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Narrative reviews in anesthesia and pain medicine: guidelines for producers, reviewers and consumers

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Received 11 May 2024

Accepted 7 June 2024

ABSTRACT

Well-established guidelines and checklists for authors, reviewers, and readers of systematic reviews and scoping reviews are readily available. However, the availability of such for narrative reviews is lacking, including, but not limited to, field-specific guidelines in the field of anesthesia and pain medicine. In this brief article, we review the differences between the major types of reviews, followed by a more detailed description of narrative reviews that clearly differentiates them from other types of reviews. We include a recommended checklist that will aid producers, editors, reviewers, and consumers of narrative reviews as well as examples specific to the field of anesthesia and pain medicine. It is the hope that the guidelines recommended here will aid producers, editors, reviewers, and consumers of narrative reviews in anesthesia and pain medicine, including *Regional Anesthesia & Pain Medicine*. Adherence to such should help differentiate between narrative reviews and other types of reviews as well as provide consistency in what elements are necessary to include in a narrative review in the field of anesthesia and pain medicine.

OVERVIEW

The amount of information in the field of anesthesia and pain medicine has increased dramatically over the last 60 years. For example, a simple free-text search of PubMed by the first author on March 16, 2024, using the search query anesthesia OR analgesia OR “pain medicine” and covering the complete years of 1963–2023 yielded a total of 1570 citations in 1963 versus 26 073 in 2023. For the busy clinical practitioner and/or clinical researcher, sifting through every piece of research on a topic they are looking for an answer to is no longer realistic. Therefore, clinicians today rely on not only guidelines articles from national organizations to help steer clinical practice and research, but also reviews of the literature. While many different types of reviews, as well as subcategories of review types, currently exist, one may broadly partition these into three categories: (1) systematic reviews, (2) scoping reviews, and (3) narrative reviews. Other less common review types such as rapid reviews, umbrella reviews, that is, review of reviews, as well as realist reviews and integrative reviews, also exist.¹ All serve different but important purposes and may be considered as complimentary to each other. However, while the guidelines for reporting, conducting, and evaluating systematic and scoping reviews are well-established,^{2–13} including guidelines for systematic reviews in acute and chronic pain,^{14–17} those for narrative reviews

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ While guidelines and checklists are available to guide authors, reviewers, and readers of systematic reviews and scoping reviews, these resources remain elusive for narrative reviews, supporting the need for field-specific guidelines.

WHAT THIS STUDY ADDS

⇒ This guideline document identifies important steps for reporting, conducting, and evaluating narrative reviews, with a focus on the field of anesthesia and pain medicine, including a checklist that prospective authors conducting narrative reviews should fulfill.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE, OR POLICY

⇒ By assisting authors who write narrative reviews, editors and peer reviewers who review narrative reviews, and readers who consume narrative reviews, this guideline aims to improve the quality of reporting, conducting, and evaluating field-specific narrative reviews.

are less lucid.^{18–29} The purpose of this brief paper is to address this gap by providing guidelines for reporting, conducting, and evaluating narrative reviews, with a focus on exemplars in the field of anesthesia and pain medicine. Consistent with the narrative review approach, the recommended guidelines that follow are intended to provide some degree of flexibility when reporting, conducting, and evaluating narrative reviews. From the authors perspective, the uniqueness of the current paper lies in (1) one condensed list for those in anesthesia and pain medicine to follow versus trying to decide on the many other different approaches that have been recommended,^{18–29} (2) examples specific to the field of anesthesia and pain medicine for narrative reviews, and (3) some leeway when reporting, conducting, and evaluating narrative reviews in anesthesia and pain medicine. It is the hope that this paper will result in an increase in both the quality and consistency of reporting, conducting, and evaluating narrative reviews in the field, including a better understanding of the major differences between a narrative review and other types of reviews.

TYPES OF REVIEWS

As described by the Cochrane Collaboration³⁰ and derived from others,^{31 32} systematic reviews gather



