Tabel 7. Uitgangsvraag 6 – Welke vorm van revalidatie kan klachten voorkomen/verminderen tijdens de ziekte- en symptoomgerichte palliatieve fase?

Study (trial) ID	Study type	Source of fun-ding/ conflicts of interest	Setting	Hypotheses	Eligibility criteria	Sample size/ Lost to follow up	Duration of the Study	Randomi-zation method	Patient cha-racteristics and group comparability	Interventions and compli-ance	Control/ Comparator (including duration, dose)	Primary Outcome Measure (s) Secondary Outcome Measure (s)	Effect size – Primary outcome(s) Effect size – Secondary outcome (s)	All other outcomes, endpoints	Critical appraisal of study quality	Level of eviden-ce
Brown 2006	Stratified RCT	Linse Bock Foundation and Saint Mary's Hosp-ital Spon-sorship Board. No indication of conflicts of interest	Division of Radiation Oncology Mayo Clinic Rochester	To examine the effect of participation in a structu-red, multidis-ciplinary in-tervention on fatigue for advanced cancer patients	Inclusion criteria: adult advanced cancer patients planned to undergo radiation therapy – cancer diag-nosis within the last 12 months, expected survival of at least 6 months, but 5-year survival probability ≤ 50%, treatment recommenda tion of radiation therapy for at	Randomi-zed: Inter-vention: 57; control: 58 Completed week 4 as-sessment: Intervention: 46; control: 54	4 weeks intervention. Completion of question-naires at week 4, 8, and 27	Stratification for tumor type, age, gender, and ECOG score, using a minimize-tion pro-cedure that balances the marginal dis-tributions	Comparable groups. 35% women, 80% over 50 years, 60% on current chemo-therapy, mean radio-therapy dose 5322 cGy in 29 fractions, 80% married, 55% em-ployed, median hemoglobin 12,3, mean MMSE 28,7, mean POMS 68, mean SDS 66, mean LASA 54, mean STAI 55	Participants attended 8 90-minutes sessions over 4 weeks. Manual about the sessions. Each sessions had a theme focusing on quality of life. Begin: 20 minutes exercise, followed by educati-onal information, cognitive-behavioral strategies, discussi-on, and support. Motion,	No inter-vention, standard care	Primary: single-item Linear Ana-logue Self Assessment (LASA) fati-gue ques-tion. Secon-dary: Profile of Mood States (POMS), Fatigue-Inertia Subscale and Vigor-Activity Sub-scale, Spiel-berger's State-Trait Anxiety Inventory (STAI), Symptom Distress Scale (SDS)	No signi-ficant differ-ences in mean fatigue scores be-tween arms at any week. There were trends noti-ced favoring the standard treatment (less fatigue when no intervention)	Overall qua-lity of life improved in the interven-tion arm (i.e. primary end-point of the initial study, but not re-ported in detail in this article)	Randomized study, but not blinded (full blinding is not possi-ble because of the inter-vention, but the investi-gators could have been blinded). To-tal number of participants is not that high	B

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					least 2 weeks. Ex-clusion crite-ria: MMSE < 20, ECOG ≥ 3, active al-cohol or sub-stance de-pendence (except nico-tine), active thought dis-order, sui-cidal plans, participation in psycho-social re-search trial					stretching, functional exercises. Individualize d home program. End of ses-sion: relaxation exercise						
Cristo-pher 2004	Pilot pre-post study in one group	No information	Oncology Community Outreach Program, University of Masachu-setts	To evaluate the impact of a commu-nity-based 12-week exercise program on physical and psychosocial well-being in	Participants of fall and winter exercise pro-grams. Women that survived cancer. No criteria about life expect-	21 patients (12 fall exercise, 9 winter exercise)	12 week exercise program, pre- en post-test question-naires	No randomi-zation	All women, al-most all breast can-cer patients, mean age 60 years, al-most all white patients, 80%	12 week exercise program, twice a week, low-impact aerobics, toning, flexibility exercises,	No control group	Pscychosoci al Adjust-ment to Ill-ness Scale (PAIS-SR), Profile of Mood States-short form (POMS-SF), Symp-	Almost no statisti-cally significant differrences were found. In the group that attended the fall exercise statisti-cally	No other outcomes	No compara-tive design, weak de-scription of important parameters, e.g. exercise program, patient re-cruitment,	C

