## Bijlage 7 Evidence tabellen

Evidence tabellen behorende bij de oorspronkelijke uitgangsvragen die in deze richtlijn via de GRADE methodiek zijn uitgewerkt.

# Uitgangsvraag COPD/hartfalen – oefentherapie

**Uitgangsvraag:**
Wat zijn de ongewenste en gewenste effecten van oefentherapie in vergelijking met control voor patiënten met pijn en COPD of hartfalen?

**Patiëntengroep**: Patiënten met pijn en COPD / hartfalen
**Intervention**: Oefentherapie
**Comparison**: Geen oefentherapie
**Outcome**: Pijn en kwaliteit van leven.

## Primary studies

| I Study ID | II Method | III Patient characteristics | IV Intervention(s) | V Results | VII Critical appraisal of study quality | GRADE assessment |
|---|---|---|---|---|---|---|
| • **Nolte** et al. (2015) | • RCT<br>• Conflicts of interest reported and none known.<br>• No details about the setting reported.<br>• Sample size: 64<br>• Follow-up: 3 months<br>• No protocol existence reported. | • **Eligibility criteria:** Symptomatic (New York Heart Association, NYHA, functional class II/III) but stable patients (>45 years) were included if they had a preserved left ventricular ejection fraction (LVEF ≥50%), echocardiographically determined diastolic dysfunction (grade I or above), sinus rhythm, and one or more of the following cardiovascular risk factors: overweight, diabetes mellitus, hypertension, hyperlipidaemia, and smoking.<br><br>• **Patient characteristics:**<br>• Age: 65 years (SD: 7).<br>• Sex: 56% female | • Usual care and exercise training<br><br>versus<br><br>• Usual care | **Pain** (reported as bodily pain with the SF-36 after three months):<br>• Intervention: 73 (SD: 29)<br>• Control: 66 (SD: 29)<br>• MD: 7.00 (95%-CI: -15.5 to 19.54)*<br><br>**Quality of Life** (reported as mental component score with the SF-36 after three months):<br>• Intervention: 51 (SD: 11)<br>• Control: 56 (SD:7)<br>• MD: -5.00 (95%-CI: -10.7 to -1.3)* | • Unclear risk of bias due to no description of randomisation, allocation concealment, blinding, selective outcome reporting and incomplete outcome data. | • Low quality of evidence due to risk of bias and imprecision. |
| • **Piotrowicz** et al. (2015) | • RCT<br>• Conflicts of interest reported and none known. | • **Eligibility criteria:** We included patients of either sex with any aetiology of left ventricular systolic HF (as defined in the ESC | • home-based telemonitored cardiac rehabilitation<br>versus | **Pain** (reported as bodily pain with the SF-36 after 8 weeks):<br>• Intervention: 2.00 (SD: 2.07)<br>• Control: 2.66 (SD: 2.22)<br>• MD: -0.66 (95%-CI: -1.40 to 0.08)* | • Unclear risk of bias due to no description of randomisation, allocation | • Low quality of evidence due to risk of bias and imprecision. |

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| | • Setting: Department of Cardiac Rehabilitation and Nonivasive Electrocardiology, Institute of Cardiology, Warswa, Poland<br>• Sample size: 152<br>• Follow-up: 8 weeks<br>• No protocol existence reported. | guidelines) diagnosed for three months and patients with left ventricular ejection fraction <40% on echocardiography, in class II or III according to the New York Heart Association (NYHA). Additionally, the study embraced patients who were clinically stable and receiving an optimal and stable medication regimen for at least four weeks before enrolment and finally those who were able to exercise using the new model of HTCR<br><br>• **Patient characteristics:**<br>• Age categories. Intervention: 60.5 (SD: 8.8), control: 56.4 (SD: 10.9)<br>• Sex categories: male, intervention: 95%, control: 85% | • outpatient-based standard cardiac rehabilitation | **Quality of Life** (reported as total score of the SF-36 after 8 weeks):<br>• Intervention: 69.2 (SD: 26.4)<br>• Control: 70.5 (SD:25.4)<br>• MD: -1.30 (95%-CI: -10.29 to 7.69)* | concealment, blinding, selective outcome reporting and incomplete outcome data. | |

* self-calculated

**Referenties**

[1] Nolte K, Herrmann-Lingen C, Wachter R, et al. Effects of exercise training on different quality of life dimensions in heart failure with preserved ejection fraction: the Ex-DHF-P trial. 2015; 22: 582-93. 10.1177/2047487314526071.

