APPENDIX A. SEARCH STRATEGIES

DATABASE SEARCHED & TIME PERIOD COVERED:

PubMed – From inception to 2/17/2016

SEARCH STRATEGY 1:

"Massage"[Mesh] OR massag*[tiab] OR massag*[ot] OR shiatsu

AND

pain[mh] OR pain*[tiab] OR pain*[ot] OR pain management[mh] OR ache*[tiab] OR sore*[tiab] OR discomfort[tiab] OR backache* OR headache*

SEARCH STRATEGY 2:

“Similar Article” searches for the following 3 publications:

Patel, K. C., A. Gross, N. Graham, C. H. Goldsmith, J. Ezzo, A. Morien and P. M. Peloso (2012)."Massage for mechanical neck disorders." Cochrane Database Syst Rev 9: Cd004871.

Furlan, A. D., F. Yazdi, A. Tsertsvadze, A. Gross, M. Van Tulder, L. Santaguida, D. Cherkin, J. Gagnier, C. Ammendolia, M. T. Ansari, T. Ostermann, T. Dryden, S. Doucette, B. Skidmore, R. Daniel, S. Tsouros, L. Weeks and J. Galipeau (2010)."Complementary and alternative therapies for back pain II." Evid Rep Technol Assess (Full Rep)(194): 1-764. Oct

Cherkin, D. C., K. J. Sherman, R. A. Deyo and P. G. Shekelle (2003)."A review of the evidence for the effectiveness, safety, and cost of acupuncture, massage therapy, and spinal manipulation for back pain." Ann Intern Med 138(11): 898-906. Jun 3

DATABASE SEARCHED & TIME PERIOD COVERED:

EMBASE - From inception to 2/17/2016

LANGUAGE:

English

SEARCH STRATEGY:

'massage'/exp OR 'massage' OR massag* OR 'shiatsu'/exp OR shiatsu

AND

pain* OR ache* OR sore* OR discomfort OR backache* OR headache*

NOT

'case report'/de

AND

Human

DATABASE SEARCHED & TIME PERIOD COVERED:

Cochrane - From inception to 2/17/2016

massag* or shiatsu:ti,ab,kw (Word variations have been searched)

AND

pain* or ache* or sore* or discomfort or backache* or headache*:ti,ab,kw (Word variations have been searched)

APPENDIX B. CRITERIA USED IN QUALITY ASSESSMENT

MODIFIED AMSTAR – A MEASUREMENT TOOL TO ASSESS THE METHODOLOGICAL QUALITY OF SYSTEMATIC REVIEWS.

NOTE: where alterations were made to original AMSTAR criteria, language is bolded. Removal of original criteria are displayed with a strikethrough, and additions are displayed in italics.

1. Was an 'a priori' design provided?

   The research question and inclusion criteria should be established before the conduct of the review.

   Note: Need to refer to a protocol, ethics approval, or pre-determined/a priori published research objectives to score a “yes.”

   Yes/ No/ Can't answer/ Not applicable

2. Was there duplicate study selection and data extraction?

   There should be at least 2 independent data extractors and a consensus procedure for disagreements should be in place.

   Note: 2 people do study selection, 2 people do data extraction, consensus process or one person checks the other’s work.

   Yes/ No/ Can't answer/ Not applicable

3. Was a comprehensive literature search performed?

   At least 2 electronic sources should be searched. The report must include years and databases used (*eg*, Central, EMBASE, and MEDLINE). Key words and/or MESH terms must be stated and where feasible the search strategy should be provided. All searches should be supplemented by consulting current contents, reviews, textbooks, specialized registers, or experts in the particular field of study, and by reviewing the references in the studies found.

   Note: If at least 2 sources ~~**+ one supplementary strategy used**~~, select “yes” (Cochrane register/Central counts as 2 sources; a grey literature search counts as supplementary).

   Yes/ No/ Can't answer/ Not applicable

4. Was the status of publication (*ie* grey literature) used as an inclusion criterion?

   The authors should state that they searched for reports regardless of their publication type. The authors should state whether or not they excluded any reports (from the systematic review), based on their publication status, language etc.

