Appendix B: Process report

This is the fifth edition of the book A*cute Pain Management: Scientific Evidence*. The first edition was written by a multidisciplinary committee headed by Professor Michael Cousins and published by the National Health and Medical Research Council (NHMRC) in 1999.

The second and third editions were written by multiple contributors and a working group chaired by Professor Pam Macintyre. The editions were approved by the NHMRC and published by the Australian and New Zealand College of Anaesthetists (ANZCA) and its Faculty of Pain Medicine (FPM) in 2005 and 2010. It was also endorsed by other major organisations worldwide.

As guidelines and key sources of information should be revised as further evidence accumulates (ideally every 5 years), a fourth edition was written by multiple contributors and a working group chaired by Professor Stephan Schug and published by ANZCA and its FPM in 2015. In view of the NHMRC changing its criteria, this edition was not submitted for NHMRC approval, but it was widely endorsed by many significant national and international organisations - the International Association for the Study of Pain (IASP), the Royal College of Anaesthetists and its Faculty of Pain Medicine, the American Academy of Pain Medicine, the Australian Pain Society, Australasian College of Sport and Exercise Physicians, the Australasian Faculty of Rehabilitation Medicine, the College of Anaesthesiologists of the Academies of Medicine of Malaysia and Singapore, the College of Intensive Care Medicine of Australia and New Zealand, the European Society of Regional Anaesthesia and Pain Therapy (ESRA), the Faculty of Pain Medicine of the College of Anaesthetists of Ireland, the Hong Kong College of Anaesthesiologists, the Hong Kong Pain Society, the Malaysian Association for the Study of Pain, the New Zealand Pain Society, the Pain Association of Singapore, PainSA (South Africa), PROSPECT (Procedure Specific Postoperative Pain Management), the Royal Australasian College of Physicians, the Royal Australian and New Zealand College of Psychiatrists, the Royal Australasian College of Surgeons and the South African Society of Anaesthesiologists.

Since the fourth edition was published in 2015, a sizeable amount of new evidence relating to the management of acute pain has been published. The aim of this fifth edition is, as with the first four editions, to combine a review of the best available evidence for acute pain management with current clinical and expert practice, rather than to formulate specific clinical practice recommendations. Accordingly, the document aims to summarise, in a concise, accessible, and easily readable form, the substantial amount of evidence currently available for the management of acute pain in a wide range of patients and acute pain settings using a variety of treatment modalities. It aims to assist those involved in the management of acute pain with the best current (up to at least August 2019) evidence-based information.

It is recognised that while knowledge of current best evidence is important, it plays only a part in the management of acute pain for any individual patient and many factors in addition to scientific evidence should be considered if such treatment is to be effective.

Evidence-based medicine has been defined as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients” and that must “integrate research evidence, clinical expertise and patient values” (Sackett 1995 **NR**). Therefore evidence, clinical expertise and, importantly, patient participation (ie including the patient as part of the treating and decision-making team, taking into account their values, concerns and expectations) are required if each patient is to get the best treatment. The information provided in this document is not intended to over-ride the clinical expertise of health professionals. There is no substitute for the skilled assessment of each individual patient’s health status, circumstances and perspectives, which health professionals will then use to help select the treatments that are relevant and appropriate to that patient.

This report provides examples of the decision-making processes that were put in place to deal with the plethora of available evidence under consideration.

Development process

An editorial working group was convened to coordinate and oversee the development process, to edit the reference and also contribute updates to some sections – members were Prof Stephan Schug, A/Prof Greta Palmer, Prof David Scott, Dr Mark Alcock, Dr Richard Halliwell, and Dr Jeff Mott. While all members of the working group contributed to the whole document, A/Prof Greta Palmer and Dr Mark Alcock provided specific input and expertise to the paediatric section. This section will remain as Chapter 10 in the PDF of the book, but In view of the largely increased amount of information in the paediatric section, it will be published as a separate volume II of the hardcopy of the book.

The editorial working group was assisted by an editorial advisory group comprising Dr Mark Rockett, nominated by the Faculty of Pain Medicine, Royal College of Anaesthetists in the United Kingdom, and Dr Clara Sze Ming Wong, nominated by the Hong Kong College of Anaesthesiologists.

