References


Commentaries

Following are three commentaries on "Diagnostic Classification of Patients with Low Back Pain: Report on a Survey of Physical Therapy Experts"

Binkley et al have addressed several important issues relevant to future considerations for physical therapy management of patients who have low back pain (LBP). They are to be congratulated for furthering this important discussion, because it is apparent that sweeping changes loom in regard to management strategies addressing the epidemic of LBP.

The first basic premise stated by the authors is of critical importance. The development of a standardized diagnostic classification system is essential. They rightly point out that efficacy studies that simply compare one treatment technique with another without regard to specific subgroups of patients with LBP are illogical. Such studies make the assumption that all LBP has the same cause and characteristics. Clinicians would not tolerate studies that compared two different treatment techniques for “knee pain” unless such studies attempted to clearly distribute patients with knee pain into similar subgroups. Binkley et al suggest that we utilize the same such standard for the low back and hence strive to pursue a diagnostic classification system. In a previous article, 1 we had suggested subgroups based on the pathomechanics gleaned through the evaluation. Regardless of one’s bias, it is clear that the profession must develop some standardized classification system.

The literature review clearly identifies the dilemma for the clinician—multiple and loosely related diagnostic groupings. This fact has hampered the opportunity for clinicians to communicate among each other in regard to patients with LBP and limits the ability to test the effects of therapeutic intervention.

The authors determined that a rating of 3 or greater constituted agreement of diagnostic classifications. This appears generous, especially when the rating of 3, as viewed by its placement in Appendix 1, does not compel the rater to the side of appropriate or not appropriate, but allows a more neutral position to be taken on the question. This neutrality is then factored into "constituted agreement" and potentially obscures the actual meaning of the results.

Clearly, the agreement on diagnostic classifications was highest in those classes that featured specific sophisticated laboratory tests. Once these first six classes are removed from further consideration, we are left with the more difficult to define classes. It might also be argued that it is precisely these next classifications that are most often seen in the physical therapy clinic and hence should be the focus of future discussion.

Although the intent of the survey approach was to measure agreement on a diagnostic classification for LBP, I
was left with the impression that the survey was asking less about a diagnostic classification than a clinical finding. I believe that there is an important difference between the two. The authors' diagnostic classification of hypomobility dysfunction illustrates this difference. Although having consensus as to the essential clinical findings for such a diagnosis, the fundamental question remains unanswered regarding its correlation with the patient's problem. This is akin to the recognized shortcomings of using the findings of radiographs to establish the diagnosis of degenerative joint disease of the spine and making the assumption that is the cause of the patient's low back complaint. Perhaps the additional finding noted as essential for the diagnostic classification of sacroiliac hypermobility illustrates why this correlation is essential to consider. Ten of the 24 respondents (without cue from the written survey) independently noted that positive sacroiliac stress tests were essential for this classification. I interpret this to mean that they are correlating the patient's complaint with the clinical finding, which should be the ideal goal with each classification and finding. This shortcoming aside, Binkley et al have made an important initial step in at least helping us determine whether agreement among clinicians is realistic in the first place.

It was revealing that chronic pain syndrome did not meet the agreement criteria for diagnostic classes, and I would have been interested in the essential diagnostic findings suggested by the authors. Perhaps this points out an important limitation of physical therapists that needs to be addressed. The physical therapist must become aware of the current medical strategy of identifying, as early as possible, the potential patient with chronic pain syndrome or those patients with a propensity toward disability. The skill to identify this diagnostic class is essential because a disproportionate percentage of patients (10%) account for 80% of the expenditures. Although early identification appears to be a daunting task, the literature clearly points out the necessity of developing such clinical skills. It has been suggested, for example, that there may be four different dimensions of pain behavior: (1) marked distortion in ambulation or posture, (2) a negative affect, (3) facial or audible expressions of distress, and (4) the avoidance of activity. Perhaps increased attention in the future needs to be placed on identification of this important diagnostic classification.

Future physical therapy research for LBP will most likely be focused primarily on efficacy of treatment and patient outcomes, because society will place increasing demands on accountability. For this to occur, however, a common terminology among clinicians must be used. Research on LBP is complicated by the fact that no two syndromes are exactly the same and the patient's subjective response to the pain is unique. It is essential, therefore, that clinicians at least develop a commonality of clinical language that allows for efficacy to be scientifically evaluated rather than relying wholly on anecdotal reports. In this regard, Binkley and colleagues' contribution to the literature is both timely and relevant.

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References


Numerous physical therapy treatments have been advocated for the patient with low back pain (LBP). An important barrier to determining the effectiveness of these treatments is the lack of a valid classification system for patient's LBP. Binkley et al have presented important and timely data that will assist clinicians and researchers toward overcoming this barrier. Several "expert" orthopedic therapists have agreed on categories by which to classify patients and on the essential findings that must be present for this classification. In their conclusions, the authors caution us that in many of the classes, the "specific pathological or anatomical cause of LBP cannot be validated with current diagnostic procedures." I agree with this statement and would like in my discussion to focus on the "clinical meaningfulness" of the classification scheme that was agreed on by the experts who were surveyed.

A fundamental goal of the treatment of patients with musculoskeletal disorders is to identify the structural abnormality causing the patient's impairment or disability. This knowledge allows the therapist to develop a mechanical basis for the patient's problem, to identify which tissues to treat, and also to predict outcomes. Relative to the extremity joints, this goal typically can be achieved with our current diagnostic procedures. The identification of structural problems that cause LBP, however, is problematic. The use of the pathological model as a means of predicting LBP may not be valid for several reasons. The spine is a multisegmental system in which tissues work together, and presumably are injured together; thus, identifying one culpable tissue (eg, disk or muscle) may be inadequate. Many radiographic and magnetic resonance imaging (MRI) findings from the lumbar spine correlate poorly with LBP. In contrast to the extremity joints, most spinal structures are not palpable. This creates difficulty when attempting to identify painful tissues during a physical examination. Additional...