   Note: If review indicates that there was a search for “grey literature” or “unpublished literature,” indicate “yes.” SIGLE database, dissertations, conference proceedings, and trial

registries are all considered grey for this purpose. If searching a source that contains both grey and non-grey, must specify that they were searching for grey/unpublished lit.

Yes/ No/ Can't answer/ Not applicable

5. Was a list of studies (included ~~and excluded~~) provided?

A list of included ~~and excluded~~ studies should be provided.

Note: Acceptable if the excluded studies are referenced. If there is an electronic link to the list but the link is dead, select "no."

Yes/ No/ Can't answer/ Not applicable

6. Were the characteristics of the included studies provided?

In an aggregated form such as a table, data from the original studies should be provided on the participants, interventions and outcomes. The ranges of characteristics in all the studies analyzed *eg*, age, race, sex, relevant socioeconomic data, disease status, duration, severity, or other diseases should be reported.

Note: Acceptable if not in table format as long as they are described as above.

Yes/ No/ Can't answer/ Not applicable

7. Was the scientific quality of the included studies assessed and documented?

'A priori' methods of assessment should be provided (*eg*, for effectiveness studies if the author(s) chose to include only randomized, double-blind, placebo controlled studies, or allocation concealment as inclusion criteria); for other types of studies alternative items will be relevant.

Note: Can include use of a quality scoring tool or checklist, *eg*, Jadad scale, risk of bias, sensitivity analysis, etc., or a description of quality items, with some kind of result for EACH study ("low" or "high" is fine, as long as it is clear which studies scored "low" and which scored "high"; a summary score/range for all studies is not acceptable).

Yes/ No/ Can't answer/ Not applicable

8. Was the scientific quality of the included studies used appropriately in formulating conclusions?

The results of the methodological rigor and scientific quality should be considered in the analysis and the conclusions of the review, and explicitly stated in formulating recommendations.

Note: Might say something such as "the results should be interpreted with caution due to poor quality of included studies." Cannot score "yes" for this question if scored "no" for question 7.

Yes/ No/ Can't answer/ Not applicable

9. Were the methods used to combine the findings of studies appropriate?

For the pooled results, a test should be done to ensure the studies were combinable, to assess their homogeneity (*ie*, Chi-squared test for homogeneity, I2). If heterogeneity exists a random effects model should be used and/or the clinical appropriateness of combining should be taken into consideration (*ie*, is it sensible to combine?).

Note: Indicate "yes" if they mention or describe heterogeneity, *ie*, if they explain that they cannot pool because of heterogeneity/variability between interventions.

Yes/ No/ Can't answer/ Not applicable

10. Was the likelihood of publication bias assessed?

An assessment of publication bias should include a combination of graphical aids (*eg*, funnel plot, other available tests) and/or statistical tests (*eg*, Egger regression test, Hedges-Olken).

Note: If no test values or funnel plot included, score "no". Score "yes" if mentions that publication bias could not be assessed because there were fewer than 10 included studies.

For strictly narrative systematic reviews (*ie*, no quantitative methods employed), some narrative discussion of publication bias is required to score yes.

Yes/ No/ Can't answer/ Not applicable

11. Was the conflict of interest included?

Potential sources of support should be clearly acknowledged in **both** the systematic review ~~**and the included studies**~~.

Note: To get a "yes," must indicate source of funding or support for the systematic ~~**review AND for each of the included studies**~~.

