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RESEARCH:
Luciola da C Menezes Costa, Christopher G Maher, James H McAuley, Mark J Hancock, Robert D Herbert, Kathryn M Refshauge, and Nicholas Henschke
Prognosis for patients with chronic low back pain: inception cohort study
BMJ 2009; 339: b3829 [Abstract] [Full text]

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Waiting for tests to clinically classify chronic low back pain patients, we need better epidemiological definitions
Stefano Negrini (16 October 2009)

Waiting for tests to clinically classify chronic low back pain patients, we need better epidemiological definitions

16 October 2009

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Send response to journal:

Re: Waiting for tests to clinically classify chronic low back pain patients, we need better epidemiological definitions

Dear Editor, dear colleagues,

I would like to thank Costa and colleagues (1) for their paper on chronic low back pain (cLBP) prognosis. Their results are very important, and their paper is very well done. However, I have an important concern: Their population isn't a natural history cohort, simply because patients have been treated. The recruiting physicians, chiropractors and physiotherapists had already received the current guidelines on low back pain treatment (1), and we can presume they proposed either a "usual" or an "evidence-based" treatment. We do not have any data on this, nor a subgroup analysis according to the recruiters' respective professions. Both these elements would have been essential in order to more fully understand the results obtained by the authors.

I also would like to introduce a main comment to the paper, relating to the need to better define cLBP both epidemiologically and, more than anything else, clinically. The usual definition of cLBP is epidemiological: In the past, the cut-off among sub-acute and cLBP was 6 months (2), but very recently it was reduced to 3 months (3,4); Costa's results seem to confirm the medical feeling that this reduction is not correct (5,6). A clinical definition of cLBP has existed for many years, and it equates to "bio-psycho-social syndrome" (7). In the context of such a reference, acute LBP is auto-resolving because it is "biological," while cLBP hardly

recovers because it is “bio-psycho-social.” Sub-acute LBP, between the previous ones, is the situation in which a conversion is ongoing but the complete syndrome is not yet developed (8). Epidemiology and clinics can meet, when recognising that time is the key factor in this pathological evolution; but for individual patients, where expertise must be combined with evidence in order to provide the best care (9), the experienced physician tries to separate cLBP patients, in which the full syndrome is clearly evident, from the sub-acute ones. The latter have only partial problems, which can be mainly physical, psychological or even social, while the former show a conglomeration of all these elements, with a series of perpetuating vicious cycles well established (8). Sub-acute patients rarely have important de-conditioning or dysfunctional disturbances, while chronic patients become disillusioned with the treatment efficacy and possibility of recovery while characteristically harbour the hope of finding the “magic bullet” that will solve the problem (10). Unfortunately, many patients cannot be classified clinically, and we lack tests to define the differences so that we can proceed beyond the expertise of the individual physician. Even disability scales allow one to distinguish high from low disability populations within the general cLBP population (4,5) but they do not distinguish patients who are sub-acute from those who are chronic. Consequently, time remains the best way to separate these populations, and epidemiology wins while we wait for better clinical methods. However, we need clear-cut timings. Looking at the data of Costa and colleagues (1), while at 3 months there is still a 42% probability of full recovery, over time this decreases significantly. Perhaps, and this should be carefully investigated in future studies, 9 months is a better point at which to define chronic patients (6% recovery in 3 more months), assuming, of course, the possibility of observing a natural history cohort. Meanwhile, we must wait for clinical methods by which to achieve the best classification.

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Competing interests: None declared