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**Expert opinions leave space for uncertainty when defining rehabilitation interventions: Analysis of difficult decisions regarding categorization of rehabilitation reviews in the Cochrane library**

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**Title:** Expert opinions leave space for uncertainty when defining rehabilitation interventions: Analysis of difficult decisions regarding categorization of rehabilitation reviews in the Cochrane library

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**Abstract**

**BACKGROUND:** In 2017, Cochrane Rehabilitation created an online relational database to crowd-source the identification and categorization of Cochrane publications for relevance to rehabilitation. One of the challenges of this work has been the lack of an operational definition to determine what is or is not a rehabilitation intervention. As such, categorization decisions have been largely based on expert opinion, with two health professionals screening each review, and with disagreements in categorization decisions being adjudicated by the Cochrane Rehabilitation Review Committee.

**AIM:** To analyze the rationale for resolving conflicts in the identification of rehabilitation reviews from all Cochrane reviews to contribute to future work on the scope and definition of rehabilitation interventions.

**METHODS:** We extracted data on decisions made about all Cochrane titles (both protocols and reviews) published between 1 January, 1996, and 31 August, 2019, and identified all titles where there had been disagreement between any people categorizing the reviews. We used thematic analysis methods to classify the reasons for including or excluding reviews from a collection of reviews on rehabilitation interventions. We compared across groups to identify areas of conflict and errors in the initial categorization.

**RESULTS:** Of the 9756 Cochrane titles screened, we identified 894 (9.2%) where some disagreement existed about whether a review was about rehabilitation interventions or not. Of these, 333 (37.2%) had met our original pragmatic criteria for being a “rehabilitation” review, while 561 (52.8%) had not. Seven hundred and nineteen of these reviews (80.4%) could be grouped by inductively created, reportable criteria to justify the initial categorization decisions. Fifty-seven reviews (6.4%) were on topics that were too idiosyncratic to easily group with others for the purposes of categorization.

Conflicts in the rationale for categorization decisions were identified in 90 reviews (10.1%) and errors in the initial categorization for 28 reviews (3.1%).

**CONCLUSION:** The challenges and conflicts identified in this study clearly indicate the need for better operational definition of rehabilitation interventions. This study provides a foundation for future work to check the utility of any new definition of rehabilitation interventions and to improve the trustworthiness of categorization decisions regarding the Cochrane Rehabilitation database.

**Keywords:** Cochrane Rehabilitation; Evidence-based medicine; Systematic reviews; Rehabilitation

## Background

Cochrane Rehabilitation was established to provide a bridge between Cochrane and the world of Rehabilitation.<sup>1</sup> Since its inception, one of the main tasks of Cochrane Rehabilitation has been to identify and collate all Cochrane reviews relevant to rehabilitation to make them more available to rehabilitation professionals worldwide. One proposed benefit of this work is that it would facilitate the introduction of the term “rehabilitation” as a keyword for searching the Cochrane library. However, completing this task has been challenging, primarily due to the lack of an operational definition that could be used to determine what is and what is not a rehabilitation intervention. After extensive discussion within the Cochrane Rehabilitation Executive and Review Committee, the only viable solution was to proceed by categorizing each Cochrane review based on expert opinion.<sup>2</sup>

In 2017, Cochrane Rehabilitation created an online relational database to crowd-source the “tagging” of Cochrane publications, both protocols and completed reviews, for relevance to rehabilitation. Rehabilitation professionals were invited to contribute to this tagging work through a public call for interest. Twenty-five people from 13 countries responded to this call. We set up the tagging system to allow one rehabilitation physician and one allied health professional to independently categorize all Cochrane reviews for: a) relevance to rehabilitation, b) relevance to specific professional groups, and c) broad areas of clinical practice by patient pathology. We resolved all disagreements between contributors by discussing these reviews during Review Committee meetings, which involved two physiotherapists and one physician, to ensure consistency of categorization decisions.

We developed a pragmatic list of criteria to describe what we considered a rehabilitation intervention as a guide for these decisions, building on this list as the work progressed. However, to contain this work, we decided to only tag Cochrane reviews as being “rehabilitation” reviews if they investigated the effectiveness of an intervention that rehabilitation professionals were responsible for delivering, rather than including all reviews that might simply be of interest to rehabilitation professionals. This would mean, for instance, that we would not categorize reviews of tendon transfer surgery for people with spinal cord injury or on total hip joint replacement for people with hip fracture as being “rehabilitation” reviews (as these interventions were performed by surgeons rather than rehabilitation physicians) but that we would categorize reviews on physical or occupational therapy to improve functional abilities after such surgeries as being about rehabilitation interventions. The advantage of this approach was that it allowed us to identify reviews that were directly relevant to the work of rehabilitation professionals. The disadvantage was that it created a tautological definition of rehabilitation, i.e.

rehabilitation interventions are interventions that are provided by rehabilitation professionals. Nevertheless, this decision provided us with a starting point for this categorization work.