Yes/ No/ Can't answer/ Not applicable

Original source:

Shea et al. BMC Medical Research Methodology 2007 7:10 doi:10.1186/1471-2288-7-10

APPENDIX C. PEER REVIEW COMMENTS/AUTHOR RESPONSES

Comment	Response
Pages 4 and 6 Steven Ezeji-Okoye should be Stephen and title should be Integrative Health Coordinator, Patient Care Services.	This has been corrected
A brief discussion of what an "active" or "inactive" comparators would be beneficial. Language is ambiguous in the literature regarding "active" or "inactive" comparators or controls and a discussion of these per study (if at all possible) may help with downstream decision making and may shed greater light on the actual comparative effectiveness of the intervention.	For all findings using the terms “active” or “inactive” we have now added examples or definitions from that particular review to provide more clarity for that finding. Because this report looks at systematic reviews, rather than individual studies, we are limited to reporting what the systematic reviews report, and could not collect these details from the included studies from each of the 31 systematic reviews.
Is it possible to add the date of publication to the evidence map? That would help the reader understand how old the review is.	The dates for each systematic review have been added to the bubble labels in the evidence map.
You might want to comment in your summary that some of these reviews are quite old and could be updated in the future. For example the review on massage in a critical care setting was done in 2000. There are other studies on massage that include patients in a critical care setting that have been published including the largest RCT of massage for postoperative pain which was funded by HSRD and published in 2007(I was a co-investigator on that study.	This has been included in the “Summary and Discussion” section.
I do not understand this sentence on page 14, line 38, "These 3 features of massage were most often reported for each primary studying including in the review, with variability between these primary studies".	This sentence has been revised to fix the grammatical issues.
My one concern is that when one looks at the Evidence Map and sees "mixed results" for so many of the LBP reviews, it gives a bit of a different picture then when one reads the text. The fact is it seems to me that overall the evidence is fairly good for the utility of massage in LBP and neck pain--and this does come through in the text--but visually when one sees that the bigger reviews of these conditions fall in the "mixed results" category the impression is that the evidence is really equivocal. I realize this may be part of how the evidence map methodology works but for some readers who will only look at the graphic and not read the text I think it is a bit problematic.	Both larger reviews described by the peer reviewer (Furlan, 2010 and Furlan, 2015) are described in the text as finding a number of positive findings, but both also included findings of no difference between massage and the control in certain comparisons. We have updated the evidence map to have these studies crossing the boundary between “mixed results” and “potentially better” in order to signal that both these important systematic reviews do lean positive, with many positive findings.

In most evidence maps that I have reviewed, there is not a bubble representing each review, but rather a bubble representing the strength of evidence for a given condition. This article's representation, which has several bubbles for many conditions, will not be as helpful to decision making (ex: Fibromyalgia has studies in 4 categories). It does represent the wide array of findings, but is not as useful a presentation for the decision makers as a synthesis.	While single bubbles for each condition may be more useful for decision makers, this type of depiction would be less faithful to the evidence, since it would require the report authors to make judgements in synthesizing findings across systematic reviews. The current figure presents the findings of each included systematic review, but does not judge how these would be integrated with each other, which would require looking at all the primary studies within each of the systematic reviews for topics with multiple bubbles. In the example of Fibromyalgia, we would need to see which studies were included in all reviews, and which were included in some but not others to determine a new finding inclusive of all potential evidence. The topics with multiple bubbles, especially with differing findings, may be areas that are ripe for an update systematic review. This is now noted in the “Summary and Discussion” section.

APPENDIX D. EVIDENCE TABLES FOR INCLUDED SYSTEMATIC REVIEWS

Author, year	Description of systematic review	Description of massage	Description of pain	Excerpted findings relevant to massage
Anthonissen 2016	includes a variety of interventions, of which massage is one 2/22 includes relevant to massage **Quality Score:** 10	**Style:** Soft tissue mobilization, massage with cocoa butter, skin rehabilitation massage (detailed descriptions provided) **Provider:** Not provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Standard care, no treatment	Scar pain	A reduction of pain was shown in 2 studies... these findings were based on subjective rating scales and mostly based on trials with small sample sizes.
Piper 2016	focused solely on massage as the intervention 6/6 includes relevant to massage **Quality Score:** 10	**Style:** Soft-tissue therapy **Provider:** Provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Placebo/sham, waiting list (wait and see), or no intervention.	Carpal tunnel syndrome, lateral epicondylitis, subacromial impingement syndrome, plantar fasciitis	Myofascial release therapy was effective for treating lateral epicondylitis and plantar fasciitis. Localized relaxation massage combined with multimodal care may provide short-term benefit for treating carpal tunnel syndrome.
Furlan 2015	focused solely on massage as the intervention 25/25 includes relevant to massage **Quality Score:** 11	**Style**: Soft-tissue manual manipulation **Provider:** Provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Acute and chronic low-back pain	Massage was better than inactive controls for pain in the short-term, but not in the long-term follow-up. Massage was better than active controls for pain both in the short- and long-term follow-ups. There were no reports of serious adverse events in any of these trials. The most common adverse events were increased pain intensity in 1.5% to 25% of the participants.

