *Collaboration*.
- 36
- 37 87. *TSA—Trial Sequential Analysis*. Copenhagen Trial Unit. <http://www.ctu.dk/tsa/>
- 38
- 39 88. *StataCorp: Stata: Release 14*. 2014, College Station, TX: StataCorp LP.
- 40
- 41 89. Moher D, Liberati A, Tetzlaff J, and Altman DG, *Preferred reporting items for systematic reviews*
- 42 *and meta-analyses: The PRISMA statement*. *PLOS Medicine*, 2009. **6**(7): p. e1000097.
- 43
- 44 90. Gluud LL, *Bias in clinical intervention research*. *Am J Epidemiol*, 2006. **163**(6): p. 493-501.
- 45
- 46 91. Kjaergard LL, Villumsen J, and Gluud C, *Reported methodologic quality and discrepancies*
- 47 *between large and small randomized trials in meta-analyses*. *Ann Intern Med*, 2001. **135**(11): p.
- 48 **982-9**.
- 49
- 50 92. Lundh A, Sismondo, S, Lexchin, J, Busuioac, OA, Bero, L, *Industry sponsorship and research*
- 51 *outcome*. *Cochrane Database Syst Rev*, 2012. **12**: p. Mr000033.
- 52
- 53 93. Moher D, Pham, B, Jones, A, Cook, DJ, Jadad, AR, Moher, M et al., *Does quality of reports of*
- 54 *randomised trials affect estimates of intervention efficacy reported in meta-analyses?* *Lancet*,
- 55 **352**(9128): p. 609-13.
- 56
- 57 94. Schulz KF, Chalmers I, Hayes RJ, and Altman DG, *Empirical evidence of bias. Dimensions of*
- 58 *methodological quality associated with estimates of treatment effects in controlled trials*. *JAMA*,
- 59 **273**(5): p. 408-12.
- 60

- 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10
 - 11
 - 12
 - 13
 - 14
 - 15
 - 16
 - 17
 - 18
 - 19
 - 20
 - 21
 - 22
 - 23
 - 24
 - 25
 - 26
 - 27
 - 28
 - 29
 - 30
 - 31
 - 32
 - 33
 - 34
 - 35
 - 36
 - 37
 - 38
 - 39
 - 40
 - 41
 - 42
 - 43
 - 44
 - 45
 - 46
 - 47
 - 48
 - 49
 - 50
 - 51
 - 52
 - 53
 - 54
 - 55
 - 56
 - 57
 - 58
 - 59
 - 60
95. Wood L, Egger M, Gluud L, Schulz K, Jüni P, Altman D, et al., *Empirical evidence of bias in treatment effect estimates in controlled trials with different interventions and outcomes: meta-epidemiological study*. *BMJ*, 2008. **336**(7644): p. 601-605.
96. Savovic J, Jones H, Altman D, Harris R, Juni P, Pildal J, et al., *Influence of reported study design characteristics on intervention effect estimates from randomised controlled trials: combined analysis of meta-epidemiological studies*. *Health Technol Assess*, 2012. **16**(35): p. 1-82.
97. Higgins JP and Thompson SG, *Quantifying heterogeneity in a meta-analysis*. *Stat Med*, 2002. **21**(11): p. 1539-58.
98. Higgins JP, Thompson SG, Deeks JJ, and Altman DG, *Measuring inconsistency in meta-analyses*. *BMJ*, 2003. **327**(7414): p. 557-60.
99. Harbord RM, Egger M, and Sterne JA, *A modified test for small-study effects in meta-analyses of controlled trials with binary endpoints*. *Stat Med*, 2006. **25**(20): p. 3443-57.
100. Egger M, Davey Smith G, Schneider M, and Minder C, *Bias in meta-analysis detected by a simple, graphical test*. *BMJ*, 1997. **315**(7109): p. 629-34.
101. Begg CB and Mazumdar M, *Operating characteristics of a rank correlation test for publication bias*. *Biometrics*, 1994. **50**(4): p. 1088-101.
102. Elbourne D, Altman D, Higgins J, Curtin F, Worthington H, and Vail A, *Meta-analyses involving cross-over trials: methodological issues*. *International Journal of Epidemiology*, 2002. **31**(1): p. 140-149.
103. Jakobsen JC, Wetterslev J, Winkel P, Lange T, and Gluud C, *Thresholds for statistical and clinical significance in systematic reviews with meta-analytic methods*. *BMC Med Res Methodol*, 2014. **14**: p. 120.
104. Hagg O, Fritzell P, and Nordwall A, *The clinical importance of changes in outcome scores after treatment for chronic low back pain*. *Eur Spine J*, 2003. **12**(1): p. 12-20.
105. Jaeschke R, Singer J, and Guyatt GH, *Measurement of health status. Ascertaining the minimal clinically important difference*. *Control Clin Trials*, 1989. **10**(4): p. 407-15.
106. Olsen MF, Bjerre E, Hansen MD, Hilden J, Landler NE, Tendal B, et al., *Pain relief that matters to patients: systematic review of empirical studies assessing the minimum clinically important difference in acute pain*. *BMC Med*, 2017. **15**(1): p. 35.
107. Olsen MF, Bjerre E, Hansen MD, Tendal B, Hilden J, and Hrobjartsson A, *Minimum clinically important differences in chronic pain vary considerably by baseline pain and methodological factors: systematic review of empirical studies*. *J Clin Epidemiol*, 2018. **101**: p. 87-106.e2.
108. Keus F, Wetterslev J, Gluud C, and van Laarhoven CJ, *Evidence at a glance: error matrix approach for overviewing available evidence*. *BMC Med Res Methodol*, 2010. **10**: p. 90.
109. DerSimonian R and Laird N, *Meta-analysis in clinical trials*. *Control Clin Trials*, 1986. **7**(3): p. 177-88.
110. DeMets DL, *Methods for combining randomized clinical trials: strengths and limitations*. *Stat Med*, 1987. **6**(3): p. 341-50.
111. Jakobsen J C, Wetterslev J, Lange T, and Gluud C, *Viewpoint: taking into account risks of random errors when analysing multiple outcomes in systematic reviews*. *Cochrane Database of Systematic Reviews*, 2016(3).

