Before Treatment	Mild/Moderate	45.2%
After Treatment	Mild/Moderate	31.6%
	Severe	29%
	Extreme	19.4%
Severity group movement	No Change	74.4%
	Improved	22.6%
	Worsened	3.2%

Using the categories set out by Gatchel et al (2009) which remain the only published means of interpreting PDQ scores clinically we have a NNT of 3.3 and a Number Needed to Harm (NNH) of 40.

My feeling is that we have a lot of patients who initially engage with our service who never accept absolutely the chronicity of their pain problem and who as a result have perceived unmet needs and re-engage with the medical model. I would like to audit our results and determine what factors distinguish responders and non-responders. Plainly the size of the data set available and the high non-responder rate significantly compromise results. What the results do provide is an objective baseline measure which we can use to assess any future change to treatment approach or service delivery.

Editorial Note

It remains a problem that baseline results from units such as this have almost no outlet that makes them available for comparative analysis, a process that should be seen as constructive but appears to strike fear into the hearts of staff and managers. Of course a total lack of standardisation in clinical outcome measurement tools employed between departments further complicates this issue. Finally political issues now affecting the entire NHS mean that the sharing of information is often seen as a risk in case it is used by rival organisations in future Tender Bids. Can I thank Steven for being visionary enough to share results and for being willing to go through the process of gaining permission to do so.

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POTENTIAL USE AS BOTH A SCREENING TOOL AND AN INTERVENTION STRATEGY.

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Red flags can be defined as "indicators of possible serious spinal pathology" (Ferguson et al. 2010). It is of vital importance that physiotherapists involved in the care of patients with back pain screen for the presence of red flags and then where appropriate refer the patient on for medical examination. Two recent studies, one in the USA and one in Scotland have identified that physiotherapists documentation of red flags is variable and could be better (Leerar et al. 2007; Ferguson et al. 2010). This is worrying considering that physiotherapists are often the first point of contact with a health care professional for some patients e.g. self-referral clinics. Arguably, identifying red flags and acting upon them appropriately could be the most important thing we do for our back pain patients. It is not clear if therapists are simply not asking a thorough set of screening questions or if they are asking them but not fully documenting the fact. Whilst the latter is preferable, neither is ideal. It has been argued that regular use of a red flags screening questionnaire would promote more robust documentation by therapists (Leerar et al. 2007).

Creating a Red Flag screening questionnaire is difficult for a number of reasons. Firstly there is a lack of consensus as to which flags should be included in such a questionnaire. For example, in the studies above which reported on appropriate documentation of red flags by therapists one study included thoracic pain but not the presence of a fever or chills (Ferguson et al. 2010) whilst the other did include the presence of fever/chills but not thoracic pain (Leerar et al. 2007). A key reason why such a consensus does not exist is that robust primary research on which red flags are indicative of serious spinal pathology is lacking. This is probably due to the fact that such research is extremely difficult to undertake, hence some red flags are supported as such by no more than simple case reports. That said there are some red flag questions, or clusters of questions, that have demonstrated modest predictive ability using more scientifically robust methodologies. For example, a combination of being ≥50 years of age, a previous history of cancer, unexplained weight loss and failure to improve after a month report a sensitivity of 100% for identifying Malignancy, but specificity levels were as low as 60% (Henscheke et al 2007). Greenhalgh & Selfe (2009) used qualitative methods to identify which red flag questions were commonly used by practising clinicians, The clinicians identified three items consistently between them – Band-like trunk pain, vague non-

specific lower limb symptoms and decreased mobility. The authors highlighted that these three items were not on any internationally recognised list of red flags. This body of work highlights the lack of consensus between clinical practice, research and clinical guidelines.

A further barrier to developing a standard screening tool is the lack of clear instructions to provide to clinicians after they have screened the patient. For example, how many positive responses to red flag questions are required to warrant referral for medical screening? Is one red flag enough or should a cluster of positive responses be required for medical referral? Additionally, are some red flags more important than others? Is Bladder dysfunction more important than a history or cancer? Or should we be referring all patients over the age of 50 for medical screening?

In this article I have attached a copy of a Red Flags Questionnaire I have developed from a non-systematic search of the literature (See Table 1). The questionnaire is something I routinely use in clinical practice. I have found it beneficial for two reasons. Firstly, as a screening tool and to facilitate the appropriate documentation of red flags. Secondly, as a psychological intervention to reduce patient anxiety that their pain is due to a serious spinal pathology. The majority of patients I see will complete the questionnaire and answer negatively to all 14 Red Flag questions included. I usually ask the patient the question and then circle yes/no as appropriate. Afterwards I provide visual feedback of the form with 14 negative responses. I discuss the questionnaire with patients and tell them that this indicates that the chance of their back pain being due to a serious or sinister condition is minimal and that they have what most people have – simple mechanical/ non-specific low back pain. Anecdotally patients report that this is good to hear and give the indication that they find it quite relieving.

The questionnaire attached is written in such a way as the patients could fill it out themselves if required using simple language (avoiding words like saddle anaesthesia) and a personalised writing style e.g. is your pain. However, it could be argued that the language is still relatively complex and I would be interested in hearing suggestions on how it could be simplified. There are a number of potential red flags I have not added e.g. failure to improve after one month. I have not added this as a question because I think there is a reasonable body of evidence that many episodes of back pain last longer than one month (Van Den Hoogen 1998; Hestbaek et al. 2003). Thus it would be quite likely that the majority of patients seen clinically would answer yes to this question, which may unnecessarily worry patients that they have a serious sinister pathology. This could negate the potential positive psychological effects of the reassuring message of 14 negative responses.