In 2019, we reported that 1 in 11 of all Cochrane reviews reported on the effectiveness of various rehabilitation interventions.<sup>2</sup> Data on all initial tagging decisions made by the contributors and all final decisions made by the Review Committee for Cochrane reviews published between 1 January, 1996, and August 31, 2018, was made publicly available via Harvard Dataverse.<sup>3</sup> The majority of reviews were easy to categorize – all health professionals contributing to tagging work consistently identified these reviews as either clearly being about a rehabilitation intervention or not about a rehabilitation intervention. However, for a proportion of these reviews, there was some degree of disagreement between the people contributing to this tagging work. This dataset, and further data from ongoing tagging work, provide information about the boundaries around what is and what is not considered a rehabilitation intervention. The aim of this study was to analyze these difficult decisions to contribute to discuss the scope and definition of rehabilitation interventions, and to provide a database for testing any proposed definition. While this work should be considered preliminary and subject to future revision, it constitutes a quality control of the categorization decisions made by the Cochrane Rehabilitation Review Committee to date.

## Method

We extracted data on decisions made about all Cochrane titles (both protocols and reviews) published between 1 January, 1996, and August 31, 2019. This included the initial categorization decisions made by the people contributing to the tagging work, the comparisons of these initial decisions for agreements and disagreements, and the final decisions made by the Review Committee regarding the categorization of all reviews as being about rehabilitation interventions or not. We also extracted notes from our Review Committee meetings on these difficult decisions.

Some of these titles were for Cochrane protocols that had been subsequently published as full reviews or were for Cochrane reviews that had been updated since we started this screening work in October 2017. In these instances, we had, in our prior work, screened these titles twice, occasionally revising our categorization decisions the second time around. Therefore, we used the Access Number for each Cochrane review (which do not change between publication updates) to identify duplicate titles and removed all earlier publications for reviews that had been subsequently updated. We then identified all titles where there had been a disagreement between any people categorizing the review and exported

these data into a separate Excel spreadsheet. We separated these reviews into two groups: those which were ultimately categorized as being about rehabilitation interventions and those that were not.

One author (WL) then used thematic analysis to classify the reasons for including or excluding reviews from our list of reviews about rehabilitation interventions.<sup>4</sup> This involved an iterative, constant comparative process of identification and classification of the reasons for including or excluding reviews, grouping reviews together that had similar reasons for inclusion or exclusion, and comparing this classification across the two groups of “included” and “excluded” reviews. We examined these data for consistencies and contradictions in our prior decision making, discussing these as a team. We used this analysis to identify areas of conflict and potential errors in the initial categorization. We used the term “conflict” to identify apparent inconsistencies in the application of reasons for categorizing reviews as being about or not about rehabilitation interventions, where there was no immediately obvious solution to these inconsistencies. We used the term “error” to identify reviews that, on reflection and as a result of this analysis, we thought had been classified incorrectly in our prior work. These errors could be “errors in inclusion,” for reviews that we initially had categorized as being about rehabilitation interventions but now thought were not, or “errors in exclusion,” for reviews that we had initially classified about not being about rehabilitation interventions, but now thought should be classified as such. We summarized the results of this analysis descriptively for further application to discuss the definition and scope of rehabilitation interventions.

## Results

We extracted data on screening decisions for 10821 Cochrane titles. After removal of early versions of these updated publications, and reviews which had been subsequently withdrawn from the Cochrane library, 9756 titles remained. Of these 9756 titles, the review committee had discussed 840 (8.6%) individually because of disagreements between individual contributors regarding whether the review was about a rehabilitation intervention or not. In addition, the review committee identified 54 (0.5%) further titles where two contributors had independently tagged the review as being about a rehabilitation intervention, but the review committee disagreed with this judgment. Therefore, in total, we had a database of 894 reviews (9.2% of all titles) where there was some disagreement about whether the review was about a rehabilitation intervention (Figure 1).

[Insert Figure 1 here.]