Author, year	Description of systematic review	Description of massage	Description of pain	Excerpted findings relevant to massage
Bervoets 2015	focused solely on massage as the intervention 26/26 includes relevant to massage **Quality Score:** 9	**Style:** Swedish massage, Thai massage, self-massage, combination of techniques, not described **Provider:** Provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Low back pain, shoulder pain, fibromyalgia, osteoarthritis of the knee, chronic musculoskeletal pain, neck pain, chronic patellar tendinopathy, carpal tunnel syndrome, hand pain, and hand osteoarthritis	Low- to moderate-level evidence indicated that: (1) massage reduces pain in the short term compared to no treatment in people with shoulder pain; (2) massage reduces pain in the short term compared to no treatment in people with osteoarthritis of the knee; (3) massage does not reduce pain in those with low back pain; (4) massage does not reduce pain in those with neck pain. Low- to very low-level evidence from single studies indicated no clear benefits of massage over active treatments in people with: (5) fibromyalgia, (6) low back pain, and (7) general musculoskeletal pain.
Calixtre 2015	focused solely on massage as the intervention 8/8 includes relevant to massage **Quality Score:** 9	**Style:** Provided **Provider:** Provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Acute and chronic temporo-mandibular disorder	Widely varying evidence that manual therapy improves pain and pressure pain threshold in subjects with temporomandibular disorder signs and symptoms, depending on the technique.
Keeratitanont 2015	focused solely on massage as the intervention 6/6 includes relevant to massage **Quality Score:** 6	**Style:** Traditional Thai massage **Provider:** Not provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Not provided	Chronic myofascial pain syndrome, chronic low back pain, scapulocostal syndrome	Traditional Thai massage benefits of pain reduction appear to maintain for up to 15 weeks.

Author, year	Description of systematic review	Description of massage	Description of pain	Excerpted findings relevant to massage
Yuan 2015	focused solely on massage as the intervention 10/10 includes relevant to massage **Quality Score:** 8	**Style:** Swedish massage, connective tissue massage, manual lymphatic drainage, myofascial release, shiatsu, a combination of different massage styles **Provider:** Provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Fibromyalgia	There is moderate evidence that myofascial release has positive effects on multiple fibromyalgia symptoms, especially pain, anxiety, and depression, for which the effect sizes are clinically relevant. Shiatsu improves pain and Swedish massage does not improve outcomes.
Loew 2014	focused solely on massage as the intervention 2/2 includes relevant to massage **Quality Score:** 11	**Style:** Deep transverse friction massage **Provider:** Provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Lateral elbow or lateral knee tendinitis	We do not have sufficient evidence to determine the effects of deep transverse friction on pain, improvement in grip strength, and functional status for patients with lateral elbow tendinitis or knee tendinitis, as no evidence of clinically important benefits was found.
Chaibi 2014	includes a variety of interventions, of which massage is one 1/6 includes relevant to massage **Quality Score:** 7	**Style:** Head and neck massage **Provider:** Provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Chronic headache	The massage therapy study included only 11 participants, but the massage group had significantly more reduction in their headache intensity than detuned ultrasound group.
Cheng 2014	focused solely on massage as the intervention 15/15 includes relevant to massage **Quality Score:** 8	**Style:** Chinese traditional massage, common Western massage, manual pressure release, strain/counterstrain technique, and myofascial band therapy **Provider:** Not provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Chronic neck pain	This systematic review found moderate evidence of manual therapy on improving pain in patients with neck pain compared with inactive therapies and limited evidence compared with traditional Chinese medicine.