A large panel of contributors was enlisted to draft sections of the document and a multidisciplinary consultative committee was chosen to review late drafts and contribute more broadly as required. A list of panel members is attached in Appendix A, together with a list of contributing authors and editorial working group members.

Structures and processes for the revised edition were developed, and within these frameworks, contributors were invited to review the evidence and submit content for specific sections according to their area of expertise. All contributors were given specific instructions about the process of the literature search and the requirements for submission of their section, were referred to the website of the NHMRC document *How to Use the Evidence: Assessment and Application of Scientific Evidence* (NHMRC 2000 **GL**), received an electronic copy of the respective contribution in the fourth edition and were directed to the ANZCA website for copies of the full fourth edition of the document.

Members of the editorial working group were responsible for the initial editing of each section, the evaluation of the literature submitted with the contributions and checking for further relevant references. In a series of meetings, the editorial working party compiled and edited an initial draft. Once the draft of a section had been prepared, it was returned to the respective contributor for comment before being redrafted for public consultation as well as review by members of the multidisciplinary panel. To ensure general applicability, there was a very wide range of experts on the contributor and multidisciplinary committee, including medical, nursing, allied health and complementary medicine clinicians and consumers (see Appendix A).

Acute Pain Management: Scientific Evidence 5th Edition (Volumes I and II) is based on the NHMRC's recommendations for guideline development. That is, this review of the best available evidence for acute-pain management focuses on improving patient outcomes, includes statements concerning the strength of levels of evidence underpinning recommendations and uses a multidisciplinary approach involving all stakeholders (including consumers).

Competing interests

Conflicts of interest were managed by the members of the working party responsible for writing the content of the document by completing an International Committee of Medical Journal Editors *Uniform Disclosure Form for Potential Conflicts of Interest*. A list of conflicts of interest is provided below:

Member	Conflicts of interest
Prof Stephan A. Schug (Chair)	Emeritus Professor and Honorary Senior Research Fellow in Anaesthesiology and Pain Medicine, Medical School, University of Western Australia, Perth Previous Chair of Anaesthesiology at University of Western Australia (retired October 2019); previous Director of Pain Medicine at Royal Perth Hospital (retired October 2019). Previous Member of Board of FPMANZCA and various committees of ANZCA and FPMANZCA (retired May 2020). Vice Chair of SIG Acute Pain of IASP and previous Chair of SIG Acute Pain of ACECC (retired May 2020). Member of Advisory Board of PROSPECT group, of Faculty of 1000 (F1000), of IASP Taskforce for ICD-11 (Pain), previous Executive Secretary and member of Board of AOSRA (retired May 2020). Current recipient of competitive research funding from ANZCA and NHMRC. The Anaesthesiology Unit of the University of Western Australia chaired by Prof Schug has received research and travel funding and speaking and consulting honoraria until October 2019, from then on Prof Schug personally, from Aspen, bioCSL, Bionomics, Biogen, Emerge, ESA, Foundry, Gruenenthal, HealthEd, iX Biopharma, Indivior, Janssen Pharmaceuticals, Luye Pharma, Mundipharma, Pfizer, Therapeutic Guidelines and Xgene over the last 5 years.
A/Prof Greta M. Palmer	Paediatric and Adult Specialist Pain Medicine Physician and Specialist Anaesthetist, Royal Children's and Royal Melbourne Hospitals; Deputy Head of the Children's Pain Management Service, Royal Children's Hospital; Research Associate, Murdoch Childrens Research Institute; Associate Professor, University of Melbourne, Melbourne. Travel funding and consultation honorarium from Gruenenthal for attendance at an international tapentadol paediatric research advisory meeting. No further industry support has been received in the last 5 years.
Prof David A. Scott	Professor, University of Melbourne; Director of the Department of Anaesthesia and Acute Pain Medicine, St. Vincent's Hospital Melbourne; Elected Councilor (honorary) to May 2020. Chair ANZCA Research Committee. No industry support or funding, either directly or indirectly, has been received in the last 5 years. Current recipient of competitive research funding from ANZCA and the NHMRC.
Dr Mark Alcock	Paediatric Specialist Pain Medicine Physician and Anaesthetist, Queensland Children's Hospital; Clinical lead of the Queensland Interdisciplinary Paediatric Persistent Pain Service, Queensland Children's Hospital; Senior Lecturer, University of Queensland. No industry support has been received in the last 5 years.