Of these 894 reviews, the review committee had originally decided that 333 (37.2%) met our pragmatic definition of a rehabilitation intervention, while 561 (52.8%) had not. We identified 776 reviews (86.8% of all “difficult decisions”) where there appeared to be no conflict or errors in the rationale for categorizing the reviews as being about or not about a rehabilitation intervention. Of these 776 reviews, 57 were considered too idiosyncratic to group with others for the purposes of categorizing the rationale of inclusion or exclusion. Examples of these idiosyncratic reviews were reviews on the treatment of thoracic outlet syndrome<sup>5</sup> and animal-assisted therapies for people with stroke<sup>6</sup> (both included), plus leeches for osteoarthritis<sup>7</sup> and pharmacological/psychosocial interventions for night eating syndrome<sup>8</sup> (both excluded). A summary of the rationale for inclusion and exclusion decisions for the other 719 (non-idiosyncratic) reviews is presented in Table 1.

**Table 1: Comparison of categories of Cochrane reviews that were included or excluded as being about rehabilitation interventions (in parenthesis: number of reviews identified in this analysis)**

Included as part of rehabilitation	Excluded; not considered part of rehabilitation or specific to rehabilitation
<p><b>Because of the type of intervention</b></p> <p><u>Exercise as therapy</u> for</p> <ul style="list-style-type: none"> <li>• A chronic health condition (19)</li> </ul> <p><u>Non-surgical management</u> of</p> <ul style="list-style-type: none"> <li>• Non-acute musculoskeletal conditions, including osteoarthritis (25)</li> <li>• pain (68)</li> </ul> <p><u>Non-pharmaceutical management</u> of</p> <ul style="list-style-type: none"> <li>• Incontinence (12)</li> <li>• Cognitive impairments (3)</li> </ul>	<p><b>Because of the type of intervention</b></p> <ul style="list-style-type: none"> <li>• Acute medical management of health conditions (57)</li> <li>• Surgery or anesthesiology, including after-care (59)</li> <li>• Emergency, paramedic, or intensive care (16)</li> <li>• Antenatal, postnatal, or neonatal care (36)</li> <li>• Primary treatment or medical management of side effects from primary treatment of cancer (12)</li> <li>• Palliative care (5)</li> <li>• Interventions for alcohol or drug abuse (4)</li> </ul>

	<ul style="list-style-type: none"> <li>• Interventions for primary visual or hearing impairments (4)</li> </ul> <p><u>Pharmaceutical or other interventions prescribed by a non-rehabilitation specialist</u></p> <ul style="list-style-type: none"> <li>• To treat mental health conditions where the primary outcome only includes hospitalization rates, mortality, or psychological symptoms or impairments (42)</li> <li>• Prescribed by a neurologist (50)</li> </ul>
<p><b>Because of the setting/patient population</b></p> <p><u>Management of problems secondary to a primary disability</u></p> <ul style="list-style-type: none"> <li>• Pressure ulcers (14)</li> <li>• Mental health problems (10)</li> <li>• Fatigue (9)</li> <li>• Spasticity or dystonia (8)</li> <li>• Long-term catheterisation (4)</li> <li>• Breathlessness (3)</li> <li>• Speech or language problems (10)</li> <li>• Swallowing disorders (5)</li> </ul> <p><u>Medical management of</u></p> <ul style="list-style-type: none"> <li>• Osteoporosis (2)</li> <li>• Restless leg syndrome (2)</li> </ul>	<p><b>Because of the setting/patient population</b></p> <ul style="list-style-type: none"> <li>• Interventions to improve health in the general population, including public health and primary healthcare (52)</li> <li>• Interventions to improve the quality of community or residential care (26)</li> <li>• Health support for people with mental health conditions (e.g. dental care) (4)</li> <li>• Occupational health interventions for non-disabled populations (12)</li> <li>• Primary or secondary prevention of health conditions (3)</li> <li>• Weight loss interventions (5)</li> </ul> <p><u>Medical management of</u></p> <ul style="list-style-type: none"> <li>• Vascular problems, varicose veins, or venous leg ulcers (22)</li> <li>• Respiratory conditions (8)</li> <li>• Diabetes (6)</li> <li>• Dementia (7)</li> <li>• Myopathies (6)</li> <li>• Orthopaedic conditions (5)</li> </ul>



