**Supplementary file 4.** List of studies included in *'Trials of this type are not a priority / are unlikely*' category, corresponding Cochrane Review Group, verbatim and categorization of reasons for their inclusion

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| **Numeral** | **Title** | **Cochrane Review Group** | **Verbatim** | **Categorization** |
|  | Infraclavicular brachial plexus block for regional anaesthesia of the lower arm | Cochrane Anaesthesia  Group | Ultrasound guidance has largely replaced neurostimulation in modern brachial plexus blockade, and has improved the efficacy of all the commonly‐used techniques. Given the high success rates reported in recent studies, it is unlikely that additional comparative trials will lead to a demonstration of a difference in efficacy between the various techniques. | Sufficient evidence about the effects of the intervention |
|  | Effects of sevoflurane versus other general anaesthesia on emergence agitation in children | Cochrane Anaesthesia  Group | Data on the effects of halothane versus sevoflurane on EA were adequate, and further research is unlikely to generate useful additional findings with respect to EA risk in children. Further investigation of dexmedetomidine and use of propofol‐based anaesthesia, as described in the included studies, is also unlikely to generate further useful data, as these interventions have been shown to be clearly effective. | Sufficient evidence about the effects of the intervention |
|  | The use of ultrasound guidance for perioperative neuraxial and peripheral nerve blocks in children | Cochrane Anaesthesia  Group | The number of trials available is now sufficient to allow us to conclude that ultrasound guidance probably offers some advantages regarding most of our beneficial outcomes: success rate (Analysis 1.1), reduced pain at one hour after surgery (Analysis 1.2), and prolonged block duration (Analysis 1.3). It seems unlikely that additional research will substantially affect these conclusions. | Sufficient evidence about the effects of the intervention |
|  | Acupuncture for the prevention of episodic migraine | Cochrane Pain and  Palliative Care Group | Although further sham‐controlled trials are desirable, we think that such studies should not have the highest priority unless they also address other important questions | No specific reason stated |
|  | Acupuncture for the prevention of tension-type headache | Cochrane Pain and  Palliative Care Group | We do not consider sham‐controlled trials a priority for the future. | No specific reason stated |
|  | Gabapentin or pregabalin for the prophylaxis of episodic migraine in adults | Cochrane Pain and  Palliative Care Group | While efficacy for high doses of gabapentin has not been ruled out, the evidence for this drug, overall, is not promising and does not lead us to recommend further studies with any degree of priority. | The evidence about the intervention is not promising |
|  | Imipramine for neuropathic pain in adults | Cochrane Pain and  Palliative Care Group | There are reasonable levels of evidence for the benefit of other anti‐epileptic and antidepressant drugs in the treatment of chronic neuropathic pain.  Larger, better‐designed studies would provide more definitive conclusions on the efficacy of imipramine, but it is unlikely that these will be carried out, given the age of the drug and the alternatives available, or that they could be justified on the basis of the available evidence. | Sufficient evidence about the effects of the intervention |
|  | Methadone for cancer pain¸ | Cochrane Pain and  Palliative Care Group | While it would be easy to suggest that further research is needed, in practice this is very unlikely to happen as this is an old drug and funding is not likely to be forthcoming. | Old intervention; monetary reasons |
|  | Normobaric and hyperbaric oxygen therapy for the treatment and prevention of migraine and cluster headache | Cochrane Pain and  Palliative Care Group | Any further investigations would need to be carefully justified. The effect of differing oxygen dosage and of other therapies administered simultaneously is not known. | Unknown/serious adverse effects |
|  | Nortriptyline for neuropathic pain in adults | Cochrane Pain and  Palliative Care Group | Larger, better‐designed studies would provide more definitive conclusions on the efficacy of nortriptyline and support its continued use in neuropathic pain, but it is unlikely that these will be carried out, given the age of the drug and the alternatives available. | Old intervention; Good alternatives are already available |
|  | Phenytoin for neuropathic pain and fibromyalgia in adults | Cochrane Pain and  Palliative Care Group | This seems unlikely to occur due to the cost of such studies and the lack of financial incentive behind them, in this case because phenytoin is out of patent and there would be little or no profit to justify the large trial costs. | Intervention out of patent; monetary reasons |