Dr Richard Halliwell	Deputy Director of Anaesthesia, Westmead Hospital, Sydney; Director of Acute Pain Service Westmead Hospital; Clinical Senior Lecturer, Discipline of Anaesthesia, Sydney Medical School. No industry support has been received in the last 5 years.
Dr Jeff Mott	Staff Anaesthetist and Specialist Pain Medicine Physician, Clinical lead Acute Pain Service, Redcliffe Hospital, Senior lecturer, Faculty of Medicine, University of Queensland No industry support has been received in the last 5 years.
Editorial Advisory Group	
Representative of FPMRCA: Dr Mark Rockett	Consultant anaesthetist and specialist in pain medicine, Plymouth University Hospitals, Plymouth, UK. Honorary Associate Professor, University of Plymouth, Faculty of Health Speaking and/or consultative honoraria from Pfizer, Grunenthal and Astellas Pharma within the last 5 years. Recipient of competitive research funding from NIAA and NIHR.
Representative of Hong Kong College of Anaesthesiologists: Dr Clara Sze Ming Wong	Consultant Anaesthetist, Eastern Health Specialist in Pain Medicine, Pain Specialists Australia Melbourne, Australia No conflicts of interest declared

No disclosures of interests were requested from contributors. Contributors conducted searches and summarised the new literature and had no influence on the content or the decisions about inclusion or exclusion of material.

Review of the evidence

This document is an extensive revision of the fourth edition of *Acute Pain Management: Scientific Evidence* published in 2015. Therefore, most of the new evidence included in this fourth edition has been published from August 2014 onwards, which was the cut-off date of literature inclusion in the fourth edition. Literature was considered when published between this date and the cut-off date for this fifth edition (August 2019). However, in rare circumstances, references published after this cut-off were considered but only if of high relevance and encountered in the editorial process. These were identified by team members. High-quality evidence-based guidelines had been published independently by a number of organisations in the areas of acute back and musculoskeletal pain and recommendations relevant to the management of acute pain were drawn directly from these.

Search strategies

Searches of the electronic databases Medline or PubMed, Embase and Cochrane were conducted for each of the main topics included in the review, from August 2014 until August 2019. Searches were limited to articles concerning humans and basic science literature for some subsections. Included literature was required to be full text, written in English language.

The initial searches were inevitably broad, given the very wide scope of the topic. “Pain”, “acute pain”, “postoperative pain” or “analgesia” was searched with the key headings of the various sections and subsections of the document such as “neuropathic”, “patient-controlled”, “epidural”, “paracetamol” and so on. For drugs and techniques, a search was also made for “efficacy”, “complications” and “adverse effects”. Hand searches were also conducted of a large range of relevant journals from August 2014 onwards and bibliographies of relevant papers were checked to identify references that may not have been identified from database search.

Levels of evidence

Levels of evidence were documented according to the NHMRC designation (NHMRC 1999 **GL**) and, as for the second and third edition of this document, clinical practice points have been added.

Levels of evidence	
I	Evidence obtained from a systematic review of all relevant randomised controlled trials.
II	Evidence obtained from at least one properly designed randomised controlled trial
III-1	Evidence obtained from well-designed pseudo-randomised controlled trials (alternate allocation or some other method)
III-2	Evidence obtained from comparative studies with concurrent controls and allocation not randomised (cohort studies), case-controlled studies or interrupted time series with a control group
III-3	Evidence obtained from comparative studies with historical control, 2 or more single-arm studies, or interrupted time series without a parallel control group
IV	Evidence obtained from case series, either post-test or pre-test and post-test
Clinical practice points	
☑	Recommended best practice based on clinical experience and expert opinion

Foreign language evidence

Where new systematic reviews or meta-analyses were identified with an English abstract, but written substantially in another language, these were considered for inclusion if there was enough information in the abstract to establish it as valid NHMRC Level I evidence. In this instance, these were included and then classified as Level I evidence for this review. Similarly, where relevant, studies with lower hierarchies in a foreign language were also considered, if there was enough information in the English abstract to establish study validity (eg critical appraisal score and relevant findings). If there was insufficient information in the abstract to establish its validity then such references were excluded. Where available in the review team, speakers of the language would be engaged for translation.

