

## Recommendations for management of low-back pain misleading

We have concerns regarding the article by Kennedy and Baerlocher,<sup>1</sup> in which they advise that most instances of low-back pain will resolve without treatment. A recent systematic review<sup>2</sup> showed that 65% of patients with acute low-back pain continue to report pain one year after onset, which suggests that optimal management of acute low-back pain requires chronic condition management strategies. The authors<sup>1</sup> recommend that most patients with acute low-back pain can be managed with analgesia and physiotherapy; however, recent evidence shows that stratified care is superior to a general approach.<sup>3</sup>

The authors<sup>1</sup> state that magnetic resonance imaging (MRI) should be obtained for patients who experience low-back pain for more than six weeks. This contradicts the guidelines put forth by the American College of Physicians.<sup>4</sup> Kennedy and Baerlocher<sup>1</sup> tout the potential benefits of load-bearing MRI as a more sensitive method of detecting degenerative changes in the spine. Degenerative changes in the spine are common in asymptomatic adults, and the more pressing issue in Canada appears to be the overuse of advanced imaging for low-back pain. A recent study in Alberta showed that only 44% of 1000 referrals for lumbar spine MRI were appropriate.<sup>5</sup>

The authors<sup>1</sup> promote vertebroplasty as an effective treatment for painful, acute vertebral compression fractures, and cite an open-label trial.<sup>6</sup> When vertebroplasty has been evaluated in randomized trials with a sham surgery control group, resulting in blinding of patients, no specific effect for vertebroplasty has been shown.<sup>7</sup>

The literature does not support the use of selective root block for low-back pain.<sup>8</sup> The authors<sup>1</sup> advocate the use of radiofrequency denervation or ablation for low-back pain with nerve-root involvement, and cite a trial<sup>9</sup> that showed no difference between radiofre-

quency denervation and intra-articular lumbar facet joint steroid injections for patients with chronic low-back pain. When compared with a sham surgical procedure, a number of trials have shown no specific effect associated with radiofrequency facet joint denervation for chronic low-back pain.<sup>10</sup>

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### The authors respond

We appreciate the dialogue initiated by Busse and colleagues<sup>1</sup> surrounding the very complex and controversial field of low-back pain.

The definitions of pain resolution are critical. In the meta-analysis<sup>2</sup> referenced by Busse and colleagues<sup>1</sup> many of the included studies define resolution of pain as the complete absence of pain. Other studies define resolution of pain as a significant improvement that results in low levels of pain.<sup>3,4</sup> Chronic back pain is a serious concern and often does warrant long-term management strategies, as noted by Busse and colleagues.<sup>1</sup> Although back pain often resolves (improves significantly) without treatment, it frequently persists with substantially lesser severity.

In our article,<sup>5</sup> we refer only to analgesia, not to narcotics specifically. Analgesia, which includes nonsteroidal anti-inflammatory drugs, COX-2 inhibitors and acetaminophen, is most certainly a well-accepted and valid means to control chronic low-back pain. Busse and colleagues<sup>1</sup> warn against the use of narcotics. In the appropriate clinical circumstances, narcotic use is indeed also indicated.<sup>6</sup> Implying otherwise would be a great disservice to the large number of patients with intractable pain.

The American College of Radiology periodically releases appropriateness criteria for nearly every type of radiology exam, which describe the relevant indications for referral. These criteria include specific indications that warrant lumbar magnetic resonance imaging (MRI), one of which is pain that lasts more than six weeks. As Busse and colleagues<sup>1</sup> note, this specific criterion is discordant with the American College of Physicians' criteria for ordering lumbar MRI.<sup>7</sup> Guidelines can be discordant with one another. We agree that lumbar MRIs are frequently ordered inappropriately. Although inappropriate use of lumbar MRIs may not alter outcomes, MRI must be used for the appropriate indication of complicated back pain.

We make no reference to the utilization of lumbar MRI to indiscriminately screen patients with low-back pain as