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To cite: Kelley GA, D'Souza RS. *Reg Anesth Pain Med* Epub ahead of print: [please include Day Month Year]. doi:10.1136/rapm-2024-105661

all empirical evidence that meets an a priori inclusion criteria in order to try and answer a specific research question. The major characteristics of a systematic review include (1) an a priori review protocol, (2) prospective registration in a trial registry such as the International Prospective Register of Systematic Reviews (PROSPERO),³³ or elsewhere,³⁴ (3) a specific, detailed and transparent search strategy, (4) predeveloped and standardized data abstraction forms, (5) an assessment of the risk of bias for each study, and (6) either a qualitative or quantitative (meta-analysis) synthesis of the findings from each study as well as an overall summary of findings, including an assessment of the strength/certainty of findings.³⁵ The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) website provides reporting guidelines, including checklists, for the various types of systematic reviews (<http://www.prisma-statement.org/>). As an example specific to pain medicine and which adhered to the PRISMA reporting guidelines, a systematic review with meta-analysis executed an a priori registered protocol to investigate whether patients with chronic pain disorders treated with spinal cord stimulation led to improvements in physical function from baseline compared with 12-month follow-up.³⁶ This meta-analysis identified a statistically significant improvement in Oswestry Disability Index scores after 12 months of spinal cord stimulation (mean difference -17.00% , 95% CI -23.07 to -10.94 , $p < 0.001$) which also met the threshold for the minimal clinically important difference (MCID), although there was very low certainty evidence in this finding per the Grading of Recommendations Assessment, Development, and Evaluations (GRADE) framework due to high risk of bias, presence of clinical, methodological, and statistical heterogeneity, and possibility for small study effects.³⁶

Similarly, a systematic review without meta-analysis should adhere to PRISMA guidelines, as highlighted in a systematic review that assessed the impact of the COVID-19 pandemic versus historical controls predating the pandemic on opioid-related outcomes in participants with or at risk of opioid use, misuse, or opioid use disorder.³⁷ The authors concluded that surrogate measures of the opioid crisis, such as emergency department visits for opioid use disorder and urine drug testing positivity for illicit substances, increased and coincided with the onset of the COVID-19 pandemic, although GRADE certainty of evidence ranged from low to very low.³⁷

In addition to the resources available for the aforementioned reviews, instruments such as A MeaSurement Tool to Assess Systematic Reviews (AMSTAR-2) are available for evaluating the quality of systematic reviews, with or without meta-analysis.² Specific to pain medicine, this instrument has been used to examine the quality of meta-analyses addressing non-opioid, pharmacological, and perioperative interventions for chronic postsurgical pain.³⁸ The AMSTAR-2 instrument can also help guide the conduct of one's own systematic review, with or without meta-analysis.

As opposed to systematic reviews, scoping reviews attempt to map key concepts in a research area as well as the types of evidence currently available.³⁹ Broader in nature than systematic reviews, the key steps include (1) an a priori protocol, (2) prospective protocol registration in a registry such as Open Science Framework (OSF, <https://osf.io/>), (3) a specific, detailed and transparent search strategy, (4) predeveloped and standardized data abstraction forms, and (5) optional assessment of the risk of bias of the included studies. The authors note here that PROSPERO does not currently allow for the registration of scoping review protocols but others such as OSF do. As an example of a scoping review in anesthesia and pain medicine,

Morrison *et al* summarized the literature on the analgesic effects and complications from pericapsular nerve group (PENG) block for hip surgery and hip fractures. The authors concluded that the scope of current evidence supporting PENG block was limited to case reports and case series, although all included studies reported sufficient analgesia or anesthesia, with rare side effects of transient motor blockade. The PRISMA group, as well as others, provide reporting guidelines, including a checklist, for scoping reviews.¹²

While the guidelines for the reporting, conduct, and evaluation of systematic reviews and scoping reviews have been well-defined,²⁻¹³ well-established guidelines for conducting and evaluating narrative reviews, as previously mentioned, are more elusive.¹⁸⁻²⁹

GUIDELINES FOR NARRATIVE REVIEWS IN ANESTHESIA AND PAIN MEDICINE

To clearly distinguish between narrative reviews from systematic and scoping reviews, we recommend the general description of a narrative review by Sukhera, that is, a “noncomprehensive and non-exhaustive sample of the literature on a specific topic”.¹⁸ By adopting this definition, a narrative review, as opposed to systematic and scoping reviews, allows for greater flexibility, including, but not limited to, a subjective look and critique of the topic undertaken. Well-conducted narrative reviews may be especially important given previous research showing that narrative reviews, also known as clinical reviews, were accessed more frequently than primary research papers or systematic reviews after the first week of publication.⁴⁰ However, this previous study included papers from the year 2001 and may not reflect current practice given the increased production of systematic reviews since that time.⁴⁰ The authors are not aware of any recent research addressing this issue.

