useful where ongoing symptoms are related to spinal hypo-mobility which cannot be restored independently with exercise or functional activity. In contrast, chronic low back pain patients with normal spinal mobility or hyper-mobility are much less likely to respond to the same treatment. Unfortunately, these basic concepts of clinical practice are not recognised in the design of many physical intervention studies for chronic low back pain. This may result in misrepresentation of the true effectiveness of mobilisation and manipulation in studies where treatments are prescribed randomly to a heterogeneous study population.

The conclusion statement of Ferreira et al casts considerable doubt on the value of spinal mobilisation and manipulation in the treatment of chronic low back pain. To help readers interpret these conclusions, I feel some recommendations as to where we go from here would be most helpful. Should we stop using these techniques when treating this patient group? Is it worthwhile including manipulation or mobilisation in future treatment studies? Are there any recommendations for the design of future studies which examine the efficacy of these treatment techniques? Without these riders to the conclusion of such reviews, there is a real danger that these techniques will be discarded from physiotherapy practice. As a result, potentially effective treatment will not be provided to some patients, and in so doing, the stimulus for future studies into the efficacy of these techniques may be lost.

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Chronic low back pain patients who benefit from spinal manipulative therapy are difficult to identify. (Reply to Edmondston S, Australian Journal of Physiotherapy 49: 63-64)

We thank Dr Edmondston for his interest in our work. His letter raises important issues concerning the validity of spinal manipulative therapy for low back pain.

We agree that in any clinical study there are people who benefit from treatments as well as those who do not, but we disagree with the implication that the average patient’s response to treatment is of no relevance to clinical decision making. Our work provides an estimate of the average effect of spinal manipulative therapy for the people with chronic back pain, based on eight randomised trials. Presumably the authors of those trials included patients for whom they thought manipulative therapy was indicated, but (in the absence of good evidence about who responds best to manipulative therapy) this was not the population that Dr Edmondston thought was most suitable. We found, on average, a small treatment effect, but the effect was so small that most therapists and patients would not consider it worthwhile. That means that even though some patients with chronic low back pain might get better when treated with manipulation or mobilisation, it is most probable that they will not. When spinal manipulative therapy is compared with placebo or other treatments, most patients with chronic low back pain do not benefit appreciably from intervention.

The lack of worthwhile effect, on average, of manipulative therapy for chronic low back pain contrasts with interventions such as exercise and behavioural treatments which have been shown to be effective for an unselected and heterogeneous population of chronic low back pain patients (van Tulder et al 2002a and 2002b). Such therapies should be employed in the treatment of this population. It is also true that spinal manipulative therapy works for unselected groups of patients with acute low back pain (Ferreira et al in press) and therefore we do not believe that there is any reason for manipulative therapy to be discarded from clinical practice.

We also agree that there might be sub-groups of chronic low back pain patients who might benefit from spinal manipulative therapy, but the problem is in identifying who comprises that sub-group. None of the included trials have been able to identify such sub-groups and thus such conclusion should not be inferred from our work.

In fact it is technically difficult to identify, with any rigour, sub-groups of responders and non-responders to therapy (Oxman and Guyatt 1992). We are currently conducting a clinical trial looking at the efficacy of spinal manipulative therapy for patients with low back pain of at least three months duration. In that trial we will attempt to identify, in a rigorous way, physical predictive factors (such as lumbar postero-anterior spinal stiffness) and psychological predictive factors in an effort to identify sub-groups of actual responders to spinal manipulative therapy within that population.

Until we can identify, with some certainty, those who will and will not respond to therapy, spinal manipulative therapy is not likely to be helpful for physiotherapists who have to treat their chronic low back pain patients. Identification of sub-groups of “spinal manipulative therapy responders” is a hope for the future.

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References