112. Wetterslev J, Thorlund K, Brok J, and Gluud C, *Trial sequential analysis may establish when firm evidence is reached in cumulative meta-analysis*. J Clin Epidemiol, 2008. **61**(1): p. 64-75.
113. Thorlund K W J, Brok J, Imberger G, Gluud C, *User manual for trial sequential analysis (TSA)*. 2011.
114. Brok J, Thorlund K, Gluud C, and Wetterslev J, *Trial sequential analysis reveals insufficient information size and potentially false positive results in many meta-analyses*. J Clin Epidemiol, 2008. **61**(8): p. 763-9.
115. Brok J, Thorlund K, Wetterslev J, and Gluud C, *Apparently conclusive meta-analyses may be inconclusive--Trial sequential analysis adjustment of random error risk due to repetitive testing of accumulating data in apparently conclusive neonatal meta-analyses*. Int J Epidemiol, 2009. **38**(1): p. 287-98.
116. Thorlund K, Devereaux PJ, Wetterslev J, Guyatt G, Ioannidis JP, Thabane L, et al., *Can trial sequential monitoring boundaries reduce spurious inferences from meta-analyses?* Int J Epidemiol, 2009. **38**(1): p. 276-86.
117. Wetterslev J, Thorlund K, Brok J, and Gluud C, *Estimating required information size by quantifying diversity in random-effects model meta-analyses*. BMC Med Res Methodol, 2009. **9**: p. 86.
118. Thorlund K, Anema A, and Mills E, *Interpreting meta-analysis according to the adequacy of sample size. An example using isoniazid chemoprophylaxis for tuberculosis in purified protein derivative negative HIV-infected individuals*. Clin Epidemiol, 2010. **2**: p. 57-66.
119. Imberger G, Gluud C, Boylan J, and Wetterslev J, *Systematic reviews of anesthesiologic interventions reported as statistically significant: problems with power, precision, and type 1 error protection*. Anesth Analg, 2015. **121**(6): p. 1611-22.
120. Imberger G, Thorlund K, Gluud C, and Wetterslev J, *False-positive findings in Cochrane meta-analyses with and without application of trial sequential analysis: an empirical review*. BMJ Open, 2016. **6**(8).
121. Guyatt G, Oxman A, Vist G, Kunz R, Falck-Ytter Y, Alonso-Coello P, et al., *GRADE: an emerging consensus on rating quality of evidence and strength of recommendations*. BMJ, 2008. **336**(7650): p. 924-926.
122. Guyatt GH, Oxman AD, Schunemann HJ, Tugwell P, and Knottnerus A, *GRADE guidelines: a new series of articles in the Journal of Clinical Epidemiology*. J Clin Epidemiol, 2011. **64**(4): p. 380-2.
123. Schunemann HJ, Best D, Vist G, and Oxman AD, *Letters, numbers, symbols and words: how to communicate grades of evidence and recommendations*. CMAJ, 2003. **169**(7): p. 677-80.
124. Voscopoulos C and Lema M, *When does acute pain become chronic?* Br J Anaesth, 2010. **105 Suppl 1**: p. i69-85.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