[2] Piotrowicz E, Stepnowska M, Leszczynska-Iwanicka K, et al. Quality of life in heart failure patients undergoing home-based telerehabilitation versus outpatient rehabilitation--a randomized controlled study. European journal of cardiovascular nursing : journal of the Working Group on Cardiovascular Nursing of the European Society of Cardiology. 2015; 14: 256-63. 10.1177/1474515114537023.

Evidence table for systematic review of RCTs and observational studies (intervention studies)

**Research question**: Bijwerkingen van opioïden

| Study reference | Study characteristics | Patient characteristics | Intervention (I) | Comparison / control (C) | Follow-up | Outcome measures and effect size | Comments |
|---|---|---|---|---|---|---|---|
| Dale 2010 | Only narrative description of 11 studies, no RCTs | Studies including adult cancer pain patients switching from one strong opioid ladder to another.<br><br>11 studies | Opiods switching | Opioids switching | Not mentioned | Side effects narratively decribed in table 1 | The evidence profiles for the outcome side effects started low. The data was considered imprecise with a high probability of reportingbias and therefore the evidence level was low |
| Langsand 2011 | All kind of studies, 55 studies in total. | Adult cancer patients receiving opioids for chronic cancer pain, addressing management of nausea and vominting either as a primary or a secondary endpoint<br><br>55 studies | Several kind of treatment of nausea/vomiting | Several kinds of treatment of nausea/vomiting | Not mentioned | Only narrative summary of findings: Several antiemetics reported to be effective (metoclopramide, levosulpiride, olanzapine, risperidone, scopolamine, tropisetron) | |
| Sande 2019 | 15 RCTs | Patients with cancer ; >=18 years of age, on opioids (weak or strong opioid) as defined by WHO's Analgestic Laddeer for | Opioid switch | Other opioid switch | Not mentioned | Narrative summary of main findings | |

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| | | cancer pain relief; nausea and/or vomiting assessed as primary or secondary outcome | | | | | |
| Ahmedzai 2010 | 23 systematic reviews, RCTs or observational studies | Studies answering the questions: What are the effects of: orla laxatives, rectally applied medications, and opioi antagonists for constipation in people prescribed opioids? | Opioids | Opioids | Not mentioned | Narrative summary of findings | |
| Stone 2010 | 26 studies | Adult patients with chronic cancer pain, containing data on the efficacy of a treatment for the opioid central nervous system (CNS) adverse effect (sedation, cognitive impairment, myoclonus, hyperalgaesia, insomnia)<br><br>26 studies | Management of opioid-induced central side effects | Management of opioid-induced central side effects | Not mentioned | Only narrative summary of findings | The overall quality of the data wa low, and the few recommendations that can be made are weak and require confirmatory studies. |
| Mehta 2016 | 6 RCTs | Studies (RCTs) published after 2007,, studying the use of methylnaltrexone fot the treatment of Opioid-induced constipation, with the | Management of opioid-induced constipation | Management of opioid-induced constipation | Not mentioned | Risk difference for opioid induced constipation favors methylnaltrexone RD=0.33 (95%CI 0.27-0.39) p< 0.0001) | |

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| | | occurrence oif an rescue-free bowel movement (RFBM) within 4 hours as primary end point. | | | | | |
| Ruston 2013 | Systematic review, however no studies included | | | | | | |
| Sivanesan 2016 | Systematic review, however only case reports included, no comparison | | | | | | |