How to interpret the red flag questionnaire below is quite controversial. I will report here how I use it but I would stipulate that this is just my personal clinical opinion rather than information based upon research evidence. Many of the patients I see are over 50 years of age thus if this is their only positive red flag (Question 2) I note that it should be monitored but I reassure the patient that it is a minor finding. Indeed it is questionable as to whether this age criterion is a red flag in isolation. If any of the questions particularly relating to Cancer (Questions 3, 4, 6, 10, 11, 12, 13, and 14) are positive, I would refer the patient to their GP within the coming week if possible, the speed of referral being partly to reduce any anxieties the patient may have, but also of course if cancer is present that it be identified and dealt with promptly. If any of the questions directly related to Cauda Equina Syndrome are positive (Questions 8 & 9) I would immediately advise the patient to go to A&E considering that it is recommended that decompression surgery be undertaken, within 48 hours of onset (Ahn et al. 2000). For the remaining questions I would tend to simply monitor and if the patient did not improve with treatment but had one of more of these red flags I would then refer them to their GP for medical screening. For some questions I would ask additional supplementary questions if the patient responded positively. For example, if the patient responded yes to Q9 (bladder/bowel issues) it would be important to identify if any incontinence issue was more likely to be related to stress incontinence rather than a serious or sinister pathology.

The most important thing to remember is that this questionnaire should not be used in isolation. Clinical Judgment is one the most important elements in the identification of potential serious pathology (Henschke et al. 2007) and clinicians should be primarily guided by their judgement rather than simply acting upon the findings of the questionnaire. Additionally, of course, clinicians should also adhere/consider any locally developed polices and pathways that exist.

A key purpose of publishing this questionnaire is to ask for clinician's feedback on it. Are there any questions that clinicians would suggest adding or removing? Or would anyone act upon the information in a different manner to what I have suggested. I would like to know if any departments use a similar questionnaire. If they do not and wish to use the attached questionnaire, or they do but want to start using the attached questionnaire instead, I would be happy for them to do so but I would appreciate if they could let me know that they are using it and whether they find it useful or not. Overall, I hope that this short paper sparks some interest in Red Flags, not just from a screening perspective but also from an intervention and reassurance perspective.

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Table 1: Red Flags Questionnaire

To the best of your ability, please answer yes or no to the following questions. If there are any questions, which you are unsure about, please ask your physiotherapist during the consultation.

NAME_____ DOB _____

1	Is your back pain the result of minor or major trauma, for example, a road traffic accident, a fall, or a strenuous lifting activity?	Yes /No
2	Are you 50 years of age or older?	Yes /No
3	Do you have a history of any type of cancer?	Yes /No
4	Do you have a fever over 100% Fahrenheit? Do you have a sensation of being cold, wake up sweating, or have temperature changes during the night?	Yes /No
5	Have you experienced a transplant of any kind, ever suffered from intravenous drug abuse, or prolonged steroid use?	Yes /No
6	Have you experienced any unexplained weight loss (>10 pounds in three months) not directly related to a change in activity or diet?	Yes /No
7	Have you had a recent bacterial infection such as a urinary tract infection?	Yes /No
8	Are you experiencing altered sensation or numbness around your genitals or back passage?	Yes /No
9	Do you experience any bladder or bowel problems/ irregularities, such as urinary retention, changes in frequency of urination or incontinence?	Yes/No
10	Are you experiencing progressive or severe weakness in your legs?	Yes /No
11	Do you experience, for no reason, any tripping or catching your feet when walking?	Yes /No
12	Do you have a "band like" pain radiating into your chest or abdomen?	Yes /No
13	Is your pain worse when you lie down?	Yes /No
14	Does your pain keep you awake at night unrelated to movement or positioning?	Yes /No

Developed by Dr. Cormac Ryan PhD (MCSP)

BOOK REVIEW – MANAGE YOUR PAIN. PRACTICAL AND POSITIVE WAYS OF ADAPTING TO CHRONIC PAIN*

By Dr Michael Nicholas, Dr Allan Molloy, Louis Tonkin and Lee Beeston.

ISBN:978-0-28564-048-1 £14.99

This newly revised book is a good resource for patients and is based on the ADAPT pain management program developed in the Royal North Shore Hospital, Sydney Australia. In turn this program is based on the well known INPUT program originally developed in St Thomas' Hospital London.

The book describes the approach used by the ADAPT program and more than this describes the conceptual basis behind this approach in words that can be understood by patients. Without going into detailed neurophysiology the book describes the effects chronic pain states can have on the body and that these affects are more than just physical. The book does not reference statements made but lists some core texts and reviews on the subject as an appendix.

Usefully the book describes pragmatic techniques including pain diaries and general exercises, using pictures and charts where appropriate, that patients can start to use. It also includes practical cognitive behavioural techniques anyone can use in both medical and home environments. Although the book is generic in that is does not outline the details of any specific pathological processes or diagnoses it does have short sections specific to children and older adults.

The book would be an excellent resource for a chronic musculoskeletal pain patient and would I'm sure significantly enlighten a freshly qualified clinician new to the area, but is unlikely to hold many surprises for clinician already working in a pain management setting. It could however act as a resource or even something to lend to patients and in this way, and with a lower than usual price tag, justifies its place on any pain management staff members book shelf.

By Dr Nicholas Harland

PPA Chairs Report for AGM 2011

The last twelve months has seen the PPA strengthen its position on a number of fronts through the hard work of the Executive Committees guided by constructive feedback from the membership. Reports from the Honorary Officers clearly and succinctly outline the progress both achieved and planned. At this point I am constitutionally obliged to remind the Executive and the Membership that I enter my final year of the three year term of office.