Letters

Physiotherapy compared with advice for low back pain

Targeting "physical factors" alone is not evidence based practice

EDITOR—Frost et al's conclusion that "routine physiotherapy" based on physical factors was no more effective than one session of assessment and advice from a physiotherapist in the management of low back pain is not surprising.[1] But the defensive nature of the responses to this research is.[2 3] This defensiveness arises partly from the perceived rivalry between healthcare professions managing low back pain and the attention grabbing headlines used.

In recent years the evidence base has highlighted that low back pain is a multifaceted phenomenon incorporating physical impairment, psychological distress, and social interruption. Thus the effective biopsychosocial management of low back pain should reflect its multifaceted nature and not just focus on the "physical factors," as was done by Frost et al. Being an evidence based practitioner should entail identifying and managing patients' risk factors because risk factors are clinical predictors of outcome and efforts to manage them may reduce the burden of low back pain for those who consult physiotherapists.

AJ PHOTO/HOP AMERICAN/SPL

Because of the recurrent nature of low back pain, talk of a "cure" is unrealistic. Thus the Physiotherapy Pain Association emphasises that patients should be taught skills to self manage their low back problem so that in the long term they are less likely to experience pain related disability and depression, thus improving their quality of life. Receiving passive treatments focusing on physical factors, which show only slight short term benefits, is not in the personal or economic interest of patients with low back pain.

As is highlighted by the responses to the study by Frost et al,[3] beliefs about treatment preferences for low back pain vary across professions and can be traced to beliefs about the cause of the problem.

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Competing interests: None declared.

1 Frost H, Lamb SE, Doll HA, Taffe Carver P, Stewart-Brown S. Randomised controlled trial of physiotherapy compared with advice for low back pain. *BMJ* 2004;329:708. (25 September.)
2 Electronic responses. Back pain and physiotherapy. bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/329/7468/694 (accessed 2 Dec 2004).
3 Electronic responses. Randomised controlled trial of physiotherapy compared with advice for low back pain. bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/329/7468/708 (accessed 2 Dec 2004).

Study supports concept of self management of pain . . .

EDITOR—As a qualified physiotherapist with postgraduate training in manipulative therapy, I believe that physiotherapists, chiropractors, and osteopaths should stop squabbling and appreciate that each discipline is valuable in its own right.[1 2]

The study by Frost et al comparing physiotherapy with advice for low back pain confirms what most therapists already know: it is extremely difficult to effectively manage chronic low back pain.[3] In the study 77% of patients would be categorised as having chronic back pain, 35% of them having had pain for a year or more.

NHS physiotherapists are often frustrated trying to help this group of patients. General practitioners commonly manage early back pain with advice, exercises, analgesia, and non-steroidal anti-inflammatory drugs. If this approach fails the next step is usually referral to a physiotherapist, chiropractor, or osteopath. If this treatment fails to "cure" the problem, what then? Consultants are rightly reluctant to intervene in all but the most severe cases of back pain, the wait to see a consultant adding to the likelihood of chronic problems developing. The patient often ends up in a loop of repeat referrals for further ineffective treatment.

Several respondents have identified the need to encourage a more self oriented approach to management of chronic back pain.[1 2] Socioeconomic, emotional, and cognitive factors are now known to have a huge influence on chronic pain, with increasing realisation of the value of expert patient and chronic pain management programmes to empower patients to manage their chronic pain. Access to clinical psychologists has been a huge advantage in this area.

Frost et al simply support this type of management approach. Constant referrals for physical hands-on treatment are not the way to manage chronic low back pain—biopsychosocial approaches are.

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2 Electronic responses. Randomised controlled trial of physiotherapy compared with advice for low back pain. bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/329/7468/708 (accessed 2 Dec 2004).
3 Frost H, Lamb SE, Doll HA, Taffe Carver P, Stewart-Brown S. Randomised controlled trial of physiotherapy compared with advice for low back pain. *BMJ* 2004;329:708. (25 September.)

. . . but at no point compared physiotherapy with chiropractic

EDITOR—The study by Frost et al was not a comparison between chiropractic and physiotherapy intervention (that has been done before), but rather a comparison between two different physiotherapy approaches to managing patients with chronic low back pain.[1]

The study was conducted well and it is therefore a shame that a combination of sloppy editorial input and sensational articles in the press have put physiotherapists in a vulnerable position.