Preferred evidence

A review of acute pain management requires a broad focus on a range of topics (eg postoperative pain, musculoskeletal pain, migraine, pain associated with spinal cord injury etc). This broad focus inevitably produces a very large number of research publications. In order to provide the best information to inform practice, it was important to concentrate on the highest ranked, highest quality evidence where available (eg Cochrane review).

Secondary evidence: High-quality systematic reviews of RCTs (NHMRC Level I) were the preferred evidence source. Reference lists of such designated Level I evidence were then scanned for the included RCTs. If these RCTs had also been identified in the literature search, they were excluded from subsequent analysis as their findings had already been accounted for in the Level I evidence. Relevant RCTs identified in the search, which had not been included in the systematic reviews or meta-analyses and relevant RCTs published since the cut-off date for literature inclusion in the systematic reviews or meta-analyses, were included in the update, to provide additional primary evidence. In case of multiple systematic reviews or meta-analyses published in parallel, or a lower-ranked meta-analysis published after a previous higher-ranked one (eg an older Cochrane Review), their results were considered after identification of the number of overlapping studies. Cochrane Reviews, which had been withdrawn due to age and lack of an update, were considered in conjunction with subsequently published Level I evidence.

Systematic reviews or meta-analyses that included non-randomised controlled studies were assigned the level of evidence of their lowest level component studies, as outlined in the NHMRC designation of evidence levels (NHMRC 1999) and identified by "**SR**" following the level of evidence eg (Roberto 2014 **Level III-2 SR**).

Primary evidence: Where Level I reviews were not available, the next preferred level of evidence was RCTs (NHMRC Level II). Where these were not available, other experimental evidence or case series were accepted as the best available evidence by the guideline developers (reflecting NHMRC Level III and Level IV). According to NHMRC guidelines, Level IV evidence is obtained from case series, either post-test or pretest and post-test; these levels refer to evidence about interventions (NHMRC 1999 **GL**). Publications describing results of audits or surveys were also included as Level IV evidence in the absence of any other higher-level evidence.

Expert opinion: In the few instances where no relevant published evidence was available, expert opinion was included as the best available information. Narrative reviews containing such evidence are identified by NR following the reference eg (Graham 2013 **NR**). Where no opinion-based reviews were available, the guideline writing team (working group) provided expert input.

Other evidence types*:* Not all evidence relating to the management of acute pain is intervention-based. In a number of instances, best practice has been derived from studies such as record audit, quality processes or single case reports, pharmacokinetic studies, human experimental data and basic science or animal data. These studies were included where relevant and identified by a research identifier following the reference. Thus readers will find CR (for case report) eg (Madadi 2010 **CR**), GL for clinical practice guidelines eg (Kowalski 2011 **GL**), BS if presenting basic science or animal data eg (LaCrois-Fralish 2011 **BS**), PK if presenting pharmacokinetic studies eg (Holford 2012 **PK**) and EH if presenting human experimental data eg (Saxena 2013 **EH**). The latter two were also assigned an evidence level in line with NHMRC hierarchy if suitable eg (Williams 2002 **Level II PK**, n=96, JS 4).

Quality scoring

Systematic reviews and meta-analyses: These studies were not directly assessed for quality using a critical appraisal instrument by the guideline development team. The quality assessment was based on the quality criteria that were reported to underpin the review. These were rated and reported in the following manner, on the assumption that if the study was reported as having been conducted along the lines of a specific quality approach, then the methodological quality of the study could be assumed.

- Reviews performed by the Cochrane Collaboration are identified as [Cochrane] in the text eg (Derry 2013 **Level I** [Cochrane]);
- Reviews that overtly state that the review conformed with an evidence-based minimum set of items for reporting referred to as Preferred Reporting Items for Systematic Reviews

and Meta-Analyses (PRISMA) (Liberati 2009) are identified as PRISMA eg (Moore 2014 **Level I** [PRISMA]);

- Reviews that overtly state that the review conformed with standards previously published as Quality of Reporting of Meta-analyses (QUOROM) (Moher 1999), a precursor of PRISMA, are identified as QUOROM eg (Macedo 2006 **Level I** [QUOROM]);
- Non-Cochrane meta-analyses that did not provide evidence of using PRISMA or QUOROM quality and reporting methods are only labelled Level I eg (Thorlund 2014 **Level I**).
- Network meta-analyses are identified as [NMA] eg (Martinez 2017 **Level I** (NMA), 135 RCTs, n=13,287).

