measures based on impairment and disability are included and compared. Though handicap and psychosocial measures are important as a consequence of unresolved morbidity, they generally do not have the specific and dynamic range of response to make them good indicators of relevant therapeutic response. Furthermore, the best outcome criteria will also depend on the type of back pain and also the type of treatment.

For example, change in the count of painful directions of back movement is good for identifying response to traction therapy in the back strain subgroup, whereas change in the area of the low back pain drawing is better for showing response to short wave diathermy in another subgroup whose side of back pain can switch between episodes. Another important matter is to identify the window of opportunity following onset of the back pain when a particular treatment can help. The guidance available is more than can be described here, but it is hoped that drawing attention to the source of such work could help researchers design future studies.

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Comment on: Analgesic effects of treatments for non-specific low back pain: a meta-analysis of placebo-controlled randomized trials: reply

Sir, We would like to thank Dr Sweetman for his valuable comments [1] on our meta-analysis [2]. The key message from his letter can be summarized by his comment: ‘Furthermore the best outcome criteria will also depend on the type of back pain and also the type of treatment’ (fourth paragraph, last sentence).

While we share Dr Sweetman’s interest in identifying effective interventions for low back pain [3, 4] we feel that his suggestion to use different outcomes for different types of back pain and different types of treatment is not the direction to pursue. As an illustration, let us think of a trial comparing two different treatments for low back pain, which is in fact the most frequently used trial design in back pain research. In a trial like that, measuring outcomes differently in the two groups would ensure that the treatment which provided the best outcomes could not be determined. We would have numbers, but their comparison would be meaningless because they have been measured on different scales. Therefore, we feel that it makes more sense to use a common yardstick when measuring treatment outcomes in clinical trials. Additionally, as highlighted in the discussion of our paper, it is likely that a measure of pain intensity will show larger responses in trials than any other outcome measure regardless of the type of treatment being evaluated [2].

Furthermore, our present understanding (or lack of understanding) on how to identify truly distinguishable subgroups of non-specific low back pain is another important barrier for Dr Sweetman’s suggestion about choosing different outcome measures for different types of back pain. For example, he suggests that the count of painful back movements should be used to identify patients in the back strain subgroup who respond to traction therapy. In our paper, we listed five randomized controlled trials [5–9] reporting conflicting evidence on clinician’s ability to identify subgroups of non-specific low back pain with differential responses to treatment. These findings indicate that research on classification systems and clinical prediction rules developed to identify such subgroups is still in its infancy.

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