Effective communication and dissemination of information is an essential core skill of physiotherapy. As other contributors have commented, this study highlights the potential benefits of encouraging patients to self manage their back pain.[2 3]

Short term pain relief, whether provided by a physiotherapist or chiropractor, has its merits, but to say that physiotherapy is inferior to chiropractic on the basis of this study is nonsense.

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2 Electronic responses. Back pain and physiotherapy. bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/329/7468/694 (accessed 2 Dec 2004).
3 Electronic responses. Randomised controlled trial of physiotherapy compared with advice for low back pain. bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/329/7468/708 (accessed 2 Dec 2004).

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Summary of responses

EDITOR—The many responses to the randomised controlled trial of physiotherapy compared with advice for low back pain by Frost et al and the accompanying editorial by McAuley raised several issues.[1 2] The general complaint was that trials are not always of good quality and therefore do not provide evidence for what works and what does not. Others added that the findings of the paper by Frost et al were not consistent with the conclusions so reports in the media had picked up the wrong message. And comparing treatment with something other than no treatment, one session with several sessions, and not considering the heterogeneity of the study sample, struck several as a pointless exercise.

The points raised in the debate between doctors, physiotherapists, and chiropractors and osteopaths were predictable, with people explaining their job profiles and discussing one profession's superiority or suitability over another. Some argued that the expense for a chiropractor or osteopath was money well spent, others that resources would be better spent on public education or early physiotherapy.

Many correspondents thought that patients needed much better information and education about how to deal with back pain and help themselves (by taking exercise and staying active, for example), others that general practitioners needed more training to be able to treat back pain successfully. Nutrition was seen as a crucial element in treating back pain. Better diagnoses based on a medical, orthopaedic approach were necessary, as was uncovering the underlying aetiology of back pain to inform treatment.

NHS treatment should be directed to protocols that are known to work. Respondents seemed fairly unanimous that mechanical treatment of back pain is one such. As one correspondent puts it, the message that hurt does not mean harm needs reinforcing. As does the fact that treatment for short term back pain should enable patients to recover from acute episodes and is not necessarily the same as treatment for chronic problems.

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1 Electronic responses. Back pain and physiotherapy. bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/329/7468/694 (accessed 2 Dec 2004).
2 Electronic responses. Randomised controlled trial of physiotherapy compared with advice for low back pain. bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/329/7468/708 (accessed 2 Dec 2004).

Are written responses to referrals acceptable?

Comprehensive referral letters are key to safe written advice

EDITOR—Tso et al highlight the potential effective use of communication in writing between primary and secondary care when both doctors—the general practitioner and the haematologist in this case—can complement each other and hence reduce unnecessary duplications of investigations and the burden on outpatient departments.[1]

The same process may be applied between general practitioners and other specialists and between hospital doctors when they refer patients to each other. For this to work effectively, however, the initial referral communication has to provide sufficient relevant clinical details that allow specific advice to be given by the specialist. For example, in this survey how many general practitioners' letters provided all the information the consultant haematologist felt necessary to give safe written advice without assessing the patient personally?

The conditions referred in the paper are heterogeneous. Some conditions such as an isolated raised mean corpuscular volume seem appropriate to give advice on while others such as leucopenia and polycythemia seem of sufficient importance to require a direct assessment by a haematologist. How many general practitioners would be sufficiently reassured by written advice alone in such cases and how many haematologists would be sufficiently confident to give such advice without more detailed haematological assessment?

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1 Tso A, Harris L, Littlewood T. Are written responses to some referrals to a general haematology clinic acceptable? *BMJ* 2004;329:946-7. (23 October.)

Telephone call may be better way of communicating

EDITOR—Tso et al highlight the value of written advice to help the primary care team deal with uncertainty.[1] The rise in the use of blood tests for monitoring chronic disease means that general practitioners are increasingly faced with slightly abnormal results in patients who otherwise seem well. Clearly referral of these patients is not feasible—the services would be overwhelmed and patients would be unnecessarily put through the anxiety of a hospital appointment.

Therefore, if advice is needed, why not pick up the telephone and speak directly to the laboratory? I have received valuable help this way and have learnt to manage similar conditions in the future. Laboratories (and other specialties) might like to consider a daily advice hour in the same way that some general practices have a telephone consultation session. Both primary and secondary care could benefit.