For all systematic reviews and meta-analyses, the number of RCTs for Level I and the number of studies for all other levels is reported as well as the number of subjects included in these, if reported or immediately obvious eg (Rabbie 2013 **Level I** [Cochrane], 9 RCTs, n=4,473); if this is not the case, the term unspecified is used eg (Hughes 2011 **Level IV SR**, 5 studies, n unspecified).

Randomised controlled trials: The Jadad scoring instrument was used to score the quality of all RCTs (Jadad 1996).

Item	Maximum points	Description	Examples
Randomization	2	1 point if randomization is mentioned	"The patients were randomly assigned into two groups"
		1 additional point if the method of randomization is appropriate	The randomization was accomplished using a computer-generated random number list, coin toss or well-shuffled envelopes
		Deduct 1 point if the method of randomization is inappropriate (minimum 0)	The group assignment was accomplished by alternate assignment, by birthday, hospital number or day of the week
Blinding	2	1 point if blinding is mentioned	"The trial was conducted in a double-blind fashion"
		1 additional point if the method of blinding is appropriate	Use of identical tablets or injectables, identical vials Use of tablets with similar looks but different taste
		Deduct 1 point if the method of blinding is inappropriate (minimum 0)	Incomplete masking
An account of all patients	1	The fate of all patients in the trial is known. If there are no data the reason is stated	"There were 40 patients randomized but the data from 1 patient in the treatment group and 2 in the control were eliminated because of a break in protocol"

Considering the reporting of dropouts throughout trials, a Jadad score point was withheld if the numbers randomised were greater than the numbers analysed and insufficient explanation was provided. No dropouts were assumed if the text did not state this, but the descriptive reporting was comprehensive (ie 60 started, 60 finished, 60 analysed, therefore assume no dropouts). If there were obvious dropouts (i.e. 60 in, 56 completed), reviewers sought information on the percentage completing the study, and the analysis approach, which was taken to account for the dropouts.

In addition to the Jadad score, the number of patients randomised (prior to dropouts) is reported for all Level II references eg (Chan 2010 **Level II**, n=4,484, JS 5).

No quality evaluation was undertaken for lower ranked evidence (Level III and Level IV), when this was the highest available level of evidence. However, the number of patients or events included is reported if obvious in the publication and the size of the study subtracts from, or adds to, the quality of the evidence eg (Morton 2010 **Level IV**, n=5,065).

Thus, this document is underpinned by the highest level, highest methodological quality evidence available for each review question.

Conflicting evidence

If evidence was consistent, the most recent, highest hierarchy and highest quality references were used. If evidence was conflicting, the same approach was taken (identifying highest level, highest quality evidence), however examples were given of differences within the literature so that readers could appreciate the ongoing debate. In some instances, particularly in acute pain management in various patient populations, evidence was limited to case reports only, which was made clear in the document as the best available evidence in this instance.

Cost analyses

The area of acute-pain management remains remarkably deficient in research on costs and health economics, one obvious example is the costs associated with the adverse effects of treatment. Where available, relevant health economic information was reported to assist clinicians to better manage both pain and some of the adverse effects of treatment, as well as better individualise treatment for each patient, and to minimise overall expenditure. This is again noted as an area warranting further research.

Key messages

These levels of evidence were also used for the key messages, which are presented in order of level of evidence from the highest to the lowest. Key messages referring to information extracted from Cochrane meta-analyses or systematic reviews were marked “Level I [Cochrane Review]”, and these were listed first, followed by those marked “Level I [PRISMA]” and “Level I [QUOROM]”. The listing of key messages continued then with those derived from systematic reviews not adhering to these standards, which were marked “Level I” and then followed by key messages in descending level of evidence. At each level, key messages based on systematic reviews or meta-analyses are listed before those based on studies at this level, eg key messages based on “Level III-2 SR” were listed before those based on “Level III-2” studies.

Updating the evidence base from the fourth edition of the guidelines

There is no standard approach to updating wording or strength of evidence of existing guideline recommendations (Vernooij 2014 **GL**). The system used by Johnston et al, as applied to the updating process in the fourth edition of these guidelines, was again used in this update to reflect the implications of new evidence on clinical recommendations when reviewed and changed as required (Johnston 2003). The guideline team found this approach to be simple and straightforward when considering the implications of new research, layered onto existing recommendations. To indicate New, Unchanged, Strengthened, Weakened, Qualified and Reversed in the key messages, the bolded letters N, U, S, W, Q and R respectively were used — see table below for examples.