First author	Year of publication	Design	Type of cannabinoid	Types of participants	Information sources	No. of trials	No. of participants or interventions	Published protocol	Outcomes	Assessment of adverse events	Assessment of bias	Assessment of error	Use of the GRADE	Conclusion
Lynch & Campbell	2011	Systematic Review	Physician nabiximols; smoked cannabis; oromucosal cannabis; chronic cannabis; nabiximols; dronabinol; and a novel THC analog.	Chronic pain, fibromyalgia, rheumatoid arthritis, and mixed chronic pain.	PubMed, EMBASE, CINAHL, EBSCO, the Cochrane Library, ISI PsycInfo, Web of Science, AD Inform (Proquest), and Dissertation Abstracts (Proquest), Academic Search Premier, EBSCO, Clinical Trials.gov, TrialCentral.org, Individual pharmaceutical company trials sites for Eli Lilly and GlaxoSmithKline, Olaner (DOLC) and	3	3 comparing interventions with placebo	No	The primary outcome was pain in subjects with chronic non-cancer pain. The secondary outcomes were sleep, function, and quality of life.	Yes	Yes, except for reporting bias; publication bias and for-profit bias	No	No	Overall there is evidence that cannabinoids are safe and modestly effective in neuropathic pain with preliminary evidence of efficacy in fibromyalgia and rheumatoid arthritis. Did not pool data for meta-analysis but data was described qualitatively.
Meng et al	2017	Selective Review and Meta-analysis	Nabiximols	Chronic pain	Google Scholar, MEDLINE, Embase, PROSPERO, ClinicalTrials.gov, and Cochrane Library, ISI PsycInfo, Pain societies (American Society of Anesthesiologists, European Society of Anaesthesiology, International Association for the Study of Pain, American Society of Regional Anesthesia and Pain Medicine, European Society of Regional Anesthesia and Pain Therapy, and World Federation of Pain) in the last 2 years were also searched.	11 (10 trials comparing interventions with placebo)	1219	No	The primary outcome was intensity of pain recorded after a minimum of 2 weeks following initiation of selective nabiximols and placebo/comparator administration, expressed on an NRS (0=no pain to 10=worst possible pain). Secondary outcomes were presence or absence of analgesia defined as reduction in pain scores (NRS/VAS) by ≥30% at 2 weeks or more after initiation of intervention, quality of life (QoL), physical function, psychological function, sleep, overall patient satisfaction, and the incidence of adverse effects of selective cannabinoids.	Yes	Yes	Yes	Yes	Selective nabiximols provide a small analgesic benefit in patients with chronic neuropathic pain.
Martin-Sanchez et al	2009	Systematic Review and Meta-analysis of Cannabis Treatment for Chronic Pain	Physician nabiximols; dronabinol; or benpropyriperidine (a synthetic tetrahydrocannabinol analog of THC)	Chronic pain of a pathological or traumatic origin	Medline, Embase, and The Cochrane Controlled Trials Register (CENTRAL)	18	7	No	The primary outcome was intensity of pain as scored by numerical rating scales. The secondary outcomes were CNS related events	Yes	Yes, except for reporting bias; detection bias and for-profit bias	No	No	Currently available evidence suggests that cannabis treatment is moderately efficacious for treatment of chronic pain, but beneficial effects may be partially (or completely) offset by potentially serious harms.
Boychuk et al	2015	The Effectiveness of Cannabis in the Management of Chronic Neuropathic Pain: A Systematic Review	Physician nabiximols; cannabis-based medicinal extracts (CBME) in the form of oromucosal sprays (nabiximols), vaporized cannabis, and synthetic cannabinoids (dronabinol, nabilone, and CT-3)	Chronic pain	PubMed, Embase, Web of Science, and all evidence-based medicine reviews and databases (Cochrane Database of Systematic Reviews, ASP Journal Club, Database of Abstracts of Reviews of Effects [DARE], and Cochrane Controlled Trials Register [CCTR])	13	771	No	Outcomes considered were reduction in pain intensity and adverse events.	Yes	Yes, except for reporting bias; publication bias and for-profit bias	No	No	Cannabis-based medicinal extracts used in different populations of chronic non-malignant neuropathic pain patients may provide effective analgesia in conditions that are refractory to other treatments.
Milicki et al	2018	Cannabis products for adults with chronic neuropathic pain	Physician nabiximols; THC oromucosal spray containing THC/ CBD, oromucosal cannabis containing THC, THC and CBD; an extract of cannabis sativa L; and synthetic cannabinoids (nabilone, dronabinol)	Chronic neuropathic pain	Cochrane Library, MEDLINE and EMBASE, the following clinical trials the databases were searched for additional data including unpublished data: US National Institutes of Health clinical trial register (www.clinicaltrials.gov), European Union Clinical Trials Register (www.clinicaltrialsregister.eu), World Health Organization (WHO) and International Clinical Trials Registry Platform (ICTRP) (apps.who.int/trialsearch/), and International Association for Cannabinoid Medicines (IACM) database (www.cannabis-med.com)	16 (15 of the trials comparing interventions with placebo)	1750	Yes	Primary outcomes: Participant-reported pain relief of 50% or greater. We preferred composite neuropathic pain scores over single-scale generic pain scores if both measures were used by studies; RIGC (Patient Global Impression of Change) much or very much improved. Withdrawals due to adverse events (tolerability); Serious adverse events (safety). Serious adverse events typically include any untoward medical occurrence or effect that at any dose results in	Yes	Yes	No	Yes	The potential benefits of cannabis-based medicines (herbal cannabis, plant-derived or synthetic THC, THCCBD oromucosal spray) in chronic neuropathic pain they might be outweighed by their potential harms.
Avram et al	2017	Efficacy of Cannabis-Based Medicines for Pain Management: A Systematic Review and Meta-Analysis of Randomized Controlled Trials	Physician nabiximols; Sativex (a non-nabilone, nabilone, dronabinol, oromucosal spray); oromucosal cannabis; vaporized cannabis; and synthetic cannabinoids (dronabinol, nabilone, and CT-3); ajulemic acetate; synthetic nitrogen analog of tetrahydrocannabinol (Nabilin)	Chronic non-malignant neuropathic pain	PubMed and Medical Subject Heading (MeSH) terms in both active drug* and placebo	43	2437	No	The outcome measure that was chosen was the variable "pain intensity," as scored by the numerical rating scale (NRS-11), numerical 11-point box (0-11), visual analog scale (VAS), and the VAS section of the questionnaire short form McGill Pain Questionnaire	Yes	Yes, except for reporting bias; publication bias and for-profit bias	No	No	The current systematic review suggests that cannabis-based medicines might be effective for chronic pain treatment, based on limited evidence, primarily for neuropathic pain patients.
Campbell et al	2001	Are cannabinoids an effective and safe treatment option in the management of acute pain? A qualitative systematic review	Oral THC, synthetic cannabinoids, nitrogen of THC (Nabilin), oral benpropyriperidine (BPP), and tetrahydrocannabinol	Acute non-malignant cancer pain	MEDLINE, EMBASE, and Cochrane Library, and Cochrane Database, and the International Clinical Trials Registry Platform	9	222	No	Outcome measures for pain intensity, pain relief, the use of supplementary analgesic patients' preferences; and adverse effects.	Yes	Yes, except for reporting bias; publication bias and for-profit bias	No	No	Cannabinoids are no more effective than codeine in controlling pain and have depressant effects on the central nervous system that limit their use. The widespread introduction into clinical practice for pain management is therefore undesirable. In acute postoperative pain they should not be used.
Deshbandh et al	2015	Efficacy and adverse effects of medical marijuana for chronic noncancer pain	Cigarettes or vaporizer containing delta-9-THC	Chronic non-malignant cancer pain	MEDLINE, EMBASE, and the International Pharmaceutical Abstracts	6	226	No	For outcomes, pain scores were extracted using the visual analogue scale (VAS) or an alternative numerical pain rating tool. If pain scores were not reported, surrogate measures of effectiveness were included (sleep, function, and quality of life). Frequency of various and most commonly reported adverse effects was collected.	Yes	Yes, except for reporting bias; publication bias and for-profit bias	No	No	There is evidence for the use of low-dose medical marijuana in refractory neuropathic pain in conjunction with traditional analgesics. However, trials were limited by short duration, variability in dosing and strength of delta-9-tetrahydrocannabinol, and lack of functional outcomes. Although well tolerated in the short term, the long-term effects of psychoactive and neurocognitive effects of medical marijuana remain unknown.
Stevens et al	2017	Systematic Review of the analgesic efficacy of nabiximols in the management of acute pain	Leonatrol nabiximols; dronabinol; -9-THC	Acute postoperative pain	MEDLINE, EMBASE, Cochrane Library, and the World Health Organization, International Clinical Trials Registry Platform	7	611	Yes	The primary outcome was the qualitative analysis of the analgesic efficacy of cannabinoids in the management of acute pain compared to placebo or active comparator. The secondary outcome was the qualitative analysis of the reported adverse effects	Yes	Yes, except for reporting bias; publication bias and for-profit bias	No	Yes	Based on the available randomized controlled trial evidence, cannabinoids have no role in the management of acute pain.
Walsh et al	2016	Cannabis for fibromyalgia	Nabilone	Fibromyalgia	Cochrane Library, MEDLINE and EMBASE	2	140	Yes	Primary outcomes: Participant-reported pain relief of 50% or greater; RIGC (Patient Global Impression of Change) much or very much improved. Withdrawal due to adverse events (tolerability); Serious adverse events (safety). Serious adverse events typically include any untoward medical occurrence or effect that at any dose results in death, is life-threatening, requires hospitalization or prolongation of existing hospitalization, results in persistent or significant disability or	Yes	Yes, except for reporting bias	No	Yes	We found no convincing, unbiased, high quality evidence suggesting that nabilone is of value in treating people with fibromyalgia. The tolerability of nabilone was low in people with fibromyalgia.

Appendix

Minimal important difference

For the determination of minimal important differences in clinical trials two types of methods are available; anchor-based methods and distributional-based methods [1].

Anchor-based methods

Anchor-based methods relate the change in on a person reported outcome score, (e.g. a score on the visual analog scale (VAS)) to a subjective global assessment rating (e.g. scores from the Clinical Global Impressions-Improvement (CGI-I)) which is used as an 'anchor' [1]. Ideally, there needs to be an established association between the person reported outcome score and the 'anchor' to make any meaningful inference about a minimal important difference [2].

There are two subtypes of anchor-based methods, i.e., the '*within-patient score*' and the '*between-patients score*' [1].