Table 1 provides a list of characteristics of narrative reviews, and for comparison purposes, the characteristics of systematic and scoping reviews also. We note here that while different in approach, all three types of reviews include both a descriptive (describing what was found), as well as critical (strengths, weaknesses, gaps) appraisal of the literature. As can be seen in table 1, we consider the characteristics of a narrative review to include the following: (1) a purpose and rationale, (2) a description of the scope of the question that is clinically relevant and includes a description of the population of interest, (3) the inclusion of empirical and theoretical literature, (4) a narrative synthesis of the data based on the authors' interpretation of the evidence, and (5) suggestions to aid clinical practice and/or future research. Characteristics not indicative of a narrative review include the following: (1) an a priori protocol, (2) a detailed search strategy, (3) a structured and detailed description for study screening and data abstraction, (4) a risk of bias assessment based on an existing instrument, and (5) an appraisal of the quality and/or certainty of the evidence-based on an existing instrument, although a qualitative evaluation based on the synthesis of evidence is important. As can be seen, the increased flexibility of a narrative review suffers from the possibility of increased bias. This is especially true as there is a heavy reliance on authors of narrative reviews to provide an honest and objective synthesis of the literature. Table 2 provides a checklist for producers of narrative reviews that we recommend as a requirement when submitting a manuscript to anesthesia and pain medicine journals, including, but not limited to, *Regional Anesthesia & Pain Medicine (RAPM)*. This checklist should also aid reviewers and consumers of narrative reviews. As an example of a narrative review, Chin *et al*

Table 1 Characteristics of systematic reviews, scoping reviews, and narrative reviews

Variable	Systematic review	Scoping review	Narrative review
Purpose/rationale for review*	To answer a specific clinical question based on explicit criteria (hypothesis-testing) by gathering data from relatively homogenous studies and providing a reproducible synthesis of available evidence.	To summarize and synthesize the existing literature on a question/topic, generally conducted when the literature is heterogenous or in its nascency when specific questions are challenging to answer; also provides an assessment of the scope of available literature and informs future gaps/directions; considered by some as the precursor to a systematic review.	To gather both empirical and theoretical evidence relevant to a problem, question, or topic; focuses on what is known about the topic and what methodology, model, concepts have been applied by others to the topic. This is often conducted by experts of a topic and can be an ongoing and iterative process.
Scope of question	Very specific and typically follows a framework (eg, population, intervention, comparison, outcome).	Scope may vary, but generally broad.	Scope may vary, but can be broad; more important to have a stated topic/problem and this is not always in the form of a question; should be clinically relevant and describe the population of interest.
Protocol registration	Prospective registration of review protocol (eg, PROSPERO registration); protocol violations/deviations should be reported in the final manuscript.	A priori protocol registration is optional, but recommended.	Not protocol-driven.
Sources of evidence	Defined study design types, ideally homogenous, are determined a priori.	May include all study types depending on the research question.	Includes both empirical and theoretical literature.
Search strategy	Explicit, transparent, reproducible, and peer-reviewed search strategy that often queries multiple databases and may also query the gray literature.	Explicit and transparent search strategy is often performed and recommended.	Not mandatory and often not performed.
Study selection	Criteria defined a priori; structured approach often involving at least two independent authors.	Structured approach involving at least two independent authors is recommended, but not mandatory.	Unstructured approach.
Data extraction	Standardized data extraction forms that collect outcomes and other a priori data items; performed by at least two independent authors.	Data extraction forms completed by at least two independent authors is recommended, but not mandatory.	Unstructured approach, often not involving data extraction forms.
Risk of bias assessment	Formal assessment of risk of bias is mandatory (eg, Cochrane risk of bias tool, Newcastle Ottawa Scale).	Critical appraisal of bias risk is not mandatory, but authors may decide to perform.	Often not applicable to topic.
Appraisal of quality or certainty of evidence	Formal assessment of quality (certainty) of evidence of primary outcome is mandatory (eg, GRADE).	Critical appraisal of quality (certainty) of evidence is not mandatory and often not performed.	Often not applicable to topic.
Synthesis of data	Tabular and/or graphical summary, sometimes accompanied by a meta-analysis; additional methods of synthesis may be conducted (eg, sensitivity analysis, subgroup analysis, meta-regression).	Narrative/tabular summary, thematic categorization of findings.	Reviewing and synthesizing the literature in narrative and/or tabular form with authors' <i>critical</i> interpretation of evidence.
Reproducibility	Synthesis is typically reproducible if steps from protocol are followed.	Not typically reproducible (prone to bias from author team).	Not typically reproducible (prone to bias from author team).
Implications for research and/or practice	Provision of concrete recommendations; can guide clinical practice and inform decision-making.	Conclusions seldom impact clinical practice, but may guide future research.	Suggestions for clinical practice and/or research but may suffer from author bias.
Guideline (checklist)	Reporting checklist: PRISMA.	PRISMA-ScR.	Not applicable.
Tool to appraise quality of review	Guidance for conducting a systematic review: IOM, Cochrane, AHRQ, etc. AMSTAR-2.	Guidance for conducting a scoping review: JBI, etc.	Not applicable; certain articles have proposed scales to appraise narrative review quality (eg, SANRA ²¹).