|  | Selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) for the prevention of migraine in adults | Cochrane Pain and  Palliative Care Group | A randomised controlled trial comparing a SSRI or a SNRI versus another drug or another non‐pharmacological intervention is not a priority in the migraine research pipeline and might not exert a significant impact on the overall evidence. | No specific reason stated |
|  | Selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) for the prevention of tension-type headache in adults | Cochrane Pain and  Palliative Care Group | However, we think that a small, or large, RCT comparing a SSRI or a SNRI versus another drug or another non‐pharmacological intervention is not a priority and might not exert a significant impact on the overall evidence. | No specific reason stated |
|  | Single dose oral aceclofenac for postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Given the large number of available drugs of this and similar classes which have good evidence of efficacy in acute postoperative pain, there is no urgent research agenda for this drug. This review should not require updating unless a substantial body of new clinical trials on aceclofenac appears, an unlikely eventuality. | Good alternatives are already available |
|  | Single dose oral acemetacin for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Given the large number of available drugs of this and similar classes, there is no urgent research agenda. | Good alternatives are already available |
|  | Single dose oral aspirin for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | It is unlikely that further studies of this sort will be carried out for aspirin, and we have a sufficiently large body of evidence to be confident with the results for the 600/650 mg dose. | Sufficient evidence about the effects of the intervention |
|  | Single dose oral dexibuprofen [S(+)-ibuprofen] for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | A considerable additional body of clinical trial results would be needed to know whether dexibuprofen has any advantages in efficacy, or faster analgesic onset, or safety over racemic ibuprofen. There seems little need for this research, as emerging evidence is that formulation is likely to be more important than chirality for NSAIDs in acute pain. | Sufficient evidence about the effects of the intervention |
|  | Single dose oral dextropropoxyphene, alone and with paracetamol (acetaminophen), for postoperative pain | Cochrane Pain and  Palliative Care Group | It is unlikely that new studies in acute pain will feature dextropropoxyphene alone or in combination with paracetamol, and there does not appear to be any pressing need for new studies because there are many alternative analgesics now available. | Good alternatives are already available |
|  | Single dose oral diflunisal for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Futher larger placebo controlled studies of good methodological quality and using clinically relevant outcomes would provide more robust estimates of efficacy, and studies including active comparators would allow head to head comparisons. However, diflunisal is not a frequently prescribed drug in developed countries, and it seems unlikely that such studies will be forthcoming. | Monetary reasons / impractical |
|  | Single dose oral etoricoxib for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | It is unlikely that further studies will be carried out for this dose and in this setting, and if they were, that they would change the result here. | No specific reason stated |
|  | Single dose oral fenbufen for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Given the large number of available drugs of this and similar classes to treat postoperative pain, there is no urgent research agenda. | Good alternatives are already available |
|  | Single dose oral fenoprofen for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Given the large number of available drugs of this and similar classes to treat postoperative pain, there is no urgent research agenda, and indeed the most recent studies identified were published in the mid 1980s. More studies could more accurately determine efficacy, but are unlikely to be performed because of well known alternatives. | Good alternatives are already available |
|  | Single dose oral indometacin for the treatment of acute postoperative pain | Cochrane Pain and  Palliative Care Group | However, it is unlikely that such studies will be performed since indometacin is one of the older NSAIDs on the market; newer, safer, and efficacious NSAIDs have since been developed. | Old intervention; Good alternatives are already available |
|  | Single dose oral lornoxicam for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Given the large number of available drugs of this and similar classes to treat postoperative pain, there is no urgent research agenda. | Good alternatives are already available |