Review and revision of key messages	
New	New evidence leads to new key message(s).
Unchanged	The new evidence is consistent with the data used to formulate the original key message. The key message in the original report remains unchanged.
Strengthened	The new evidence is consistent with the data used to formulate the original key message. The key message in the original report remains unchanged or expanded. The level of evidence and/or content of the key message in the original report has been strengthened to reflect this additional evidence.
Weakened	The new evidence is inconsistent with the data used to inform the original key message(s). However, the new evidence does not alter the key message but weakens the level of evidence.
Qualified	The new evidence is consistent with the data used to formulate the original key message. The key message in the original report remains unchanged but applicability may be limited to specific patient groups/ circumstances.
Reversed	The new evidence is inconsistent with the data used to inform the original key message(s). The strength of the new evidence reverses the conclusions of the original document.
Note	Clinical and scientific judgment informed the choices made by the Working Party members; there was no mandatory threshold of new evidence (eg number of studies, types of studies, magnitude of statistical findings) that had to be met before classification of categories occurred. The first letter of each of the words (**N** for **N**ew, **U** for **U**nchanged etc) was used to denote the classification, and changes (if any) from the last edition of this document.

An example of the use of this system is taken from the key messages in Section 4.2.3.

KEY MESSAGES

1. Topical NSAIDs are effective in treating acute strains, sprains or sports injuries with systemic adverse effects comparable to placebo; gel formulations show superior efficacy over creams (**S**) (**Level I** [Cochrane Review]).
2. Topical NSAIDs are of limited analgesic efficacy for traumatic corneal abrasions, but reduce rescue analgesia requirements (**W**) (**Level I** [Cochrane Review]).
3. Topical NSAIDs reduce anterior chamber inflammation and thereby pain after cataract surgery (**N**) (**Level I** [PRISMA]).
4. The efficacy of NSAIDs for peri- or intra-articular injection as a component of local infiltration analgesia compared with systemic administration remains unclear (**U**) (**Level I** [PRISMA]).

Where the new evidence led to reversal of a conclusion and key message, this was noted in a green text box and labelled R in the key message. For example, this appears in the text:

Note: reversal of conclusion
This reverses the Level I key message in the previous edition of this document; a preceding meta-analysis had described no effect of hypnosis on postoperative pain scores.

and the related key message reads:

3. Hypnosis may reduce … postoperative pain (**R**) (**Level I**) …. .

Drug names

This document uses the generic names of drugs that apply in Australia and New Zealand (Australian Approved Names [AAN]); the Therapeutics Goods Administration (TGA) has updated medicine ingredient names in 2015 and where applicable, the new names in accordance with this update have been used (TGA 2015 **GL**). Where this name differs from the International Nonproprietary Name (INN) or the United States Adopted Name (USAN), these are given in brackets on first use within each of the chapters.

Bibliographic citations

Citations and bibliographic style are based on a modified Harvard (Author-Date) style. In-text citations use the format "First Author" then "Year of Publication" eg (Madden 2012). A decision was made to omit "et al" for in-text citations that had more than one author, for brevity and improved readability. Multiple references supporting one statement are listed in order of level of evidence and within each level from newest to oldest eg (Chan 2011 **Level II**, n=423, JS 5; Wylde 2011 **Level IV**, n=1,334; Haroutiunian 2013 **NR**; Macrae 2008 **NR**; Kehlet 2006 **NR**).

Small letters further qualify multiple publications by the same first author in the same year in in-text citations eg (Anderson 2014a) (Anderson 2014b) as in the reference lists eg

Anderson BJ & Dare T (2014b) We need to confirm, not relearn old information. *Paediatr Anaesth* **24**(6): 549–52.

Web pages are shown with their uniform resource locator (URL) and the date assessed by a member of the Working Group.

Public consultation

Following finalisation of the draft its availability was advertised in a national newspaper. The public consultation period was from XXX to XXX. The draft was made available on a website and Colleges of many of the contributors and multidisciplinary consultative committee members were notified of the availability of the draft and asked to disseminate this information to their members. The public was also invited to provide comments on the draft.

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