- Within-patient score defines minimal important difference as the average minimal change in a given person's reported outcome score that leads to a clinically observable change in the subjective global assessment rating (the latter is used as an anchor) [1]. For example, to ascertain the minimal important difference regarding depression management, Moncrieff et. al describes the linking of within-patient scores (change from baseline) scores on the Hamilton Depression Rating Scale (the most commonly used depression rating scale) to scores on the Clinical Global Impressions-Improvement (CGI-I) scale, a scale which rates improvement on a scale of 1 (very much improved from baseline) through 4 (no change from baseline) to 7 (very much worse from baseline) [3]. Moncrieff et. al conclude that seven points on the Hamilton Depression Rating Scale correspond to a minimal important difference when using within-patient scores [3].
- The between-patients score method, also known as 'the group difference' method, compare the reported outcome scores between a group of people with no clinically observable change (based on a subjective global assessment rating (used as an anchor)) to a group of people with clinically observable change (based on a subjective global assessment rating (used as an anchor)). The minimal important difference is then estimated as the mean difference between these two groups [4]. For example, Musoro et. al defines the minimal important difference (MID) as the group difference in terms of quality of life assessed by HRQOL scores [5]. Participants were assigned to distinct subgroups reflecting various levels of change (e.g. no change, small positive changes, large positive changes, small negative changes or large negative changes). The group difference was identified by the

1
2
3
4 comparison of the average of the HRQOL scores of the group of participants with at 'small change'
5 to the HRQOL scores of the group of participants with 'no change' [5].
6
7
8

9 There are also other anchor-based methods (e.g. the sensitivity- and specificity-based method and the social
10 comparison method) [1]. The sensitivity- and specificity-based method aims to identify the minimal
11 important difference that allows for the best discrimination between groups of patients (i.e., the score that
12 produces the greatest sensitivity and specificity) [1]. For example, an outcome measure (e.g. NRS score) is
13 considered a 'diagnostic test' and the anchor (e.g. Global Perceived Effect) is used as gold standard and hence
14 standard methods may be used to estimate sensitivity and specificity. Sensitivity is the proportion of patients
15 who report an improvement on the external criterion (anchor) and whose person reported outcome scores
16 are above the threshold minimal important difference value [1]. Specificity is the proportion of patients who
17 do not report an improvement on the external criterion (anchor) and whose person reported outcome scores
18 are below the threshold minimal important difference value [1]. Receiver operating characteristic (ROC)
19 curves are then used to identify the person reported outcome score with the greatest sensitivity and
20 specificity [6-8].
21
22
23
24
25
26
27
28
29
30

31 *The distributional-based methods*

32 Distribution-based methods are based on the statistical characteristics of the obtained sample [9]. Crosby et.
33 al [9] have identified two general types of distribution-based methods for estimations of minimal important
34 differences:
35
36

- 37 • The first type of distribution-based method evaluate change in relation to sample variation [9].
38 Different types of variation can be used: effect size, standardised response mean, and
39 responsiveness statistic [9]. The effect size represents individual change in relation to the number of
40 pre-test standard deviations (SDs) [9]. Cohen et. al has suggested benchmarks to better interpret the
41 effect sizes: .20 for "small" effects, .50 for "moderate" effects, and .80 for "large" effects [10].
42 Whereas the effect size is the ratio of individual change to the baseline standard deviation of the
43 sample, standardised response mean is the ratio of individual change to the standard deviation of
44 that change [11]. A large standardised response mean indicates that the change is large in
45 comparison to the background variability in the measurements [9]. Guyatt et. al has proposed a
46 responsiveness statistic as a variation of standardised response mean; calculated by dividing the
47 difference between pre-test and post-test by the standard deviation of change observed for a group
48 of stable participants [12].
49
50
51
52
53
54
55
56
57
58
59
60

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
- The second type distribution-based method is based on the measurement precision of the instrument [9]. This method include the standard error of the mean (SEM) and evaluate the change in relation to variation of the instrument as opposed to variation in the sample [9]. Standard error of the mean (SEM) is a measure of the precision of a test instrument and considered an attribute of the measure and not a characteristic of the sample per se [13]. The standard error of the mean (SEM) for a given measure is likely to vary across samples depending upon the method used to estimate reliability and the presence of extreme scores [9]. Different thresholds for a minimal important difference have been suggested, i.e., values of 1 SEM [14], 1.96 SEM [15], and 2.77 SEM [13, 15].

19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38

In conclusion, different methods for estimating minimal important differences exist, but no single method has been shown to be the optimal method. The question of whether to use anchor-based or distribution-based methods for determining clinically meaningful change has received considerable attention and debate [9]. Dworkin et. al defined the clinical importance of patient improvement as the clinically important changes in individuals that can be identified using either within-patient anchor-based method or distributional-based method [16, 17], while the clinical importance of group differences could be the clinical difference between a treatment group and a placebo group or between two different treatment groups [18]. Dworkin et. al claim that the clinical important difference identified in individuals cannot be directly extrapolated to the evaluation of group differences [17, 19-22]. The U.S. Food and Drug Administration also states in their web site “When defining meaningful change on an individual patient basis, that definition is generally larger than the minimum important difference for application to group mean comparisons” [22].

39
40
41
42
43
44
45

While it is claimed that the within-patient differences are larger the between-group difference [22], based on the studies included in our review we are not able to find a significant difference between the minimal important difference estimated by the two different methods.

46 47

Previously conducted reviews on this subject

- 48
49
50
51
52
53
54
55
56
57
58
59
60
- Lynch & Campbell and Boychuk et. al both concluded that cannabinoids are a modestly effective and a safe treatment option for neuropathic pain [23, 24]. Lynch & Campbell and Boychuk et. al did not publish a protocol on beforehand [23, 24].
 - Meng et. al concluded that there is moderate quality evidence to suggest that nabiximols (phytocannabinoid mixture) is effective in reducing neuropathic pain [25].

- Mücke et. al concluded that there is no high-quality evidence for the efficacy of any cannabis-based medicine in any condition with chronic neuropathic pain [26]. Mücke et. al further concluded that some adverse events may limit the clinical usefulness of cannabis-based medicines [26].
- Deshpande et. al concluded that current evidence suggests that very low-dose medical marijuana (< 34 mg/d) is associated with an improvement in refractory neuropathic pain of moderate severity in adults using concurrent analgesics. Deshpande et. al did not publish a protocol on beforehand [27].
- Martín-Sánchez et. al concluded that treatment of chronic pain based on cannabinoid compounds would entail more risk of adverse events than benefit [28]. Martín-Sánchez et. al included trials randomising participants with either neuropathic pain, cancer pain, fibromyalgia related pain and nociceptive pain [28]. Martín-Sánchez et. al did not publish a protocol on beforehand [28].
- Aviram et. al concluded that cannabinoid-based medicines were not effective for postoperative pain, however further investigation is advised [29]. Aviram et. al also concluded that evidence suggests a moderate to good treatment effect on neuropathic pain [29]. Furthermore, neuropathic pain patients should be advised that the inhalation of cannabinoids showed relatively better pain reduction effects than other routes of administration [29]. Aviram et. al stated that the total number of adverse events that were accumulated in the meta-analysis indicated that cannabinoid-based medicines should be used with caution [29]. Aviram et. al did not publish a protocol on beforehand [29].
- Campbell et. al concluded that levonantradol (synthetic cannabinoid analogue) was superior to placebo on postoperative pain but no more effective than codeine [30]. Campbell et. al also stated that there are suggestions of efficacy in spasticity and in neuropathic pain and that increasing the cannabinoid dose to increase the analgesia will increase adverse effects [30]. Campbell et. al did not publish a protocol on beforehand [30].
- Stevens et. al concluded that cannabinoids have no role in the management of acute pain, but cannabinoids were found to be well-tolerated, with most reported adverse effects only mild to moderate in severity [31].
- Walitt et. al concluded that no convincing, unbiased evidence suggests that nabilone (synthetic cannabinoid analog) is of value in treating people with fibromyalgia [32]. The tolerability of nabilone was low and adverse events (particularly somnolence, dizziness, vertigo) may limit its clinical usefulness [32].

