Back pain: a National Health Priority Area in Australia?

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TO THE EDITOR: On behalf of the Australian Association of Musculoskeletal Medicine (AAMM) and the Australasian Faculty of Musculoskeletal Medicine (AFMM), we would thank Briggs and Buchbinder for raising the topic of back pain as a National Health Priority Area (NHPA) for debate.¹ The AAMM and its teaching arm, the AFMM, have been arguing for years that higher priority should be given to the management of low back pain, and we certainly support the arguments for making back pain an NHPA.

We agree that back pain is a major burden on society, and that coordinated action that includes all stakeholders is required. Currently, members of the AAMM and AFMM are involved in contributing to the Australian Core Competencies in Musculoskeletal Basic and Clinical Science project,² which aims to standardise the undergraduate teaching in musculoskeletal medicine around Australia.

As well as supporting undergraduate initiatives, the AAMM and AFMM have been the significant providers of postgraduate education for doctors around Australia over the past 20 years, being engaged in activities that include the development of evidence-based guidelines and university-based postgraduate diploma and masters programs.³ It is then very disappointing to read disparaging comments about doctors with a special interest in musculoskeletal medicine.

Briggs and Buchbinder assert that one potential disadvantage of making back pain a health priority is that it may provide "justification for those with ... vested interests to promote clinically ineffective interventions". The example they cite is a questionnaire survey of Victorian doctors in 2004, highlighting that a self-reported interest in low back pain or musculoskeletal medicine, or both, was strongly associated with back pain management beliefs and practices that are contrary to the best available evidence.⁴

The title of the *Spine* journal article⁴ is mischievous and misleading. The article implies that members of the AAMM have poorer knowledge about low back pain than doctors with no special interest in back pain. The real facts are that no attempt was made by the authors to specify what training or continuing medical education doctors had received, or whether they were members of the AAMM.

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1 Briggs AM, Buchbinder R. Back pain: a National Health Priority Area in Australia? *Med J Aust* 2009; 190: 499-502.

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TO THE EDITOR: In the recent article by Briggs and Buchbinder, the authors propose that one advantage of including back pain as a National Health Priority Area (NHPA) is that it will increasingly encourage the management of back pain in accordance with best-practice clinical care guidelines.¹

The emergency department (ED) is a key point of presentation for people with back pain. Research suggests that optimal management of low back pain incorporates multidisciplinary input, ensuring the provision of adequate analgesia and rational use of further investigations.^{2,3} On the basis of such data, we devised an interactive decision-support tool for completion by ED staff. The “Low Back Pain Assessment and Treatment” (LBPAT) guidelines were designed by a multidisciplinary team of nursing, medical, physiotherapy and pharmacy staff, based on accepted evidence-based standards of practice already in use.⁴

Use of these guidelines enables rapid assessment of “red flags” that may require further investigation and treatment. The guidelines include a flow diagram divided into three pain-management options for patients with mild, moderate or severe pain, with prompts for referral to physiotherapy and neurosurgery. The LBPAT guidelines indicate which imaging studies and blood tests may be required and when, as directed by findings. Information to assist discharge planning, including follow-up by a physiother-

apist and general practitioner, and provision of information, is included.

Once they were developed, we evaluated the effectiveness of the LBPAT guidelines in improving ED clinical practice. A retrospective case-record study of patients presenting to the ED and identified from International classification of diseases, ninth revision (ICD-9) codes (for back pain or low back pain) was undertaken before implementation of the guidelines (October–December 2006; 87 patients), immediately after implementation (May–August 2007; 96 patients), and about a year later (July–August 2008; 28 patients).

Uptake of the LBPAT guidelines was only 47%–50% in both postimplementation periods. However, adherence to pain management guidelines improved significantly after implementation (59% [57/96] compared with 46% [40/87]; $P=0.02$), and was maintained a year later (57% [16/28]). Use of aperients in patients who were coprescribed opiates was much improved in the period immediately after implementation (40% [27/68] compared with 16% [11/69]; $P<0.001$) and 1 year later (70% [14/20]). Postimplementation data suggested a reduction in unnecessary blood tests (ie, no red flags requiring further investigation). For patients discharged from the ED, discharge planning and continuity of care did not improve immediately after implementation, but were greatly improved 1 year later.

If back pain is included as an NHPA, use of a clinical decision tool such as the LBPAT guidelines is one potential method of preserving resources and improving patient outcomes in cases of back pain in the ED setting.

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IN REPLY: The two preceding letters highlight that there are many stakeholders with an interest in back pain in Australia. Many craft groups are involved with the provision of postgraduate education and have contributed to the musculoskeletal core competencies initiative. Vaughan and colleagues describe promising results from using a clinical decision tool for acute back pain in an emergency department. On a national scale, implementation of such a tool in all emergency departments may significantly improve outcomes and reduce costs. Making back pain a national priority would provide unique opportunities to rigorously study these types of approaches.

A timely illustration of our concern about vested interests potentially promoting ineffective or unproven interventions¹ is the lively debate centred on the recently published United Kingdom National Institute for Health and Clinical Excellence guidance for the early management of persistent non-specific low back pain.² The recommendation that injections of therapeutic substances into the back for non-specific low back pain should not be offered, as the evidence of effectiveness is lacking, led to the forced resignation of the president of the British Pain Society because of his refusal to denounce the guidelines he helped to formulate.³

To suggest that the title of the *Spine* journal article is misleading and mischievous is patently incorrect, as the title, “Doctors with a special interest in back pain have poorer knowledge about how to treat back pain”, simply summarises the main study findings.⁴ Based on 3831 responses from general practitioners in New South Wales and Victoria, collected in 1997, 2000 and 2004, doctors who reported a special interest in low back pain were significantly more likely to believe that patients with acute low back pain should be prescribed complete bed rest until the pain goes away (relative risk [RR], 1.89; 95% CI, 1.53–2.33); that they should not return to work until they are almost pain-free (RR, 1.55; 95% CI, 1.31–1.83); and that lumbar spine x-rays are useful in their work-up (RR, 1.36; 95% CI, 1.21–1.52). We also reject the suggestion that we made disparaging remarks about doctors with a special interest in musculoskeletal medicine. After adjusting for the presence of special interests in back pain, there were no important differences in back pain beliefs between those with and without a special interest in musculoskeletal medicine. While we cited a survey that found that Australian Association of Musculoskeletal

Medicine (AAMM) members see a high caseload of patients with back pain,⁵ we made no claims about the knowledge base of AAMM members.

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