Study (trial) ID	Study type	Source of fun-ding/ conflicts of interest	Setting	Hypotheses	Eligibility criteria	Sample size/ Lost to follow up	Duration of the Study	Randomi-zation method	Patient cha-racteristics and group comparability	Interventions and compli-ance	Control/ Comparator (including duration, dose)	Primary Outcome Measure (s) Secondary Outcome Measure (s)	Effect size – Primary outcome(s) Effect size – Secondary outcome (s)	All other outcomes, endpoints	Critical appraisal of study quality	Level of eviden-ce
				women cancer survivors	ancy				married, mean time since diagnosis 44 months, mean time since treat-ment ended 22 months	relaxation techniques		tom Distress Scale (SDS), Piper Fati-gue Scale (PFS), Qua-lity of Life-Cancer Sur-vivors Scale (QOL-CS)	significant improvement was mea-sured on subscales (domestic environment, psychosocial distress, and social well-being)		poor article, very few pa-tients, no distinction in cancer stage and life expectancy	
Cramp 2008	Coch-rane syste-matic review	No external sources of support, internal source: faculty health social care, University West Eng-land, no indi-cations of conflict of interest	-	To evaluate the effect of exercise on cancer-rela-ted fatigue during and after cancer treatment	Only RCT's were inclu-ded. Adults of any age, regardless of gender, tu-mour type, tumour sta-ge, type of cancer treat-ment. Pa-tients could be in active treatment, in long-term follow-up or receiving	28 RCT's included, total 2083 patients	-	-	Most patients had breast can-cer, stages of cancer varied, sta-ges of treat-ment varied, most pa-tients were women, mean age 39-69 years	Any exercise intervention aimed to reduce fa-tigue asso-ciated with cancer	No exercise, usual care, alternateve treatment	Patient-reported fatigue (mul-tiple scales), exercise maintenance on follow-up, attrition, time spent exer-cising, aero-bic capacity, quailty of life measures, anxiety, de-pression, self-efficacy	Less fatigue in pa-tients that were in the inter-vention group (SMD -0,23; 95% BI -0,33- -0,13). Pre-post test changes: intervention more effect-tive (SMD -0,23; 95% BI -0,36- -0,09) In breast	Only meta-analyses reported in this evidence table. To re-port valid re-sults of sing-le studies (that are mentioned in the review), one should have more information of those single trials	Good Coch-rane syste-matic re-view. Value for this guideline however limited, because of no distincti-on in the analyses in subgroups of cancer stage (although these data are collected	A1

Study (trial) ID	Study type	Source of fun-ding/ conflicts of interest	Setting	Hypotheses	Eligibility criteria	Sample size/ Lost to follow up	Duration of the Study	Randomi-zation method	Patient cha-racteristics and group comparability	Interventions and compli-ance	Control/ Comparator (including duration, dose)	Primary Outcome Measure (s) Secondary Outcome Measure (s)	Effect size – Primary outcome(s) Effect size – Secondary outcome (s)	All other outcomes, endpoints	Critical appraisal of study quality	Level of eviden-ce
					palliative care								cancer pa-tients this effect was even bigger		as stated in the paper)	
London 2005	Prospec-tive ob-servatio-nal study	Robert Wood Johnson Foundation Promoting Excellence National Pro-gram Office, Supportive Care of the Dying	CALL Care sites, facile-ties of sup-portive care for the dying: a coalition for compas-sionate care	To evalu-ate the CALL-in-terventi-on in pa-tient with life-threa-tening can-cer, cardiac illness, res-piratory conditions or dementia	Cancer stage IV, Car-diac illness stage III or IV or ejection fraction ≤ 25%, De-mentia stage 6 or 7 of FAST, Res-piratory Illness Kar-novsky score < 50 or re-quired oxy-en for acti-vities of daily living	295 pa-tients at enrol-ment, no completed question-naires at 18 months (94 patients died during the study)	18 months	No randomi-zation	Mean age 72 years, 62% female, 88% whites, 41% lived at home with family, 21% alone at home, and 26% in a nursing home	CALL Care Approach: a variety of services (e.g. coordi-nate physic-cian visits, connect with spiritual care provider, educate patient and family, plan for universal activities, pro-active bereavement follow-up), coordinated by a specific multidisciplin-ary CALL Care team	No control group	Scores on Modified City of Hope Patient Question-naire (55 items on physical, emotionnal/ relationship, spiritual, health-care experience, and health care provi-ders commu-nication) at enrollment, 1, 3, 6, 9, 12, 15, and 18 months	Comparing the enroll-ment score and the last data alive there were better, but insignificant scores on fatigue and nau-sea, and better sig-nifycant scores on sleep, mouth/ food symptoms (e.g. dry mouth, appetite changes), intestinal problems, breathing	No other outcomes	No compara-tive design, no informa-tion on pa-tient recruit-ment, large amount of patients lost-to-follow-up, probably selective	C