	<ul style="list-style-type: none"> <li>• Cardiac conditions (3)</li> </ul>
<p><b>Because of the primary outcome</b></p> <p><u>Interventions targeting activity or participation</u></p> <ul style="list-style-type: none"> <li>• For a chronic health condition, including cancer and mental health conditions (34)</li> <li>• After surgery (5)</li> <li>• As part of a pathway of care (4), <i>e.g. organised inpatient (stroke unit) care for stroke, which includes the acute phase of recovery</i></li> </ul>	
	<p><b>Because of the lack of specificity to rehabilitation</b></p> <ul style="list-style-type: none"> <li>• General healthcare practice (30), <i>e.g. strategies to improve appointment attendance; aspirin for headache; interventions to increase critical incident reporting</i></li> <li>• Practice to improve quality of research (6), <i>e.g. factors to impacting on recruitment in clinical trials; effects of placebo interventions for all conditions</i></li> <li>• Telemonitoring of chronic health conditions (2)</li> </ul>

The remaining 118 reviews included 28 reviews (0.3% of the total reviews and 3% of the sample selected for this paper) where, on reflection, an error had been made in the original classification, plus 90 reviews (0.9% and 10% of the total and current sample, respectively) where there was a conflict in the rationale used to categorize publications as being about or not about rehabilitation interventions. Of the 28 reviews where a classification error had been made, 18 had been included, but should have been

excluded and 10 had be excluded but should have been included (see Table 2). For the reviews where there was a conflict in the rationale for classification, there were 10 areas where conflicts occurred (see Table 3). These conflicts represent areas where categorization decisions are currently based on expert opinion, but where it is difficult to provide an objective reason for including or excluding reviews from a list of reviews on rehabilitation interventions. Further discussion is required to be able to provide a reportable rationale for differentiating between these types of reviews.

**Table 2: Errors in initial classification of rehabilitation reviews**

<b>Reviews that were initially included, but should be been excluded</b>	
<b>Should have been excluded because the review was about:</b>	<b>No. of reviews</b>
Emergency, paramedical or intensive care	3
General healthcare practice	6
Intervention to improve quality of community or residential care	3
Interventions to improve health in the general population, including public health and primary healthcare	1
Interventions to treat mental health conditions where the primary outcome only includes hospitalization rates, mortality, psychological symptoms and impairments	2
Medical management of myopathies	1
Primary treatment or medical management of side effects from primary treatment of cancer	1
Surgery or anaesthesiology, including after-care	1
TOTAL	18
<b>Reviews that were initially excluded, but should be been included</b>	
<b>Should have been included because the review was about:</b>	<b>No. of reviews</b>
Exercise as therapy for a chronic health condition	1
Interventions for mental health conditions where the primary outcomes targeted the domain of activity or participation	2
Management of mental health problems secondary to a primary disability	1
Non-surgical management of pain	5
Therapeutic interventions for swallowing disorders	1
TOTAL	10

**Table 3: Conflicts in classifications of rehabilitation reviews**

<b>Area of clinical practice</b>	<b>No. of reviews included as “rehabilitation” reviews</b>	<b>No. of reviews excluded as “rehabilitation” reviews</b>

Acupuncture to treat a medical problem or pain condition	5	9
Hyperbaric oxygen therapy	3	7
Management of secondary behavioural problems	2	1
Management of tinnitus	2	1
Medical management of bowel or bladder disorders	1	3
Pharmaceutical management of inflammatory arthritic conditions (e.g. psoriatic arthritis; rheumatoid arthritis)	14	5
Physical therapies (excluding exercise) for respiratory conditions	7	4
Self-management interventions for chronic health conditions	4	10
Treatment of erectile dysfunction	1	3
Yoga for a chronic health condition	3	5
TOTAL	42	48

The full citations for all 894 reviews included in this analysis, along with our categorization of the rationale for their inclusion or exclusion in a list of “rehabilitation” reviews, plus classification of errors and conflicts, are published as an open source dataset in Harvard Dataverse<sup>9</sup>.

## Discussion

In this secondary analysis of work previously completed to classify the relevance of Cochrane reviews to rehabilitation, we identified that 9.2% of all reviews needed to be individually discussed because of disagreements regarding their categorization. We found that there was overall coherence in the categorization decisions made to date, albeit incomplete. Broadly speaking, the main categories identified post-hoc to classify the reasons for inclusion or exclusion focused on the type of intervention being provided and who provided it, the type of setting or population involved, the type of outcome primarily targeted by the intervention, and whether the subject of the review was sufficiently specific to rehabilitation. Even then, at the end of this process, we were left with 57 reviews that were too idiosyncratic to easily classify and 90 reviews where further work is required to objectively justify classification decisions. Nevertheless, bearing in mind that this analysis focused only on the difficult classification decisions, and that there were another 8862 reviews in the Cochrane library that we classified without problems<sup>2</sup>, the pragmatic criteria for the classification of rehabilitation reviews

developed for this work could be consistently applied to over 98% (9581/9756) of the total reviews screened. Broadly speaking, it is possible to consistently identify rehabilitation interventions, but it is difficult to describe the rationale for these decisions in simple terms.