Author, year	Description of systematic review	Description of massage	Description of pain	Excerpted findings relevant to massage
Li 2014	focused solely on massage as the intervention 9/9 includes relevant to massage **Quality Score:** 10	**Style:** Swedish massage, connective tissue, Shiatsu, therapeutic touch, unspecified, Chinese traditional massage, myofascial therapy **Provider:** Not provided **Co-interventions:** None **Duration:** Provided **Comparators:** Provided	Fibromyalgia	Massage therapy with duration ≥ 5 weeks had beneficial immediate effects on improving pain in patients with fibromyalgia. The meta-analyses showed that massage therapy with duration ≥ 5 weeks significantly improved pain (SMD, 0.62; 95% CI 0.05 to 1.20; p = .03)
Kong 2013	focused solely on massage as the intervention 12/12 includes relevant to massage **Quality Score:** 10	**Style:** Massage therapy, Chinese traditional massage, soft tissue massage, slow-stroke back massage, manual pressure release, strain/counterstrain technique, myofascial band therapy, Thai massage **Provider:** Not provided **Co-interventions:** None **Duration:** Provided **Comparators:** Provided	Acute and chronic neck pain, acute and chronic shoulder pain	In immediate effects, the meta-analyses showed significant effect of MT for neck pain (standardised mean difference, SMD, 1.79; 95% confidence intervals, CI, 1.01 to 2.57)
Patel 2012	focused solely on massage as the intervention 15/15 includes relevant to massage **Quality Score:** 10	**Style:** Included Swedish techniques, fascial or connective tissue release techniques, cross fibre friction, and myofascial trigger point techniques **Provider:** Provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** included no treatment, hot packs, active range-of-movement exercises, acupuncture, exercises, sham laser, manual traction, mobilization, and education	Acute and chronic neck pain without radiculopathy, cervicogenic headache, neck disorders with radiculopathy	No firm conclusions could be drawn and the effectiveness of massage for improving neck pain and function remains unclear. There was very low-level evidence that massage may have been more beneficial than education in the short term for pain bothersomeness.

Author, year	Description of systematic review	Description of massage	Description of pain	Excerpted findings relevant to massage
van den Dolder 2014	includes a variety of interventions, of which massage is one 7/23 includes relevant to massage **Quality Score:** 9	**Style:** Not provided **Provider:** Not provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Acute and chronic shoulder pain	There is low-quality evidence that soft tissue massage is effective for improving pain in patients with shoulder pain in the short term.
Smith 2012	focused solely on massage as the intervention 6/6 includes relevant to massage **Quality Score:** 11	**Style:** Slow stroke, effleurage, variety of techniques, none specified **Provider:** Partner, masseuse, not reported **Co-interventions:** None **Duration:** Provided **Comparators:** Provided	Labor pain	Massage may have a role in reducing pain, and improving women's emotional experience of labour.
Terhorst 2011 Terhorst 2012	includes a variety of interventions, of which massage is one 6/60 includes relevant to massage **Quality Score:** 9	**Style:** Swedish massage, connective tissue massage, tui na and yoga, massage **Provider:** Not provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Fibromyalgia	Of the 5 pooled studies, 4 showed no effect; and the composite effect indicated that massage was not effective in reducing FM pain in this set of studies. All studies scored low- or very low-quality.

