Reviewer's report

Title: Assessment of the Feasibility of High-Concentration Capsaicin Patches in the Pain Unit of a Tertiary Hospital for a Population of Mixed Refractory Peripheral Neuropathic Pain Syndromes in Non-Diabetic Patients

Version: 5
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Reviewer: Michael Serpell

Reviewer's report:

General comments; Major compulsory revisions

I agree with the conclusions of this paper, we utilise Qutenza in the same way (for treatment resistant pts with peripheral NeuP).

In order to gain more meaningful insight, we need to have a description of what the usual activity of your pain clinic is. You give a little information on Page 12, but please expand. For example, in our unit we have two treatment rooms on a procedure list. A patient having Qutenza would effectively block one of them for 2.5 hours. How do you work flexibly around that to reduce the negative impact of that (less patients treated)? Similarly, if I were to do this during a consultation clinic, I would have to leave the room several times to perform/supervise certain aspects of the procedure, with less patients being seen in my clinic. And that is assuming that someone else will be monitoring them whilst I go back to the clinic.

We use our nurses to do the procedure, but similarly, they have to be in attendance all the time, and can not do their own clinics or ward rounds during the Qutenza procedure. So we reschedule other tasks to them that can be done during certain phases of the Qutenza application. Do you do this?

You need to explain all of this in your paper, otherwise the study is meaningless to the uniformed reader.

Also, it looks like your practice is to apply LA before the Qutenza. This time factor does not seem to be in your calculations. Please explain.

The paper shows a worthwhile response in 40% of 20 patients (Pain VAS reduction >30%). Similar to our results (actually very good when you consider they are non-responders to many treatments for NeuP). I noted that concomittent meds were NOT increased. You would expects this as 1) you are adding a new treatment and wanting to observe the effect, and 2) they have already tried multiple treatments and presumably are on optimal doses. Could you comment on principle of reducing concommitent analgesic drug consumption in those responders?

Specific comments. Compulsory revisions

Page 4, Methods - para 1, line 4 -- "your study", should this be "the study taking
place"

Page 4, Methods, para 2, line 2 - Blood Pressure measured with cuff, not controlled.

Page 5, para 3. What happened if the previous week, a patient had had applicartion of Qutenza at the clinic? What then would then be your reference day?

Page 5, last para - time to determine & mark the painful area - if this includes application of LA, then the time ranges measured are too short as the LA pre-treatment needs to be applied for 60 mins. Recent research evidence has demonstrated that LA preparation can be be ommitted and procedure pain adequately controlled with Tramadol PO instead. Can you comment on whether this was done in your centre during Oct 2010 to Sept 2011? If not, then new changes would reduce time to do the whole procedure.

Page 8, RESULTS, para 2 - CRPS I is not a form of peripheral neuropathic pain (CRPS II is)

Page 9, para 2 - you do not mention any time for application of LA. Was this your practice? You do mention this later on (bottom of Page 9), it needs to be mentioned eralier and these times needs to be included in the analysis as it adds a minimum of one hour to the whole procedure time!!!

Page 11, para 1. What was the change in EuroQol in the responders?

Fig 1 unclear. I would suggest to include total N for each pain condition.

Level of interest: An article of limited interest

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

'I declare that I have no competing interests'