**Appendix 1: Methods**

Whereas this is a narrative review, we used a systematic approach to identify the relevant literature. We performed two searches on PubMed from inception to September 2019 for terms related to radicular pain and chemotherapy induced peripheral neuropathy.

The search terms for radicular pain were (radicul\* OR nerve root pain OR sciatica) and for chemotherapy induced peripheral neuropathy the terms were (Chemotherapy induced peripheral neuropathy OR chemotherapy induced neuropathy OR chemotherapy induced peripheral nerve pain OR chemotherapy induced neuropathic pain OR chemotherapy induced polyneuropathy). These terms were cross-referenced with terms relating to physiotherapy, namely (therap\* OR physiotherap\* OR physical therapy OR exercis\* OR manual therapy OR training OR massage OR mobilisation OR mobilization). We limited our search to the last fifteen years because exploratory searches found few trials published before this time. We also searched through studies’ reference lists for studies that did not appear in our search. Studies were included if they compared a physiotherapy intervention against a control intervention and reported its effect on an outcome measure reflecting pain or unpleasant symptoms. Physiotherapy is a multimodal approach and may include a wide range of interventions. Here, we restricted the eligible physiotherapy interventions to exercise and manual therapy. Studies using a physiotherapeutic intervention other than exercise or manual therapy (e.g., acupuncture, electrophysiological agents) were excluded. Exercise and manual therapy are recommended in current guidelines on the management of lumbar radicular pain [[2]](https://www.zotero.org/google-docs/?DvOVhV). Furthermore, they are part of most undergraduate curricula unlike other interventions (e.g., acupuncture). Control interventions could include no interventions, non-physiotherapeutic interventions (e.g., pharmacology) or another physiotherapeutic intervention. We included randomised controlled trials (RCTs) only.

A single investigator identified the relevant studies. A different investigator used the Cochrane Risk of Bias Tool version 2 [[3]](https://www.zotero.org/google-docs/?L1eiby) to assess the quality of the studies. Study quality measures are reported (Supplementary Table 1) but did not influence study eligibility for this review.  Relevant study data were extracted into excel sheets by a single investigator. All eligible studies used null hypothesis significance testing with p=0.05 as the cut off point for significance. In reporting on these studies’ results, we have tried to avoid a potentially misleading dichotomous interpretation of the p-values and have interpreted the findings in the context of clinical meaningfulness instead [[4]](https://www.zotero.org/google-docs/?sthM9o). Following the National Institute for Clinical Health Excellence guidelines on low back pain and radicular pain [[2]](https://www.zotero.org/google-docs/?pKrOHs), we defined 10%, or 1 point on a ten point pain scale, to constitute a minimal clinically important between-group difference (although we recognise this construct is sensitive to factors like baseline pain and the nature of the intervention). Where available, previously published data on minimal clinically important differences were used for specific outcome measure tools [[1,5]](https://www.zotero.org/google-docs/?DnDgkc).

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