*All types of review should provide justification of the article's importance to the readership.

AHRQ, Agency for Healthcare Research and Quality; AMSTAR-2, A Measurement Tool to Assess Systematic Reviews; GRADE, Grading of Recommendations Assessment, Development and Evaluation; IOM, Institute of Medicine; JBI, Joanna Briggs Institute; PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses; PRISMA-ScR, Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews; PROSPERO, International Prospective Register of Systematic Reviews; SANRA, Scale for the Assessment of Narrative Review Articles.

defined the scope of their article as reviewing evidence and identifying knowledge gaps on proposed mechanisms of action underlying fascial plane blocks.⁴¹ The authors justified that this topic was considered important, timely, and of interest to the

readership because mechanisms of action from fascial plane blocks are controversial.⁴¹ After reviewing both empirical data (eg, areas of injectate spread with time, concentrations of local anesthetic in various compartments with time, necessary local

Table 2 Checklist list for narrative reviews in anesthesia and pain medicine

Item	Location reported
Purpose and rationale for review stated and acceptable.	—
Scope of question acceptable with a clinically relevant question asked.	—
Sources of evidence include both empirical and theoretical literature.	—
Synthesis of data conducted in a narrative and/or tabular format with appropriate interpretation of the evidence.	—
Recommendations for practice and/or future research appropriate and acceptable based on the literature reviewed.	—

anesthetic concentration for neural conduction blockade) as well as theoretical data (eg, promotion of bulk flow and fascial plane spread from higher volumes), the authors synthesized and reported these data in tabular and graphical format.⁴¹ They concluded that their synthesis represents their subjective analysis of the current evidence, and that the two most plausible mechanisms of analgesia from fascial plane blocks include: localized action on nociceptors at the site of the injection within the fascial plane which is mediated by bulk flow and diffusion, and systemic effect from vascular absorption of local anesthetic.⁴¹ The authors also reported that the relative importance of each mechanism is uncertain and an area of future research.⁴¹ Despite the uncertainty, the authors recommended that clinicians should accept that the efficacy from fascial plane blocks may be unpredictable in any given patient, and this modality should be included as part of multimodal analgesic pathways.⁴¹

The decision to pursue a narrative review instead of other types of reviews (eg, systematic review, scoping review) may depend on several factors, including the scope and context of the question, adequacy of available literature, outcomes of interest, and other factors. The following is a list of examples, three real and one hypothetical, of when a narrative review would be appropriate:

- ▶ Therapeutic mechanism of action (eg, peripheral nerve stimulation)—What are the central and peripheral mechanisms of peripheral nerve stimulation in relieving acute and chronic pain from preclinical models and how do they apply to the human model?⁴²
- ▶ Use of adjunct analgesics in the perioperative setting (eg, methadone)—What are the advantages and disadvantages of incorporating methadone into enhanced recovery after surgery pathways?
- ▶ Regional anesthetic blocks for postoperative analgesia (eg, motor-sparing blocks for orthopedic surgery)—Are motor-sparing blocks for hip and knee surgery preferable to traditional regional blocks in terms of analgesia and return of strength?⁴³
- ▶ Evidence-based recommendations on therapy optimization (eg, outcomes from spinal cord stimulation)—What are the causes for therapy habituation to spinal cord stimulation and what strategies can be employed to salvage relief?⁴⁴

CONCLUSIONS

The guidelines recommended here should aid producers, reviewers, and consumers of narrative reviews in anesthesia and pain medicine, including *RAPM*. Adherence to such should help differentiate between narrative reviews and other types of reviews as well as provide consistency in what elements are necessary to include in a narrative review in the field of anesthesia and pain medicine.

Collaborators Not applicable.

Contributors GAK participated in study design, data collection, writing the manuscript, editing the manuscript, and coordinating meetings. RSD

participated in study design, data collection, writing the manuscript, and editing the manuscript. GAK is the guarantor for all information associated with this manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient and public involvement statement Not applicable.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data sharing not applicable as no data sets generated and/or analysed for this study.

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