Author, year	Description of systematic review	Description of massage	Description of pain	Excerpted findings relevant to massage
Furlan 2010 Furlan 2012	includes a variety of interventions, of which massage is one 35/356 includes relevant to massage **Quality Score:** 11	**Style:** Myofascial pressure release, transverse friction, connective tissue, traditional Chinese massage, soft tissue, Swedish, Thai, bone setting, reflexology, accupressure, underwater, roptrotherapy, undescribed styles **Provider:** included: licensed or experienced massage therapists, physical therapists, reflexologists, acupressure therapists, folk healers, general practitioners, manual therapists, bone setter, chiropractic students, and not provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Acute and chronic low back pain, neck pain	Massage was superior to placebo or no treatment in reducing pain (grade: moderate) immediately post-treatment only in subjects with acute/subacute but not in subjects with chronic low back pain (grade: low). Massage was significantly better than relaxation (clinical importance of difference: medium degree) or physical therapy (clinical importance of difference: large degree) in reducing chronic nonspecific low back pain intensity immediately after the treatment (grade: low to moderate). Massage was better than no treatment in reducing immediate-term post-treatment pain intensity in subjects with chronic or unknown duration of nonspecific pain (grade: low). Massage was better than placebo in reducing neck pain intensity immediately after the treatment in subjects with acute/subacute or unknown duration of nonspecific pain (grade: low).
Ernst 2009	focused solely on massage as the intervention 8/14 includes relevant to massage **Quality Score:** 7	**Style:** Style not directly addressed aside from: “Classical massage was defined as a manual treatment using effleurage (long, slow strokes), friction (small circular strokes), percussion (chopping and drumming motions) and petrissage (kneading action on muscles).” **Provider:** excluded lay persons **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Cancer palliation	Collectively, studies suggest that massage can alleviate pain, however the methodological quality was poor, preventing definitive conclusions

Author, year	Description of systematic review	Description of massage	Description of pain	Excerpted findings relevant to massage
Wilkinson 2008	focused solely on massage as the intervention 4/10 includes relevant to massage **Quality Score:** 10	**Style:** Soft tissue manual manipulation, including foot massage, Swedish, unspecified, aromatherapy/carrier oil massage. **Provider:** A therapist with recognized qualification **Co-interventions:** Not provided **Duration:** Provided **Comparators:** Provided	Cancer symptoms including pain	In the 4 studies using pain as an outcome measure, there was a nonstatistically significant trend towards improvement.
Ezzo 2007	focused solely on massage as the intervention 14/19 includes relevant to massage **Quality Score:** 8	**Style:** Soft tissue manual manipulation, including Swedish techniques, fascial or connective tissue release techniques, cross fiber friction, and myofascial trigger point techniques. **Provider:** Not provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Acute and chronic neck pain	The contribution of massage to managing cervical pain remains unclear.
Bardia 2006	includes a variety of interventions, of which massage is one 4/18 includes relevant to massage **Quality Score:** 11	**Style:** Not provided **Provider:** Not provided **Co-interventions:** Unclear **Duration:** Provided **Comparators:** Provided	Cancer pain	Mix of results from methodologically weak studies
Smith 2006	includes a variety of interventions, of which massage is one 1/14 includes relevant to massage **Quality Score:** 9	**Style:** Directional firm rhythmic massage comprised of effleurage, sacral pressure, and shoulder and back kneading. **Provider:** Researcher and partner **Co-interventions:** Standard care **Duration:** Provided **Comparators:** Standard care	Labor pain	There was a significant reduction in women's perception of pain for the massage group compared to the control group during all 3 phases of labour in the one included study. The efficacy of massage has not been established.