TABEL 1

First author	Title	Year of publication	Design	Type of cannabinoid	Types of participants	Information sources	No. of trials	No. of participants	Published protocol	Outcomes	Assessment of adverse events	Assessment of risk of bias	Accounts for random error	Use of the GRADE	Conclusion
Lynch & Campbell [23]	Cannabinoids for treatment of chronic non-cancer pain; a systematic review of random	2011	Systematic Review	Phytocannabinoids ; Smoked cannabis, oromucosal extracts of cannabis-based medicine, and synthetic cannabinoids ; nabilone, dronabin	Neuropathic pain, fibromyalgia, rheumatoid arthritis, and mixed chronic pain.	PubMed, EMBASE, CINAHL (EBSCO), PsycInfo (EBSCO), The Cochrane Library, ISI Web of Science, ABI Inquest, Dissertation Abstracts (Proquest), Academic Search	18	766	No	The primary outcome was pain in subjects with chronic non-cancer pain. The secondary outcomes were sleep, function, and quality of life.	Yes	Yes, except for reporting bias, publication bias and for-profit bias	No	No	Overall there is evidence that cannabinoids are safe and modestly effective in neuropathic pain with preliminary evidence of efficacy

	mi ze d tria ls			ol and a nove l THC anal ogue .		Premie r (EBSCO) Clinical Trials.g ov, TrialsC entral. org, individ ual pharm aceutic al compa ny trials sites for Eli Lilly and GlaxoS mithKli ne, OAlste r (OCLC) and Google Scholar .									in fibro myal gia and rheu mato id arthr itis. Did not pool data for meta - analy sis but data was descr ibed quali tativ ely.
Me ng et. al [25]	Sel ect ive Cann abino ids for Chro	20 17	Sys tema tic Re vie w and Meta-	Dron abin ol, nabil one and nabi ximo ls	Ne urop athic pai n	Medlin e, Embas e, Cochra ne Library , PROSP ERO, clinical	11 (1 0 trials com pa rin g th	12 19	N o	The primar y outco me was intensi ty of pain record ed	Ye s	Ye s	Bon ferr oni adju stm ent for multi ple testi	Y e s	Selec tive cann abin oids provi de a small analgesic bene

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

	nic Ne ur op ath ic Pai n: A Sys te ma tic Re vie w an d Me ta- an aly sis		an aly sis			trials.g ov, and Google Scholar . Pain societi es (Ameri can Society of Anesth esiolog ists, Europe an Society of Anaest hesiolo gy, Internat ional Associ ation for the Study of Pain, Americ an Society of Region al Anesth esia and Pain Medici ne, Europe an	e int er ve nti on wi th pla ce bo)			after a minim um of 2 weeks followi ng initiati on of selecti ve cannab inoid and placeb o/com parato r admini stratio n, expres sed on an NRS (0—no pain to 10— worst possibl e pain). Second ary outco mes were presen ce or absenc e of analge sia define d as			ng was not perf orm ed as per rec om me nda tion s in the Coc hra ne Han dbo ok.		fit in patie nts with chro nic neur opat hic pain.
--	--	--	------------------	--	--	---	---	--	--	--	--	--	--	--	---

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

						Society of Regional Anesthesia and Pain Therapy, and World Institute of Pain) in the last 2 years were also searched.				reduction in pain scores (NRS/VAS) by $\geq 30\%$ at 2 weeks or more after initiation of intervention, quality of life (QoL), physical function, psychological function, sleep, overall patient satisfaction, and the incidence of adverse effects of selective cannabinoids.				
--	--	--	--	--	--	---	--	--	--	---	--	--	--	--

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60	Martín-Sánchez et. al [28]	Systematic Review and Meta-analysis of Cannabinoids Treatment for Chronic Pain	2009	Meta-analysis	Phytocannabinoids and synthetic derivatives of THC, such as dronabinol, nabilone, or benzopyranoperidine (a synthetic nitrogen analog of THC)	Chronic pain of a pathological or traumatic origin	Medline/Pubmed, Embase, and The Cochrane Controlled Trials Register (CENTRAL)	18	?	No	The primary outcome was intensity of pain as scored by numerical rating scales. The Secondary outcomes were CNS related events	Yes	Yes, except for reporting bias, detection bias and for-profit bias	No	No	Currently available evidence suggests that cannabis treatment is moderately efficacious for treatment of chronic pain, but beneficial effects may be partially (or completely) offset by potentially serious
---	----------------------------	--	------	---------------	--	--	---	----	---	----	--	-----	--	----	----	--

															us harm s.	
8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60	Boy chu k et. al [24]	Th e Eff ect ive ness of Cann abi noids in the Man age ment of Chro nic Non mali gnant Neur opath ic Pain: A Syste matic Re	20 15	Sys tema tic Re vie w	Phyt ocan nabi noid s ; smoked cann abis, cann abis- base d medi cinal extra cts (CB ME) in the form of oro muc osal spra ys (nabi ximo ls), vapo rized cann abis, and synt hetic cann abin oids ; dron	Ne ur opath ic pain	PubMe d, Embas e, Web of Scienc e, and all eviden ce- based medici ne review s and databa ses (Cochr ane Databa se of System atic Review s, ASP Journal Club, Databa se of Abstra cts of Review s of Effects [DARE] , and Cochra ne Contro lled	13	77 1	N o	Outco mes consid ered were reducti on in pain intensi ty and advers e events.	Ye s	Ye s, exce pt for, re porti ng bias, publi cations bias and for- profi t bias	No	N o	Cann abis- base d medi cinal extra cts used in diffe rent popu lations of chro nic non- mali gnant neur opath ic pain patie nts may provi de effec tive analge sia in condi tions that are refra ctory

	view			abinol, nabiximols, and CT-3		Trials Register [CCTR])									to other treatments.
Mücke et al [26]	Cannabis products for adults with chronic neuropathic pain	2018	Cochrane Review	Phytocannabinoids ; oromucosal spray containing THC or THC/CBD mix, smoked cannabis containing THC, THC and CBD as extract of cannabis sativa L., and synt	Neuropathic pain	Cochrane Library, MEDLINE and EMBASE. Following clinical trials databases were searched for additional data including unpublished data: US National Institutes of Health clinical trial register (www.ClinicalTrials.gov)	16 (15 of the trials compared)	1750	Yes	Primary outcomes: Participant-reported pain relief of 50% or greater. We preferred composite neuropathic pain scores over single-scale generic pain scores if both measures were used by studies;	Yes	Yes	No	Yes	The potential benefits of cannabis-based medicine (herbal cannabis, plant-derived or synthetic THC, THC/CBD oromucosal spray) in chronic neuropathic pain might be