Study (trial) ID	Study type	Source of fun-ding/ conflicts of interest	Setting	Hypotheses	Eligibility criteria	Sample size/ Lost to follow up	Duration of the Study	Randomi-zation method	Patient cha-racteristics and group comparability	Interventions and compli-ance	Control/ Comparator (including duration, dose)	Primary Outcome Measure (s) Secondary Outcome Measure (s)	Effect size – Primary outcome(s) Effect size – Secondary outcome (s)	All other outcomes, endpoints	Critical appraisal of study quality	Level of eviden-ce
													problems, and pain			
Lowe 2009	Syste-matic review	National Cancer Institute of Canada Canadian Cancer So-ciety, Socio-behavioral Cancer Re-search Net-work	-	To review the evid-ence of physical activity as supportive care inter-vention in palliative cancer patients	A study had to examine a physical act-vity inter-vention in palliative cancer pa-tients, aged 18 years or older, re-gardless of gender, tu-mor type, or type of can-cer treat-ment. Palliative cancer was defined as progressive, incurable lo-cally recur-rent or me-tastatic can-cer, with a life expec-	6 studies, total 84 patients. All pilot studies, some case-reports	-	-	Mean age 58 years, 64/84 women, most pa-tients having breast can-cer, followed by gastroin-testinal can-cer	Supervised group exer-cise pro-grams and unsupervi-sed home-based phy-sical activity program (Duke Ener-gizing Exer-cise Plan for 9 patients, Arm-chair Fitness and gentle exer-cise video for 38 breast cancer patients, group exercise program focused on muscle strength,	Most studies had no com-parison	Primary outcomes: Patient-re-ported quality of life, patient-reported physical functioning, patient-reported fatigue. Secondary outcomes: objective measures of physical fitness and physical functioning, patient-re-ported palliative symptoms	In one of the studies sig-nificant lower decline in total well-being scores in intervene-tion group. The only RCT showed no significant differences	No other outcomes	Systematic review of poor studies, only one RCT, rest of the studies non-compa-rative and even case reports. No meta-analy-sis. Classifi-cation on the validity is not possible due to the poor quality of the underlying studies	No level

Study (trial) ID	Study type	Source of fun-ding/ conflicts of interest	Setting	Hypotheses	Eligibility criteria	Sample size/ Lost to follow up	Duration of the Study	Randomi-zation method	Patient cha-racteristics and group comparability	Interventions and compli-ance	Control/ Comparator (including duration, dose)	Primary Outcome Measure (s) Secondary Outcome Measure (s)	Effect size – Primary outcome(s) Effect size – Secondary outcome (s)	All other outcomes, endpoints	Critical appraisal of study quality	Level of eviden-ce
					tancy of less than 12 months					standing balance and aerobic en-durance for 34 patients)						
Mustian 2006					Newly diag-nosed can-cer patients undergoing curative treatment → therefore this study is excluded for further analysis											
Oldervoll 2006	Pilot study, Phase II	Norwegian Foundation for Health and Reha-bilitation and the Norwegian Cancer So-ciety. No in-dication of conflict of interest	Oncological outpa-tient clinic at St. Olav Hospi-tal in Trond-heim and Hos-pice Lovenberg	To evaluate the effect of a 6-week structured exercise pro-gram on HRQOL, fatigue, and physical per-formance in cancer pa-tient with	Cancer pa-tients with a life expec-tancy be-tween 3 and 12 months, Karnofsky performance score ≥ 60, adequate pain relief, and lived	63 patients at enroll-ment, 29 patients dropped out due to sudden death, or medical or social rea-sons. There seems to be	6 weeks	No randomi-zation	15 males, 19 females, mean age 65 years, 88% not employ-yed, median KPS 80, differ-rent types of cancer (16 gastro-intes-tinal cancer),	Exercises in groups (3-8 patients per group), twice a week, 50 minutes per session, 6 weeks long. Warm-up session, circuit trai-ning with 6	No control group	EORTC-Quality of Life Ques-tionnaire-C 30 (EORTC QLQ-C30), Fatigue Question-naire (FQ), 6 minute walk, timed sit-to-stand, functi-	Significant improvement in emotional functioning (69→78, p= 0,002). Fatigue score de-creased: 51→43 (p=0,06; less fatigue).	Increase in walking distance by 29 meter (p= 0,007), de-crease in time sit-to-stand of 1 second (p=0,001)	Well-docu-mented study, but non-compa-rative de-sign. Only a few patients in the study	C