|  | Single dose oral lumiracoxib for postoperative pain in adults | Cochrane Pain and  Palliative Care Group | We see no implications for research in the field of single dose acute pain studies. | No specific reason stated |
|  | Single dose oral mefenamic acid for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Given the large number of available drugs of this and similar classes to treat postoperative pain, there is no urgent research agenda. More studies could more accurately determine efficacy, but are unlikely to be performed because of well known alternatives. | Good alternatives are already available |
|  | Single dose oral meloxicam for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Given the large number of available drugs of this and similar classes to treat postoperative pain, there is no urgent research agenda. | Good alternatives are already available |
|  | Single dose oral nabumetone for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Given the large number of available drugs of this and similar classes to treat postoperative pain, there is no urgent research agenda. | Good alternatives are already available |
|  | Single dose oral nefopam for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Given the large number of available drugs of this and similar classes, there is no urgent research agenda. | Good alternatives are already available |
|  | Single dose oral paracetamol (acetaminophen) for postoperative pain in adults | Cochrane Pain and  Palliative Care Group | It is unlikely that further studies will alter the estimates for the primary outcome of at least 50% pain relief over four to six hours. | No specific reason stated |
|  | Single dose oral rofecoxib for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | There is no obvious requirement for further research in classical acute pain trials for two reasons. There is already a large body of data providing results unlikely to change with more trials. In addition, the licensed status of rofecoxib in many parts of the world make it unlikely to be used, making new research in the acute pain model unnecessary. | Sufficient evidence about the effects of the intervention; monetary reasons |
|  | Single dose oral sulindac for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Given the large number of available drugs of this and similar classes to treat postoperative pain, there is no urgent research agenda. | Good alternatives are already available |
|  | Single dose oral tenoxicam for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Given the large number of available drugs of this and similar classes to treat postoperative pain, there is no urgent research agenda. | Good alternatives are already available |
|  | Single dose oral tiaprofenic acid for acute postoperative pain in adults | Cochrane Pain and  Palliative Care Group | Given the large number of available drugs of this and similar classes to treat postoperative pain, there is no urgent research agenda. | Good alternatives are already available |
|  | Sweet tasting solutions for reduction of needle-related procedural pain in children aged one to 16 years | Cochrane Pain and  Palliative Care Group | For school‐aged children: Despite the small number of studies examining analgesic efficacy of sweet taste in school‐aged children, the available evidence from the two studies included in this review, as well as three studies of sweet taste during CPT (Mennella 2010; Miller 1994; Pepino 2005), suggest that this intervention is not of sufficient benefit to recommend at this time. Further studies of sweet tasting solutions, substances, or foods to reduce procedural pain cannot be recommended as a research priority in this population. | Sufficient evidence about the effects of the intervention |
|  | Topical capsaicin (low concentration) for chronic neuropathic pain in adults | Cochrane Pain and  Palliative Care Group | Studies using repeated applications of low‐concentration capsaicin have not convincingly demonstrated good efficacy. No new studies of low‐concentration topical capsaicin have been published since 1997 and been found worthy of inclusion in this review. It seems unlikely that further research with low‐concentration creams is worthwhile. | Sufficient evidence about the effects of the intervention |
|  | Valproic acid and sodium valproate for neuropathic pain and fibromyalgia in adults | Cochrane Pain and  Palliative Care Group | Evidenced‐based decisions require further study, but since these drugs are associated with known serious adverse effects, and alternative therapies are available, it is unlikely that any large trials will be conducted. | Unknown/serious adverse effects |
|  | Zolmitriptan for acute migraine attacks in adults | Cochrane Pain and  Palliative Care Group | Further large, good quality randomised controlled trials making direct comparisons of efficacy and harm between zolmitriptan and other triptans, common analgesics (aspirin, ibuprofen, paracetamol, diclofenac) and ergot derivatives now seem unlikely to be done. | No specific reason stated |