Author, year	Description of systematic review	Description of massage	Description of pain	Excerpted findings relevant to massage
Haraldsson 2006	focused solely on massage as the intervention 19/19 includes relevant to massage **Quality Score:** 11	**Style:** Soft tissue manual manipulation including Swedish techniques, fascial or connective tissue release techniques, cross fiber friction, and myofascial trigger point techniques **Provider:** Provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Chronic neck pain	No recommendations for practice can be made at this time because the effectiveness of massage for neck pain remains uncertain.
Huntley 2004	includes a variety of interventions, of which massage is one 2/12 includes relevant to massage **Quality Score:** 10	**Style:** Provided **Provider:** Not provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Labor pain	Both of the massage trials showed positive effects for the relief of pain during labor. These trials did not rate highly on the Jadad scale because and it is impossible to make any definitive conclusions regarding effectiveness in labor pain control.
Cherkin 2003	includes a variety of interventions, of which massage is one 8/17 includes relevant to massage **Quality Score:** 9	**Style:** Included to therapeutic massage, comprehensive massage, unspecified. **Provider:** Not provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Back pain	Two reviews, including 5 studies total, concluded that high-quality trials were needed before the value of massage for back pain could be determined. The 3 RCTs that evaluated massage reported that this therapy is effective for subacute and chronic back pain. Initial studies suggest that massage is effective for persistent back pain.
Simkin 2002	includes a variety of interventions, of which massage is one 1/38 includes relevant to massage **Quality Score:** 9	**Style:** Desribed as for back, head, hands, feet **Provider:** Partner **Co-interventions:** Lamaze **Duration:** Provided **Comparators:** Usual care	Labor pain	The randomized controlled trial of massage by partners in labor found that the massaged women had significant emotional and physical relief, as reported by the women themselves, and assessed by their partners and a blinded observer. The intervention of massage has not undergone sufficient scientific study to provide clear conclusions regarding benefits and risks.

Author, year	Description of systematic review	Description of massage	Description of pain	Excerpted findings relevant to massage
Pan 2000	includes a variety of interventions, of which massage is one 3/21 includes relevant to massage **Quality Score:** 6	**Style:** Swedish massage, unspecified **Provider:** Not provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Palliative care patients' pain	Massage with or without aromatherapy, might provide short-term relief for patients with intractable cancer pain. Evidence level 3.3 (second lowest rating of 6).
Richards 2000	focused solely on massage as the intervention 4/22 includes relevant to massage **Quality Score:** 5	**Style:** Therapeutic massage, myofascial trigger point therapy, Swedish, unspecified **Provider:** Provided **Co-interventions:** Provided **Duration:** Provided **Comparators:** Provided	Pain in critical care setting	In studies in which the effect of massage on discomfort was investigated, it was found to be effective in reducing pain.
Ernst 1999	focused solely on massage as the intervention 4/4 includes relevant to massage **Quality Score:** 6	**Style:** Gentle stroking back massage, light effleurage, soft tissue lumbosacral massage, underwater massage **Provider:** Not provided **Co-interventions:** None **Duration:** Provided **Comparators:** Provided	Low back pain	It is concluded that too few trials of massage therapy exist for a reliable evaluation of its efficacy. Massage seems to have some potential as a therapy for LBP.
Kong 2011	focused solely on massage as the intervention 10/10 includes relevant to massage **Quality Score:** 3	**Style:** Swedish massage, tui na, other soft tissue manual manipulation **Provider:** Not provided **Co-interventions:** Not provided **Duration:** Provided **Comparators:** Provided	Fibromyalgia	All studies reported an association between the therapeutic massage and improved clinical symptom of pain. The meta-analysis results showed that 4 studies with 3 to 10 weeks of therapy had a decrease in pain versus either other therapies or no treatment controls. The pooled effect size was -0.92 (95% CI, -1.28 to -0.56) favoring therapeutic massage. The studies are very heterogeneous, and there is insufficient evidence for a definitive conclusion.

Author, year	Description of systematic review	Description of massage	Description of pain	Excerpted findings relevant to massage
Lewis 2006	focused solely on massage as the intervention 20/20 includes relevant to massage **Quality Score:** 9	**Style:** Therapeutic massage, including Swedish **Provider:** Provided **Co-interventions:** None **Duration:** Provided **Comparators:** Provided	Musculoskeletal pain (low back, neck, various chronic, shoulder, diffuse, eccentric exercise limb, post-running soreness)	Research on the effectiveness of TM to relieve pain of musculoskeletal origin is inconclusive. TM was superior to no treatment in 5 out of 10 comparisons, superior to sham laser treatment in one out of 2 comparisons, and superior to active treatment in 7 out of 22 comparisons.