Study (trial) ID	Study type	Source of fun-ding/ conflicts of interest	Setting	Hypotheses	Eligibility criteria	Sample size/ Lost to follow up	Duration of the Study	Randomi-zation method	Patient cha-racteristics and group comparability	Interventions and compli-ance	Control/ Comparator (including duration, dose)	Primary Outcome Measure (s) Secondary Outcome Measure (s)	Effect size – Primary outcome(s) Effect size – Secondary outcome (s)	All other outcomes, endpoints	Critical appraisal of study quality	Level of eviden-ce
				short life expectancy	less than 30 minutes from the hospital. Consecutive patients	selective follow-up → 34 pa-tients in analysis			80% meta-stases	stations, relaxation/ stretching session. Focus on muscle strength, standing ba-lance, and aerobic en-durance		onal reach	Same trends on other sca-les. Physical functioning and global quality of life remained stable. Dys-pnea redu-ced (42 →60, p= 0,006), role + social functioning improved (50→ 63, p=0,02 and 55→65, p=0,008).			
Porock 2000	Pre-test post-test design, pilot study	Silver Chain Nursing Foundation and Edith Cowan Uni-versity	Home Hos-pice Care Service in Perth, Wes-tern Austra-lia	To deter-mine the effects of an individuali-zed exercise program (Duke Ener-gizing Exer-cise Pro-	Patients with advanced cancer, ECOG clas-sification of 1 and more, estimated life expectancy of at least 1	11, 2 drop-ped out for selective reasons (feeling unwell, fin-ding it all too much), 6 comple-ed	4 weeks	No randomi-zation	9 patients, mean age 60 years, 6 female, 4 bowel can-cer, 2 pancreas cancer, 7 pa-tients with	Physiotherap ist spe-cialized in oncology and palliative care conduc-ted home vi-sit and edu-cated the	No control group	Multidimen-sional Fatigue Inventory (MFI), Symp-tom Distress Scale (SDS), Hospital Anxiety and	Minimal fluctuation in the mean MFI sub-scale sco-res, quality of life scores improved from day 0 to	No other outcomes	Very few patients in the study, lack of com-plete data, non-compa-rative study	C

Study (trial) ID	Study type	Source of fun-ding/ conflicts of interest	Setting	Hypotheses	Eligibility criteria	Sample size/ Lost to follow up	Duration of the Study	Randomi-zation method	Patient cha-racteristics and group comparability	Interventions and compli-ance	Control/ Comparator (including duration, dose)	Primary Outcome Measure (s) Secondary Outcome Measure (s)	Effect size – Primary outcome(s) Effect size – Secondary outcome (s)	All other outcomes, endpoints	Critical appraisal of study quality	Level of eviden-ce
				gram) on levels of fatigue in patient with advanced cancer	month. Ex-clusion cri-teria: eviden-ce of confu-sion or de-mentia, uncontrolled symptoms over the past 24 hours, inability to walk 50 me-ers or more pain free, any preex-sting condi-ions or other medical rea-son for which exercise would be contraindi-cated	all 5 MFI scale mea-surements			metastases, 3 patients on current treat-ment, 7 pa-tients on opioids, 7 on antiemetics, 4 on anal-gesics, 4 on bowel treat-ment, 4 pa-tients had additional care	patient and prescri-bed an indivi-ualiz-ed plan. Patients were given a range of activities through the day. Home visit in the week follo-wing the start, and telephone call in the second week		Depression Scale (HADS), Quality of Life Scale (QOL Scale)	day 14			
Rad-bruch 2008	Narrative review → therefore no further analysis															