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

				<p>hetic cann abin oids; nabil one, dron abin ol</p>	<p>Trials.g ov), Europe an Union Clinical Trials Registe r (www. clinical trialsre gister. eu), World Health Organi zation (WHO) Interna tional Clinical Trials Registr y Platfor m (ICTRP) (apps. who.in t/trials earch/) , and Interna tional Associ ation for Canna binoid Medici nes (IACM) databa nk</p>			<p>PGIC (Patien t Global Impres sion of Chang e) much or very much improv ed;</p> <p>Withdr awals due to advers e events (tolera bility);</p> <p>Seriou s advers e events (safety). Seriou s advers e events typicall y include any untow ard medica l occurr ence</p>			<p>outw eigh ed by their pote ntial harm s.</p>
--	--	--	--	---	--	--	--	---	--	--	---

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

						<p>(www.cannabis-med.org/studies/study.php)</p>				<p>or effect that at any dose results in death, is life-threatening, requires hospitalisation or prolongation of existing hospitalisation, results in persistent or significant disability or incapacity, is a congenital anomaly or birth defect, is an 'important medical</p>				
--	--	--	--	--	--	---	--	--	--	---	--	--	--	--

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

	ment: A Systematic Review and Meta-Analysis of Randomized Controlled Trials		and synthetic cannabinoids ; dronabinol and nabilone, CT-3, ajulemic acid, synthetic nitrogen analog of tetrahydrocannabinol (NIB), fatty acid amide hydrolase-1 (FAAH1) inhibitor (PF-04457845) (bloc	perative pain		drug and placebo		numerical 11-point box (BS-11), visual analog scale (VAS), and the VAS section of the questionnaire short form McGill Pain Questionnaire.		d for-profit bias		tive for chronic pain treatment, based on limited evidence, primarily for neuropathic pain patients.
--	---	--	---	---------------	--	------------------	--	---	--	-------------------	--	--

				king degr adati on of endo cann abin oids) , benz opyr anop eridi ne (BPP) , and levo nant radol											
Ca mp bell et. al [30]	Ar e cann abin oids an effe ctive and safe treat ment option in the mana	20 01	Sys tema tic Re vie w	Oral THC, an oral synt hetic nitro gen anal ogue of THC (NIB) , oral benz opyr anop eridi ne (BPP) , and intra mus cular	Ac ute , chr oni c non- ma lig na nt pai n, and canc er pai n	MEDLI NE, EMBAS E, Oxford Pain Databa se, and Cochra ne Library	9	22 2	No	Outco me measu res for pain intensi ty; pain relief; the use of supple menta ry analge sia; patient s' prefer ences; and advers e effects .	Yes	Yes, ex cept for, re po rti ng bi as, pu bli ca tio n bi as and for- pr	No	No	Cann abin oids are no more effec tive than code ine in contr ollin g pain and have depr essa nt effec ts on the centr

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

	gement of pain? A qualitative systematic review			levonantadol								ofit bias			al nervous system that limit their use. Their widespread introduction into clinical practice for pain management is therefore undesirable. In acute postoperative pain they should not be used.
Des hpa	Effi cac	20 15	Sys te	Cigar ettes	Ne ur	MEDLI NE,	6 tri	22 6	N o	For outco	Ye s	Ye s,	No	N o	Ther e is

nd e et. al [27]	y an d ad ver se eff ect s of me dic al mari ju an a for chro nic non can cer pai n		ma tic Re vie w	or vapo rizer cont ainin g delta -9- THC	op ath ic pai n	EMBAS E, and the Intern ational Pharm aceutic al Abstra cts	als co m pa rin g int er ve nti on wi th pla ce bo . Pla ce bo bei ng cigar ett es or va po riz er co nt ain ing 0% del ta- 9- TH C or wi th ca			mes, pain scores were extract ed using the visual analog ue scale (VAS) or an alterna tive numeri cal pain rating tool. If pain scores were not report ed, surrog ate measu res of effecti veness were include d (sleep, functio n, and quality of life). Freque ncy of serious and		ex ce pt fo r, re po rti ng bi as, pu bli ca tio n bi as and for pro fit bi as		evid ence for the use of low- dose medi cal mari juana in refra ctory neur opat hic pain in conj uncti on with tradi tiona l anal gesics. How ever, trials were limit ed by short dura tion, varia bility in dosi ng and
----------------------------------	---	--	-----------------------------	--	-----------------------------	--	---	--	--	---	--	---	--	--

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

							nn abi no id re m ov al		most comm only report ed advers e effects was collect ed.					stren gth of delta -9- tetra hydr ocan nabi nol, and lack of funct ional outc ome s. Altho ugh well toler ated in the short term , the long- term effec ts of psyc hoac tive and neur ocog nitiv e effec ts of medi cal marij
--	--	--	--	--	--	--	--	--	---	--	--	--	--	---

															una rema in unkn own.
11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60	Steven et. al [31]	20 17	Systematic Review	Levonant radol , nabilone, AZD 1940 , GW8 4216 6, dronabinol, Δ-9-T HC	Acute postope rative pain	MEDLINE, EMBASE, Cochrane Library , and the World Health Organization International Clinical Trials Registry Platform	7 trials comparing interve ntion with placebo , Ketoprofen , Pethidine , Naproxen , and Ibuprofen	61 1	Yes	The primary outcome was the qualitative analysis of the analgesic efficacy of cannabinoids in the management of acute pain compared to placebo or active comparator. The secondary outcome was the qualitative	Yes	Yes, except for, publication bias and for- profit bias	No	Yes	Based on the available randomized controlled trial evidence, cannabinoids have no role in the management of acute pain.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

							rof en			analysi s of the report ed advers e effects .					
W a l l i t t e t . a l [3 2]	C a n n a b i n o i d s f o r f i b r o m y a l g i a	2 0 1 6	C o c h r a n e R e v i e w	N a b i l o n e	F i b r o m y a l g i a	C o c h r a n e L i b r a r y , M E D L I N E a n d E M B A S E	2 t r i a l s c o m p a r i n g t h e i n t e r v e n t i o n w i t h e i t h e r (1) p l a c e b o r (1) a m i t r i p t y l i n e	7 2 (4 0)	Y e s	P r i m a r y o u t c o m e s : P a r t i c i p a n t - r e p o r t e d p a i n r e l i e f o f 5 0 % o r g r e a t e r . P G I C (P a t i e n t G l o b a l I m p r e s s i o n o f C h a n g e) m u c h o r v e r y m u c h i m p r o v e d . W i t h d r a w a l d u e t o a d v e r s e e v e n t s	Y e s	Y e s , e x c e p t f o r p u b l i c a t i o n b i a s .	N o	Y e s	W e f o u n d n o c o n v i n c i n g , u n b i a s e d , h i g h q u a l i t y e v i d e n c e s u g g e s t i n g t h a t n a b i l o n e i s o f v a l u e i n t r e a t i n g p e o p l e w i t h f i b r o m y a l g i a . T h e t o l e r a b i l i t y o f n a b i l o n e

