Comment on StEP

Posted by Hans_Timmerman on **18 May 2009** at **08:43 GMT**

Comment on: A novel tool for the assessment of pain: Validation in low back pain
(Scholz et al. 2009)

With interest we read the article about the validation for the distinction between patients with radicular and axial low back pain (LBP) of the standardized evaluation of pain (StEP) by Scholz et al [1]. The high sensitivity and specificity and relative easy use makes this instrument a promising one. However, we have some major concerns about this novel assessment tool.
(1) StEP is constructed as a tool that differentiates in different pain phenotypes independent of etiology, e.g. construe a relation between (sub-)patterns en biological mechanisms. Neuropathic pain is considered, especially in a mechanism based classification, to be present only when there are definite signs of a nervous lesion [2,3]. What about nociceptive nerve pain as a biological mechanism in patients with diabetic neuropathy?
(2) Is the validation of this instrument performed for the diagnosis of neuropathy or for the diagnosis of radiculopathy in patients with LBP? Is the distinction between radicular and axial low back pain (LBP) the same as the ability to distinguish between neuropathic pain and non-neuropathic pain? Or is chronic radicular low back pain with radiculopathy a pain syndrome in which both types of pain are present? According to a substantial number of studies the latter seems to be so [4-7].
(3) In recent years an effort is made to move towards a rational and symptom-based treatment for the improvement of LBP therapy: Physicians should distinguish the nociceptive and neuropathic pain components in their patients and realize there are co-morbid conditions [5,8]. Treede et al defined neuropathic pain as 'pain arising as a direct consequence of a lesion or disease affecting the somatosensory system' [4]. Following this grading system and according to Bennett [6], a combination of neuropathic and non-neuropathic pain is possible and pain itself can be more or less neuropathic of origin. It is the greatest challenge to diagnose the group of patients that doesn't fit exactly in the radicular or axial group. In this study six patients (4%) are excluded after clinical classification of their pain but before statistical analysis. Inclusion of these six patients in the analysis should be considered because of 'real-life clinical practice'.
(4) Finally, we have concerns about the use of spinal magnetic resonance imaging (MRI) in only 52% of the patients. As written in the article, the gold standard should be a conclusive clinical diagnosis which is based on several sources including additional investigations as MRI. In patients with axial LBP in 26 cases a spinal MRI is present. Of these, 5 patients are diagnosed after clinical diagnosis as radicular LBP. When no MRI is performed only 1 of 40 patients is re-diagnosed as radicular LBP. To our meaning, from every patient there should be a MRI to standardize the final diagnosis in studies validating assessment tools for the distinction between radicular en axial LBP.

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