Study (trial) ID	Study type	Source of fun-ding/ conflicts of interest	Setting	Hypotheses	Eligibility criteria	Sample size/ Lost to follow up	Duration of the Study	Randomi-zation method	Patient cha-racteristics and group comparability	Interventions and compli-ance	Control/ Comparator (including duration, dose)	Primary Outcome Measure (s) Secondary Outcome Measure (s)	Effect size – Primary outcome(s) Effect size – Secondary outcome (s)	All other outcomes, endpoints	Critical appraisal of study quality	Level of eviden-ce
Strasser 2004	Retro-spective descrip-tive com-parative study	Swiss Cancer Re-search	Multidisci-plinary Clinic and traditi-onal pain and symp-tom mana-gement clinic at the U-niversity of Texas MD Anderson Cancer Center	To cha-racterize symp-toms, recommen-dations, and effect of multidisc-ciplinary team on symptom expression and overall satisfaction of patient and fami-lies. Com-parison with traditional pain and symptom manage-ment	First 138 consecutive patients at the MD clinic and a cones-cutive sam-ple of 77 pa-tients seen at the PSM clinic	138 patients in MD clinic, 77 patients in PSM cli-nic. No lost-to-follow-up due to retro-specttive design	Retrospec-tive chart analysis, + follow-up (mean 9 days) at MD Center	No randomi-zation	Adults with primary tumors of various types. Refer-ral to the clinics for pain control, end-of-life issues (only MD), and management of multiple symptoms (only MD), 54% female, mean age 54 years, me-dian survival 10 weeks in MD, and 51 weeks in PSM clinic	MD Clinic has no wait--ing area, pa-tients have private room with bed and bathroom. In 5 hours the patient is assessed by a physician, nurse, social worker, physical, oc-cupational, speech the-rapist, phar-macist, nu-tritionist, psychiatric nurse practi-tioner, and pastoral care worker. On-site counse-ling, specific education, and simple interventions	Traditio-nal pain and symptom management given by a physician and a nurse	In MD Clinic: ad-hoc question-naire with 7 items, to be answered on a 5-point scale, focus-sed on satis-action. Re-trospective chart review on symp-toms, results of stand-ardized as-sessments, and recom-mendations	In the MD group pa-tients received median 4 non-phy-sician recommend-dations, in the PSM group none. In MD group significant improvement in pain, nausea, de-pression, anxiety, sleep, shortness of breath, and well-being, but not in fatigue, a-norexia, or drowsiness. No compa-rative data, patients in	No other outcomes	Both groups are not com-parable at baseline due to differen-ces in the severity of the disease. Almost no comparisons have been made be-tween the groups, so this study is best worth given a non-comparative retrospective study, how-ever with useful infor-mation	C

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										are provided. Multidisciplin-ary team discussion on assess-ment and recommenda tion, given to the patient. Follow-up in 1-2 weeks is provided			the MD clinic were overall as on sub-scores very satisfied			
Solà 2004	Coch-rane syste-matic review			To deter-mine the effective-ness of non-invasive inter-entions delivered by health-care professio-nals in im-proving symptoms, psychosocial functionning and quality of life	Only RCT's and CCT's were inclu-ded. Studies on patients of either sex and any age diagnosed with lung cancer (also with some patients with other thora-cic cancer) at any stage of their ill-	9 studies	-	-	No aggre-gate data on patient cha-racteristics, no speci-fic data for those pa-tients that are in the palliative phase of their disea-se, all pa-tients had lung cancer	Various interventi-ons have been stu-died in the RCT's and CCT's, divided in 6 groups: Nursing interven-ions to manage breathless-ness, nur-sing pro-grams, nutrit-	-	Well-being (sub-jective or objective perception of improvement in physical health, or of symptoms related to cancer, me-tastases or side effects of treat-ment; or improvement of psycho-	Nurse led breathing programs may produce beneficial effects. Nurse follow-up can be as effect-tive and leads to greater patients satisfaction than phy-sician follow-up, coun-	No other outcomes	Well design-ned Coch-rane syste-matic review with exten-sive descrip-tion of the methods, no metaanalysis	A1