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

										<p>existing hospitalisation, results in persistent or significant disability or incapacity, is a congenital anomaly or birth defect, is an 'important medical event' that may jeopardise the person, or may require an intervention to prevent one of the above</p>					
--	--	--	--	--	--	--	--	--	--	---	--	--	--	--	--

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

										charac teristic s/cons equen ces.									
--	--	--	--	--	--	--	--	--	--	---	--	--	--	--	--	--	--	--	--

References

1. Copay AG, Subach BR, Glassman SD, Polly DW, and Schuler TC, *Understanding the minimum clinically important difference: a review of concepts and methods*. Spine J, 2007. **7**(5): p. 541-6.
2. Guyatt GH, Osoba D, Wu AW, Wyrwich KW, and Norman GR, *Methods to Explain the Clinical Significance of Health Status Measures*. Mayo Clinic Proceedings, 2002. **77**(4): p. 371-383.
3. Moncrieff J and Kirsch I, *Empirically derived criteria cast doubt on the clinical significance of antidepressant-placebo differences*. Contemp Clin Trials, 2015. **43**: p. 60-2.
4. Hagg O, Fritzell P, and Nordwall A, *The clinical importance of changes in outcome scores after treatment for chronic low back pain*. Eur Spine J, 2003. **12**(1): p. 12-20.
5. Musoro ZJ, Hamel J, Ediebah DE, Cocks K, King MT, Groenvold M, et al., *Establishing anchor-based minimally important differences (MID) with the EORTC quality-of-life measures: a meta-analysis protocol*. BMJ Open, 2018. **8**(1).
6. Stratford PW, Binkley JM, Riddle DL, and Guyatt GH, *Sensitivity to change of the Roland-Morris Back Pain Questionnaire: part 1*. Phys Ther, 1998. **78**(11): p. 1186-96.
7. Riddle DL, Stratford PW, and Binkley JM, *Sensitivity to change of the Roland-Morris Back Pain Questionnaire: part 2*. Phys Ther, 1998. **78**(11): p. 1197-207.
8. Van der Roer N, Ostelo RW, Bekkering GE, van Tulder MW, and de Vet HC, *Minimal clinically important change for pain intensity, functional status, and general health status in patients with nonspecific low back pain*. Spine (Phila Pa 1976), 2006. **31**(5): p. 578-82.
9. Crosby RD, Kolotkin RL, and Williams GR, *Defining clinically meaningful change in health-related quality of life*. J Clin Epidemiol, 2003. **56**(5): p. 395-407.
10. Cohen J, *CHAPTER 1 - The Concepts of Power Analysis*, in *Statistical Power Analysis for the Behavioral Sciences*, Cohen J, Editor. 1977, Academic Press. p. 1-17.
11. Fayers PM and Machin D, *Quality of life: assessment, analysis and interpretation*. John Wiley & Sons, 2000.
12. Guyatt GH, Bombardier C, and Tugwell PX, *Measuring disease-specific quality of life in clinical trials*. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne, 1986. **134**(8): p. 889-895.
13. Wyrwich KW, Tierney WM, and Wolinsky FD, *Further evidence supporting an SEM-based criterion for identifying meaningful intra-individual changes in health-related quality of life*. J Clin Epidemiol, 1999. **52**(9): p. 861-73.
14. Wolinsky FD, Wan GJ, and Tierney WM, *Changes in the SF-36 in 12 months in a clinical sample of disadvantaged older adults*. Med Care, 1998. **36**(11): p. 1589-98.
15. McHorney CA and Tarlov AR, *Individual-patient monitoring in clinical practice: are available health status surveys adequate?* Qual Life Res, 1995. **4**(4): p. 293-307.

- 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10
 - 11
 - 12
 - 13
 - 14
 - 15
 - 16
 - 17
 - 18
 - 19
 - 20
 - 21
 - 22
 - 23
 - 24
 - 25
 - 26
 - 27
 - 28
 - 29
 - 30
 - 31
 - 32
 - 33
 - 34
 - 35
 - 36
 - 37
 - 38
 - 39
 - 40
 - 41
 - 42
 - 43
 - 44
 - 45
 - 46
 - 47
 - 48
 - 49
 - 50
 - 51
 - 52
 - 53
 - 54
 - 55
 - 56
 - 57
 - 58
 - 59
 - 60
16. Lydick E and Epstein RS, *Interpretation of quality of life changes*. Qual Life Res, 1993. **2**(3): p. 221-6.
17. Beaton DE, Bombardier C, Katz JN, Wright JG, Wells G, Boers M, et al., *Looking for important change/differences in studies of responsiveness. OMERACT MCID Working Group. Outcome Measures in Rheumatology. Minimal Clinically Important Difference*. J Rheumatol, 2001. **28**(2): p. 400-5.
18. Dworkin RH, Turk DC, McDermott MP, Peirce-Sandner S, Burke LB, Cowan P, et al., *Interpreting the clinical importance of group differences in chronic pain clinical trials: IMMPACT recommendations*. Pain, 2009. **146**(3): p. 238-44.
19. Cella D, Bullinger M, Scott C, and Barofsky I, *Group vs individual approaches to understanding the clinical significance of differences or changes in quality of life*. Mayo Clin Proc, 2002. **77**(4): p. 384-92.
20. Guyatt GH, *Making sense of quality-of-life data*. Med Care, 2000. **38**(9 Suppl): p. li175-9.
21. Testa MA, *Interpretation of quality-of-life outcomes: issues that affect magnitude and meaning*. Med Care, 2000. **38**(9 Suppl): p. li166-74.
22. U.S. Department of Health Human Services FDA Center for Drug Evaluation Research, U.S. Department of Health Human Services FDA Center for Biologics Evaluation Research, U.S. Department of Health Human Services FDA Center for Devices Radiological Health, *Guidance for industry: patient-reported outcome measures: use in medical product development to support labeling claims: draft guidance*. 2006. **4**: p. 79.
23. Lynch M E and Campbell F, *Cannabinoids for treatment of chronic non-cancer pain; a systematic review of randomized trials*. Br J Clin Pharmacol, 2011. **72**(5): p. 735-44.
24. Boychuk D G, Goddard G, Mauro G, and Orellana M F, *The effectiveness of cannabinoids in the management of chronic nonmalignant neuropathic pain: a systematic review*. J Oral Facial Pain Headache, 2015. **29**(1): p. 7-14.
25. Meng H, Johnston B, Englesakis M, Moulin D E, and Bhatia A, *Selective Cannabinoids for Chronic Neuropathic Pain: A Systematic Review and Meta-analysis*. Anesth Analg, 2017. **125**(5): p. 1638-1652.
26. Mücke M, Phillips T, Radbruch L, Petzke F, and Häuser W, *Cannabis-based medicines for chronic neuropathic pain in adults*. Cochrane Database of Systematic Reviews, 2018(3).
27. Deshpande A, Mailis-Gagnon A, Zoheiry N, and Lakha S F, *Efficacy and adverse effects of medical marijuana for chronic noncancer pain: Systematic review of randomized controlled trials*. Can Fam Physician, 2015. **61**(8): p. e372-81.
28. Martin-Sanchez E, Furukawa T A, Taylor J, and Martin J L, *Systematic review and meta-analysis of cannabis treatment for chronic pain*. Pain Med, 2009. **10**(8): p. 1353-68.
29. Aviram J and Samuelly-Leichtag G, *Efficacy of Cannabis-Based Medicines for Pain Management: A Systematic Review and Meta-Analysis of Randomized Controlled Trials*. Pain Physician, 2017. **20**(6): p. E755-e796.
30. Campbell F A, Tramèr M R, Carroll D, Reynolds D J M, Moore R A, and McQuay H J, *Are cannabinoids an effective and safe treatment option in the management of pain? A qualitative systematic review*. Bmj, 2001. **323**(7303): p. 13.
31. Stevens A J and Higgins M D, *A systematic review of the analgesic efficacy of cannabinoid medications in the management of acute pain*. Acta Anaesthesiol Scand, 2017. **61**(3): p. 268-280.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