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Author's reply

EDITOR—Mohammed wonders whether other doctors and haematologists might be concerned about giving written advice about leucopenia and polycythemia. The brevity of the article meant that we could not give fuller details. For example, a referral letter for leucopenia was received in which we established that the most likely reason was racial origin (people of African ancestry have lower mean neutrophil counts than white people). A referral for polycythemia was clearly related to chronic hypoxia secondary to chronic obstructive pulmonary disease. I did not believe that haematological intervention was required in either case.

Fisher worries that a flood of written referrals would overwhelm the system and make patients endure the anxiety of an outpatient visit. I think that our article is about precisely this: a method for encouraging not discouraging referrals, but with the understanding that we will respond in writing if appropriate.

Fisher also wonders about a telephone system of advice. We operate this as well: general practitioners and other hospital doctors can seek advice at any time. This will be highly appropriate in many cases. However, it is helpful in many cases to take time to assess all the results, examine the blood film, and then respond. This is better done after receipt of a letter.

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The PROGRESS trial three years later

HOPE trial may shed some light

EDITOR—Wennberg and Zimmermann are correct in pointing out that it is simplistic, and potentially misleading, to interpret PROGRESS as indicating that patients with stroke benefit from the combination of perindopril and indapamide.[1] In applying these results clinically, doctors need to know whether the benefit in stroke reduction is due mainly to indapamide or to some synergistic effect of the two. After all, given the prevalence of polypharmacy and the cost, why give two drugs when one might suffice?

To sort out this question it is helpful to compare the results of PROGRESS with those of HOPE, in which ramipril was found to cause a significant relative risk reduction in stroke of 32% (95% confidence interval 16% to 44%) compared with

placebo.[2] This reduction was sustained for fatal and non-fatal strokes and for ischaemic strokes.[3]

How are clinicians to reconcile the beneficial effect of ramipril monotherapy in HOPE with the non-significant effect of perindopril monotherapy in PROGRESS? The answer may lie in the profile of those enrolled in PROGRESS. Since this was an Australian, New Zealand, and Southeast Asian collaboration, almost 40% of participants in PROGRESS were oriental. The profile of cardiovascular disease among Asians is very different from that among white people.[4] Ischaemic heart disease predominates in white people, whereas cerebrovascular disease predominates in Asians.

Ethnic variation in blood pressure and response to anti-hypertensive agents has been noted before in other groups—for example, African Americans.[5] At least part of the disparity between HOPE and PROGRESS may therefore be due to potentially different mechanisms of vascular disease in Asians compared with white people, and perhaps differing response to angiotensin converting enzyme inhibitors.

Rather than being a source of confusion and debate, such conflicting results should prompt new hypotheses, in this case, that potential ethnic variation should be explored. Using the methods of genetic epidemiology in this setting may hold the key to greater understanding of the genetic and environmental factors in vascular disease.

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1 Wennberg R, Zimmerman C. The PROGRESS trial three years later: time for a balanced report of effectiveness [with commentary by S MacMahon, B Neal, A Rodgers, J Chalmers]. *BMJ* 2004;329:968-71. (23 October.)
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Clear and accurate interpretations of studies are needed

Editor—Like Wennberg and Zimmermann, I am troubled by the interpretation of the results of PROGRESS published in the original *Lancet* article and reiterated by others; by the amalgamation of the perindopril and perindopril-indapamide arms under the rubric "perindopril based therapy"; and by the chief conclusions about such treatment attributed by the trialists.[1 2]

Interestingly, this has affected my own work. A neurologist referee of a recent article on secondary stroke prevention I published with Kapral in the *Canadian Journal of Neurological Sciences* strongly criticised our paper for simply noting the difference in efficacy between the two active treatment arms of PROGRESS[3]; this anonymous reviewer adamantly stated that the trial was not sufficiently powered to show a distinction. Perhaps the best way to look at PROGRESS is that it is really two parallel but different randomised trials with the same control group. Therefore, combining these two very different treatment arms for analysis may be an oversimplification.

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One pill or two?