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					ness. Non-invasive interventions					ional inter-ventions, psychothe-apeutic in-terventions, exercise, and refle-xology		social funct-oning), qua-lity of life (by validated scales, clas-sification and measure-ment)	seling may be effective in helping patient to cope, no evi-dence of any beneficial effect of in-creasing oral nutritional intake			
Temel 2009	Uncon-trolled feasibility study	Public funds	Hospital-based	To assess feasibility of exercise pro-gram for patients with advanced NSCLC	Patients<12 weeks of diagnosis of non-small cell lung cancer (NSCLC)	25/14	12 weeks	None	Patients aged 48-81 with advan-ed NSCLC, mostly (70%) treated with chemothera-py	A Structured exercise pro-gram consis-ting of 16 twice weekly sessions over 12 weeks. The program took place in groups (8-10 patients) lasting 90-120 minutes. After warm-ing up a 30 minutes ae-	No control	Feasibility (adherence to the inter-vention); secondary: functional capacity (6 m walking test), quality of life (QOL), symptoms and fatigue (FACT-L)	Of 25 ac-crued pa-tients, 20 completed baseline assessment and 11 atten-ded all ses-sions (44% adherence) ; No changes in QOL, fati-gue or mood. Lung cancer symptoms improved.	-	It is unclear what selec-tion of eligi-ble patients participated. It is unclear whether observed effect is re-lated to the intervention	C

Study (trial) ID	Study type	Source of fun-ding/ conflicts of interest	Setting	Hypotheses	Eligibility criteria	Sample size/ Lost to follow up	Duration of the Study	Randomi-zation method	Patient cha-racteristics and group comparability	Interventions and compli-ance	Control/ Comparator (including duration, dose)	Primary Outcome Measure (s) Secondary Outcome Measure (s)	Effect size – Primary outcome(s) Effect size – Secondary outcome (s)	All other outcomes, endpoints	Critical appraisal of study quality	Level of eviden-ce
										robic exer-cise. A strength component consisted of 3 sets of 10 repititions of 6 different excercises over 30-40 minutes						
Yoshioka 1994	Uncon-trolled study		Hospice-based		Terminal cancer pa-tients (<6 months to death) admitted to a hospice and provided with a rehabil-itation pro-gram.	355/?	6 months		Patients aged 17-88 with terminal cancer	Comfortable or relaxed positioning with pillow for relief of cancer pain, therapeutic exercise saimed at improvement in muscular strength, range of motion and balance, ADL excer-cises compri-	No control	ADL (Barthel index). Question-naires mailed to relatives 3 months after death.	No adheren-ce data. Most pa-tients experienced some relief	-	26% of eligible pa-tients accru-ed in the study	C

Study (trial) ID	Study type	Source of fun-ding/ conflicts of interest	Setting	Hypotheses	Eligibility criteria	Sample size/ Lost to follow up	Duration of the Study	Randomi-zation method	Patient cha-racteristics and group comparability	Interventions and compli-ance	Control/ Comparator (including duration, dose)	Primary Outcome Measure (s) Secondary Outcome Measure (s)	Effect size – Primary outcome(s) Effect size – Secondary outcome (s)	All other outcomes, endpoints	Critical appraisal of study quality	Level of eviden-ce
										sed bed excercises, endurance training, chesty physiothera-py, + some specific treatments						
Marciniak 1996	Retro-spective case series		Hospital-based		Adult cancer patients admitted for comprehensi ve inpatient rehabilitation	159			Patients aged 17-88, 38% of which had metastatic disease	No specific intervention mentioned	No control	Functional status	Functional gains be-tween ad-mission and discharge (mean 42.9->56.0) (p< 0.001) Pre-sence of metastatic disease did not influence funct. out-come.			C
Headley 2004	Quasi-experime ntal study				Women ≥17 years with stage IV breast can-cer	38/32		No rando-mization		30min. sea-ted exercise program (armchair fitness) 3	No exercise program	Fatigue and QOL (FACIT-F); pain	Less in-crease in fatigue and less decine in QOL for		Unclear how patients were assign-ned to treat-ment group.	B

Study (trial) ID	Study type	Source of fun-ding/ conflicts of interest	Setting	Hypotheses	Eligibility criteria	Sample size/ Lost to follow up	Duration of the Study	Randomi-zation method	Patient cha-racteristics and group comparability	Interventions and compli-ance	Control/ Comparator (including duration, dose)	Primary Outcome Measure (s) Secondary Outcome Measure (s)	Effect size – Primary outcome(s) Effect size – Secondary outcome (s)	All other outcomes, endpoints	Critical appraisal of study quality	Level of eviden-ce
					schedule-ed to receive chemothera-py and able to sit.					times a week. 84% adhe-rence			expirimental group		Subjects in the control group more educated and more frequently unmarried.	