Author's response to reviews

Title: An observational descriptive study of the epidemiology and treatment of neuropathic pain in a UK general population

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General
Neuropathic back pain is a controversially debated clinical entity. The fact that there is no READ code nor an ICD-Code reflects the lack of general acceptance of this diagnosis. The authors acknowledge that this entity cannot be defined and state they have done the analysis for exploratory purposes. However it remains unclear why you tried to estimate the prevalence of neuropathic back pain. Actually according to your findings neuropathic back pain is about twenty times more common than any diabetic neuropathy according to the authors. Please state clearly that pain treated with radicular back pain associated is conventionally not considered as neuropathic pain. Readers should also be informed that current guidelines do not recommend anticonvulsive drugs for radicular low back pain due to a lack of conclusive clinical trials.

Response: The reviewer is quite correct that the definition of neuropathic back pain is a mess, which we acknowledge in the Discussion. It is also true that neuropathic back pain symptoms may be managed with antiepileptic drugs even though there are so few good trials (and hence guidelines avoid the topic). Therefore we included back pain treated with antiepileptics in our case definition (provided the patients did not have epilepsy). We cannot (and do not) make any claim that the numbers for neuropathic back pain are accurate, but it seems quite plausible that such symptoms are likely to be commoner than PDN given that back pain is so common.

The discussion now reads: ‘Neuropathic back pain within the study definition increased over the study period from 49 to 62 per 10,000 patient-years. This cannot be considered to be a true incidence because, without a specific code for neuropathic back pain, the study definition lacked specificity. For example, patients with back pain or radiculopathy treated with tramadol would have been included in the analysis although tramadol is often also used in nociceptive, rather than neuropathic pain. Conversely patients with neuropathic back pain but
without a neuropathic code and treated with opioid/non-opioid combinations would not have been identified. Additionally, radicular back pain is not always considered to be neuropathic. The prescribing patterns in the neuropathic back pain cohort differed from the other pain conditions, with tramadol the most frequent first-line therapy and other opioid/non-opioid analgesics commonly prescribed. This may be because of co-existing nociceptive pain for which tramadol efficacy is established [10, 27] or indicate that cases of purely nociceptive pain were included in the cohort.

International readers won't know what co-codamol is.

Response: we have added ‘(codeine phosphate and paracetamol)’ after the first mention of co-codamol in the main text and ‘(codeine-paracetamol)’ to the abstract. We have also added (paracetamol and dihydrocodeine) after the first mention of co-dydramol in the text and in the abstract.

Introduction

The first sentence is implying that people with chronic pain have not enough access to pain specialist. This is a strong and unproven claim, please rephrase. Pain does not mean somebody needs to see a pain specialist.

Response – The sentence now reads ‘A fifth of adults in Europe report moderate or severe chronic pain with 2% managed by a specialist.’

Methods

The attempt you made to validate your secondary data should have a proper subheading in the method section.

Response – The heading ‘Validation of diagnosis’ has been added.

Results

You are reporting absolute numbers but the total remains unclear.

Response: We weren’t clear which numbers you were referring to. Results are presented as number and rate (either per 100,000 or %) as appropriate.

Discussion

The discussion should have subsections

E.g. Strength and limitations

Response: We have added a sub-heading ‘Strengths and limitations’ to the existing 3 sub-headings.

The presence of a coded condition without specific treatment does not mean somebody is undertreated. There are many additional reasons you are not addressing. GPs code for billing purposes, and coded pain does not mean that patients require or wish a treatment.
Response: While GPs in the UK health care system do receive payment for some preventive medicine they do not code diagnoses and prescribing for billing purposes. We don’t believe the reporting of completed preventive medicine will have affected our results, except perhaps increasing the rate of diagnosis of neuropathy thereby providing a more accurate incidence rate.

We have added ‘or when the patients did not require or want a prescription treatment’ to the other reasons for not finding a therapy already listed.

Your need to address the biases of your attempt to validate the secondary data with the questionnaire.

Response: We have added the following paragraph: ‘The validation questionnaire was sent to a small sample and, while the response rate was good, we have no data on the quality of the response and some bias is possible. For example, those finding working rather than final diagnoses in their records or inconstancies between the questionnaire and their notes may be more or less likely to reply.’

Conclusion

The conclusion is problematic. GPs cannot be blamed for adhering to guideline recommendations which do not reflect evidence established posthoc or elsewhere. You should rather blame the guidelines

Response: The conclusion is stating a fact based on the findings of the study rather than apportioning blame to GPs or guidelines. We think that the discussion addresses the issue of GPs adhering to guidelines that were available at the time. The discussion includes ‘The prescribing analysis period of 2006- 2010 was, for the most part, prior to the publication of the current UK and European recommendations on neuropathic pain treatment, although after the publication of key randomised controlled trials for the newer antiepileptics, antidepressants and opioids in neuropathic pain.’