Moreover, the article by Wennberg and Zimmermann does not at all distract from implementation of the trial results, as argued by the PROGRESS trialists. With combination treatment with angiotensin converting enzyme inhibitors and diuretics we get the best of both worlds, and a combination indapamide-perindopril regimen exists and is manufactured by Servier. I also find it interesting that a higher dose of perindopril monotherapy (8 mg) did not prevent stroke in the recent massive EUROPA study, despite a reduction of 5/3 mm Hg in blood pressure.[4]

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1 Wennberg R, Zimmerman C. The PROGRESS trial three years later: time for a balanced report of effectiveness [with commentary by S MacMahon, B Neal, A Rodgers, J Chalmers]. *BMJ* 2004;329:968-71. (23 October.)
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Evangelism is understandable

Editor—I think the reasons for the evangelical tone of the last paragraph of the commentary by MacMahon et al on the PROGRESS trial are that the authors are academic specialists in medicine.[1] They have a clear view from their hill over the confused swampy lowlands of everyday practice and believe they can help guide us poor souls groping about in it.

To help my patient decide if he or she wants to risk the adverse effects of antihypertensive drugs and whether he or she can be bothered to take several tablets a day for the rest of his or her life, it would be nice to have some decent information with which to help him or her to make a decision. This information is slowly emerging, but is far from clear as yet.

Even if patients can understand the concepts of numbers needed to treat and the like, they will often say "No thanks, I would rather not" when confronted with their NNT of 20 or whatever to prevent a stroke over five years.

A lot will say yes to please their doctor, then collect the prescription regularly but not take it (it will probably be free on the NHS), and a lot will take it when they feel a bit unwell in the morning, for whatever reason.

Others may actually take it regularly and see it as a reason why they can carry on smoking and drinking too much as the medicine the nice doctor gives them "reduces risk" and balances out their bad habits a bit.

Others will conscientiously take it and acquire exemplary lifestyles and so get the life preserving benefits the authors are extolling, to die on average a few months later of some other major "preventable" disease. This last group, in my inner city practice, is rather small.

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Competing interests: None declared.

1 Wennberg R, Zimmerman C. The PROGRESS trial three years later: time for a balanced report of effectiveness [with commentary by S MacMahon, B Neal, A Rodgers, J Chalmers]. *BMJ* 2004;329:968-71. (23 October.)

All aspects of secondary prevention after stroke need to be improved

Editor—A strong evidence base exists for many aspects of stroke care particularly secondary prevention. Stroke units reduce death and disability regardless of severity, but only half of UK patients receive this care. The risk of stroke is greatest within the first few days after a transient ischaemic attack, yet waiting times for neurovascular clinics may be weeks or months even if a local service is available.

Hypertension is the most important risk factor for the primary prevention of stroke but before the perindopril protection against recurrent stroke study (PROGRESS) was published in 2001, uncertainty prevailed about the benefits of blood pressure lowering for secondary prevention.[1] Since then the debate has changed to whether the substantial reduction in stroke risk seen in this trial (relative risk reduction 43%, 95% confidence interval 30 to 54) is due to specific effects of the combination of perinodopril and indapamide, indapamide

alone, a class effect of these drugs, or blood pressure lowering itself.

These views are strongly held, as can be seen in the article by Wennberg and Zimmermann and the commentary by MacMahon et al.[2] Surely the time has come to move on and look at the bigger picture, which is ensuring that blood pressure lowering and other effective measures are widely and appropriately implemented—for example, aspirin, cholesterol lowering, carotid endarterectomy for carotid stenosis, and warfarin for atrial fibrillation. Cost effective implementation strategies are required, not endless academic debate. Some will use perindopril and indapamide; others will use other blood pressure lowering drugs—three years on we need to agree to disagree and move on.

This important issue is that only 65% of hypertensive patients receive treatment at follow up after discharge.[3] Surely patients deserve better?

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Competing interests: HR was a site investigator for PROGRESS and has received lecture fees from Servier. She is a member of the Intercollegiate Stroke Working Party.