32. Walitt B, Klose P, Fitzcharles M A, Phillips T, and Hauser W, *Cannabinoids for fibromyalgia*. Cochrane Database Syst Rev, 2016. **7**: p. Cd011694.

For peer review only

PRISMA-P (Preferred Reporting Items for Systematic review and Meta-Analysis Protocols) 2015 checklist: recommended items to address in a systematic review protocol*

Section and topic	Item No	Checklist item	(Page No.#)
ADMINISTRATIVE INFORMATION			
Title:			
Identification	1a	Identify the report as a protocol of a systematic review	1
Update	1b	If the protocol is for an update of a previous systematic review, identify as such	
Registration	2	If registered, provide the name of the registry (such as PROSPERO) and registration number	
Authors:			
Contact	3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author	1
Contributions	3b	Describe contributions of protocol authors and identify the guarantor of the review	25-26
Amendments	4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments	
Support:			
Sources	5a	Indicate sources of financial or other support for the review	25
Sponsor	5b	Provide name for the review funder and/or sponsor	
Role of sponsor or funder	5c	Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol	
INTRODUCTION			
Rationale	6	Describe the rationale for the review in the context of what is already known	3-9
Objectives	7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)	9
METHODS			
Eligibility criteria	8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review	10-12
Information sources	9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage	12-13
Search strategy	10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated	

Study records:			
Data management	11a	Describe the mechanism(s) that will be used to manage records and data throughout the review	13-14
Selection process	11b	State the process that will be used for selecting studies (such as two independent reviewers) through each phase of the review (that is, screening, eligibility and inclusion in meta-analysis)	13
Data collection process	11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators	13-14
Data items	12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications	14
Outcomes and prioritization	13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale	11-12
Risk of bias in individual studies	14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis	15-17
Data synthesis	15a	Describe criteria under which study data will be quantitatively synthesised	16
	15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I ² , Kendall's τ)	19-21
	15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)	22-23
	15d	If quantitative synthesis is not appropriate, describe the type of summary planned	21
Meta-bias(es)	16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)	17
Confidence in cumulative evidence	17	Describe how the strength of the body of evidence will be assessed (such as GRADE)	21

*** It is strongly recommended that this checklist be read in conjunction with the PRISMA-P Explanation and Elaboration (cite when available) for important clarification on the items. Amendments to a review protocol should be tracked and dated. The copyright for PRISMA-P (including checklist) is held by the PRISMA-P Group and is distributed under a Creative Commons Attribution Licence 4.0.**

From: Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart L, PRISMA-P Group. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and explanation. BMJ. 2015 Jan 2;349(jan02 1):g7647.

**Search strategies for
'Cannabinoids versus placebo for pain'
(J Barakji)**

Preliminary searches performed 1 July 2019

Total number of records identified	4106 records
Number of duplicates removed	1079 records
Number of records in final list	3027 records

The Cochrane Central Register of Controlled Trials (CENTRAL) in the Cochrane Library (2019, Issue 6) (961 hits)

- #1 MeSH descriptor: [Cannabis] explode all trees
- #2 MeSH descriptor: [Cannabinoids] explode all trees
- #3 (cannabi* or mari*uana or nabixmol* or dronabinol* or marinol* or nabilon* or cesamet* or hash* or hemp* or levonantradol* or anandamid*)
- #4 #1 or #2 or #3
- #5 MeSH descriptor: [Pain] explode all trees
- #6 (pain* or ache* or migraine*)
- #7 #5 or #6
- #8 #4 and #7

MEDLINE Ovid (1946 to July 2019) (465 hits)

- 1. exp Cannabis/
- 2. exp Cannabinoids/
- 3. (cannabi* or mari*uana or nabixmol* or dronabinol* or marinol* or nabilon* or cesamet* or hash* or hemp* or levonantradol* or anandamid* or 2-AG).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 4. 1 or 2 or 3
- 5. exp Pain/
- 6. (pain* or ache* or migraine*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 7. 5 or 6
- 8. 4 and 7
- 9. (random* or blind* or placebo* or meta-analys*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 10. 8 and 9

Embase Ovid (1974 to July 2019) (1829 hits)

- 1. exp cannabis/
- 2. exp cannabinoid/
- 3. (cannabi* or mari*uana or nabixmol* or dronabinol* or marinol* or nabilon* or cesamet* or hash* or hemp* or levonantradol* or anandamid* or 2-AG).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word, candidate term word]
- 4. 1 or 2 or 3
- 5. exp pain/
- 6. (pain* or ache* or migraine*).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word, candidate term word]
- 7. 5 or 6
- 8. 4 and 7
- 9. (random* or blind* or placebo* or meta-analys*).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word, candidate term word]
- 10. 8 and 9

LILACS (Bireme; 1982 to July 2019) (51 hits)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

(cannabi\$ or mari\$uana or nabixmol\$ or dronabinol\$ or marinol\$ or nabilon\$ or cesamet\$ or hash\$ or hemp\$ or levonantradol\$ or anandamid\$ or 2-AG) [Words] and (pain\$ or ache\$ or migraine\$) [Words]

Science Citation Index Expanded (1900 to July 2019) and Conference Proceedings Citation Index – Science (1990 to July 2019) (Web of Science) (623 hits)

#5 #4 AND #3

#4 TS=(random* or blind* or placebo* or meta-analys*)

#3 #2 AND #1

#2 TS=(pain* or ache* or migraine*)

#1 TS=(cannabi* or mari*uana or nabixmol* or dronabinol* or marinol* or nabilon* or cesamet* or hash* or hemp* or levonantradol* or anandamid* or 2-AG)

Biosis (1969 to July 2019; Web of Science) (177 hits)

#5 #4 AND #3

#4 TS=(random* or blind* or placebo* or meta-analys*)

#3 #2 AND #1

#2 TS=(pain* or ache* or migraine*)

#1 TS=(cannabi* or mari*uana or nabixmol* or dronabinol* or marinol* or nabilon* or cesamet* or hash* or hemp* or levonantradol* or anandamid* or 2-AG)