These results confirm the complexity involved in providing a coherent definition of rehabilitation interventions that can be used to classify reviews. This study also clearly demonstrates that rehabilitation interventions cannot be easily classified based on the tasks of the intervention alone – there also needs to be consideration of other parameters to account for such decision. Interestingly, some parameters identified in this analysis reflect component of the PICO acronym: population (P), type of intervention (I), and outcome (O). Other parameters were specific to the scope of this project, e.g. the need for interventions to be within the remit of rehabilitation professionals and be specific to rehabilitation. Nevertheless, the absence of a comprehensive definition of rehabilitation for research purposes makes such efforts highly difficult and potentially subject to arbitrary decision making. As such, one key conclusion of this study is the need for work to continue to develop such a definition.

This study also highlights areas of conflict or disagreement regarding the scope or nature of rehabilitation interventions. We identified 90 reviews where it was difficult to apply reportable criteria to consistently identify rehabilitation interventions. These difficulties with categorization decisions are highlighted when attempting to analyze a large dataset, as was the case in this study. Once one decision is made (e.g. exercise provided by a physiotherapist for chronic low back pain is rehabilitation) then other decisions come into question (e.g. Is yoga provided by a physiotherapist for chronic low back pain rehabilitation? Is the yoga provided by anyone for chronic low back pain rehabilitation? Is yoga for treating the psychiatric symptoms of schizophrenia rehabilitation? Is any intervention to treat the psychiatric symptoms of schizophrenia rehabilitation?) Some of these types of conflicts may arise because of differences in the scope of rehabilitation practice between countries and world regions – a factor that we excluded in our analysis. Alternatively, these conflicts may be explained by conceptualizing rehabilitation as a process, often involving multiple interventions, provided within a specific context. For instance, there are some medications and healthcare procedures, which are not inherently “rehabilitation” interventions (e.g., extubation of patients on mechanical ventilation or prescription of the drug heparin), but which may be considered part of rehabilitation when linked to a rehabilitation process. Other interventions, such as the use of spasmolytic drugs or movement retraining, are more commonly considered rehabilitation intervention regardless of context. This means that it is not always the category of intervention (e.g. the drugs, physical techniques, behavioral

strategies, etc) that makes something a “rehabilitation” intervention – it is the process or context within which the intervention is applied.

There are some limitations to this study. First, only one researcher was involved in the initial categorization of reasons for including or excluding reviews from a list of “rehabilitation” reviews. While this improved consistency of application of categories, it reduces the trustworthiness of the analysis. Second, some reviews could potentially be categorized in more than one way: a review of acupuncture for chronic low back could be classified as “acupuncture for a medical condition” or “non-pharmaceutical management of a pain condition.” This means that the exact categorization of reviews in this study is open to interpretation. Third, while all categorization decisions in this study are openly available for critique,<sup>9</sup> such a large dataset makes it difficult for others to comprehensively check the categorization decisions underpinning this analysis. The findings from this analysis, therefore, cannot be considered conclusive. There is a need to better define and understand the decisions taken. A new definition of rehabilitation interventions may make it easier to justify future categorization decisions of this nature but is unlikely to solve all the problems highlighted by this study. Nevertheless, we argue that categorization attempts like this are informative in terms of helping identify where problems with definition lie. Future work should include wider discussion of these types of difficult decisions, with reference to any new operational definition of rehabilitation interventions.

## Conclusion

Overall, it is possible to justify decisions regarding the categorization of rehabilitation interventions for the vast majority of Cochrane reviews. However, it is difficult to provide a simple explanation for these decisions. The challenges and conflicts identified in this study clearly indicate the need for better operational definition of rehabilitation interventions. It also supports the use of PICO elements for part of the development of a definition of rehabilitation interventions. Finally, this study provides a foundation for future work to check the utility of any new definition of rehabilitation interventions and to improve the trustworthiness of categorization decisions regarding the Cochrane Rehabilitation database.

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