1 PROGRESS Collaborative Group. Randomised trial of perinopril-based blood pressure lowering regimen among 6105 individuals with previous stroke or transient ischaemic attack. *Lancet* 2001;358:1033-41.
2 Wennberg R, Zimmerman C. The PROGRESS trial three years later: time for a balanced report of effectiveness [with commentary by S MacMahon, B Neal, A Rodgers, J Chalmers]. *BMJ* 2004;329:968-71. (23 October.)
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Seriousness of adverse events: medical judgment is important

Editor—In his letter asking for definition of "serious" and "severe" adverse reactions Frankenfeld does not take into account what the Council for International Organisations of Medical Sciences specifies.[1 2]

Important medical events that may not be immediately life threatening or result in death or hospitalisation but may jeopardise the patient or require intervention to prevent one of the other outcomes listed in the definition of seriousness (death, life threatening, hospitalisation or extended existing hospitalisation, severe disability or incapacity, congenital anomaly or birth defect) should also be considered as serious. Seriousness criteria therefore do not need redefinition, but good medical judgment should be exercised when deciding if an adverse event or reaction is or is not serious.

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1 Frankenfeld C. "Serious" and "severe" adverse drug reactions need defining. *BMJ* 2004;329:573. (4 September.)
2 Council for International Organisations of Medical Sciences. *Current challenges in pharmacovigilance: pragmatic approaches. Report of CIOMS working group V.* Geneva: CIOMS, 2001.

Betting your life on it

Gambling harms both health and equality

Editor—The editorial by Griffiths provides strong arguments why gambling and problem gambling are public health concerns.[1] But there are also substantial ethical concerns around liberalising access to gambling, given that it may contribute to poverty and increase inequality.

For example, national survey data from New Zealand found that expenditure on gambling was disproportionately higher among people with lower levels of education, people with "lower status occupations," Maori, and Pacific peoples.[2] This study also found that poorer socioeconomic status was a significant risk factor for current problem gambling and probable pathological gambling. Such an association has also been reported in the Netherlands,[3] in Sweden (when considering social welfare recipients as having low socioeconomic status[4]), and in the United States.[5]

Such health and justice problems imply that, from a societal perspective, it may be best for governments to further tighten restrictions on access to gambling as a whole, and particularly on the most hazardous forms for inducing gambling disorders (gaming machines and track racing).

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Competing interests: None declared.

1 Griffiths M. Betting your life on it. *BMJ* 2004;329:1055-6. (6 November.)
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Author's reply

Editor—Wilson raises issues that I had raised in an earlier version of my editorial. Owing to space constraints, my article was cut at the proof stage, removing my referral to an earlier *BMJ* editorial on the topic of gambling and health.[1]

McKee and Sassi argued that gambling was a health issue because it widened the inequalities of income and that an association existed between inequality of income in industrialised countries and lower life expectancy.[1] This complements the issues raised by Wilson and shows that social and public health policy on gambling needs to be addressed at microlevels and macrolevels in society.

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1 McKee M, Sassi F. Gambling with the nation's health. *BMJ* 1995;311:521-2.

Patients with chronic fatigue syndrome are being ignored

Editor—Earlier this year more than 28 000 people signed a petition calling for urgent government funded research into the physical causes of myalgic encephalomyelitis and chronic fatigue syndrome. Such is the frustration of people who do not believe that their views are being listened to by the medical establishment.

So White's editorial reviewing the possible causes of myalgic encephalomyelitis and chronic fatigue syndrome should be welcome news.[1] But is it?

Many doctors support the idea of a disease model with predisposing, precipitating, and perpetuating factors. However, White does not offer any innovative suggestions as to how this could be used to better understand an illness that now covers a wide variety of clinical presentations and an equally diverse range of pathophysiological findings. Having created this mess, the medical profession must now accept that this heterogeneous group of patients is unlikely to have the same pathoaetiology and respond to the same form of treatment, be it pharmacological or behavioural.

What is needed is thought provoking research that dispenses with the oversimplistic view that myalgic encephalomyelitis and chronic fatigue syndrome entail little more than a vicious circle of abnormal illness beliefs and behaviour, inactivity, and deconditioning. The World Health Organization now classifies both myalgic encephalomyelitis and chronic fatigue syndrome as neurological disorders in section G93.3 of ICD-10. The time has come to look at the neurology of central fatigue—instead of pouring yet more money into the bottomless pit of psychological research.

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Competing interests: CS is a physician whose myalgic encephalomyelitis was precipitated by chickenpox encephalitis and who used to be physically very active as a child as well as before developing his illness.

1 White P. What causes chronic fatigue syndrome? *BMJ* 2004;329:928-9. (23 October.)