Author's response to reviews

Title: The use of CAM and conventional treatment among primary care consulters with chronic musculoskeletal pain

Authors:

Majid Artus (m.artus@cphc.keele.ac.uk)
Peter Croft (p.r.croft@cphc.keele.ac.uk)
Martyn Lewis (a.m.lewis@cphc.keele.ac.uk)

Version: 2 Date: 10 March 2007

Author's response to reviews: see over
Authors’ response to Reviewer’s report:
We would like to thank the reviewer for the objective and fair comments and helpful suggestions. We do not object to any of them and we have tried to revise the manuscript taking them into consideration.

Reviewer’s report
Title: The use of CAM and conventional treatment among primary care consulters with chronic musculoskeletal pain
Version: Date: 16 November 2006
Reviewer: Alison M Elliott

Reviewer’s report:
General
This is an interesting and well-written paper from a respected pain research unit looking at complementary and alternative medicine use among primary care consulters with chronic musculoskeletal pain. In general, the paper is well presented and clear. The analyses used are sound and appropriate methods have been used. The paper would benefit from a few simple revisions before publication.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)
1. I found the Introduction slightly misleading. From reading it I would have been left with the impression that very little has been done looking at CAM use and that all of what has been done is with health professionals rather than patients. Although limited, studies have been conducted with patients looking at CAM use both in the general population and in pain populations. These studies have not looked in-depth at the types of CAM treatments used, but they do provide some indication of how much CAM use there is. These studies should be acknowledged a bit more. What previous studies haven’t done is focus on a musculoskeletal population, look in-depth at the range of CAM treatments used, or look at the perceived helpfulness of treatments from the patient’s perspectives and I think these are the real strengths of this study. In terms of focusing on a musculoskeletal patient population, did the authors have any a-priori hypotheses about CAM use being different in this group compared to a general chronic pain group?

Authors’ response: The introduction has been revised in light of the above comments. This study was particularly interested in primary care patients. We are not aware of a UK study that looked at CAM use by directly asking primary care patients themselves. Previous studies have suggested that CAM users were particularly reluctant to inform their doctors of their use of CAM (e.g. Eisenberg 1998), which we saw as a good reason to exploring this issue directly. Our a-priori hypothesis was that within the general group of chronic pain patients, chronic musculoskeletal pain patients do use CAM more commonly. We based that on findings from previous studies (e.g. Ong CK 2002, Thomas KJ 2001).

2. This study found that 84% of patients had used CAM in the previous year and 65% were current users.
There is no discussion of this overall rate of CAM use in comparison with other studies. According to the sample size calculation CAM use was estimated to be between 30 and 50% based on CAM use in previous surveys, but there is no discussion of these studies or why this study found higher rates of CAM use. A discussion of the rates of CAM use reported in other studies (general population and pain samples) and why the rate in this study was higher should be included.

Authors’ response: We have revised the Discussion section to address this important issue (please see revised manuscript). In summary, and to continue from point one above, it was difficult to compare the findings of our study with other studies in the UK because of the lack of such similar studies looking at a similar population of primary care consulters with chronic musculoskeletal pain. However, previous surveys have shown that CAM is most commonly used for chronic musculoskeletal pain. It is also know that primary care is the most common health care service accessed by this same group. The two main characteristics of our participants, namely actively using primary care and suffering from chronic musculoskeletal pain, would make them, therefore, the most common users of CAM. This could possibly be the explanation of the high rate we found.

3. The authors should highlight that one of the main limitations of this paper is that by focusing on consulters they cannot comment on CAM use amongst non-consulters. They were therefore less likely to find users of CAM only and this study will underestimate those relying on CAM medicines alone. Previous studies have suggested that a greater number of individuals with chronic pain are seeking only alternative health care when compared to the general population. This important sub-group couldn’t be examined in this paper and this should be acknowledged. Similarly in the conclusion the sentence starting “The fact that the majority of CAM users remained active users of conventional medicine...” should be amended. We do not know from this study that the majority of CAM users also use conventional medicine. We know that amongst consulters this is true, but that is not surprising in this population.

Authors’ response: We completely agree that we could not comment on CAM use among non-consulters and we have addressed this point in the revised discussion (please see revised manuscript). As we mentioned in our response to point one, in this study we were interested in consulters only. The issue of CAM use among non-consulters is a completely separate matter and we were very careful not to generalise our findings to them. We are aware and keen to emphasise that our findings are specific to this group of patients and only generalisable to other similar groups considering all other relevant factors surrounding CAM use.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)
1. Methods: The authors state that language was not an excluding criterion. What provisions were made for non-English speakers? What proportion of the sample were non-English speakers?
Authors’ response: It was explained to those who were invited that translation and interpretation facilities will be made available when needed and provisions were made available for that. None of those who responded to our invitations were non-English speakers. However, we only sent invitation letters in English.

2. Results: “Of the 427 patients invited, 138 interviews were completed”. Did more than 138 agree to take part, but couldn’t be completed or did only 138 agree to take part, all of which were completed.

Authors’ response: 138 agreed to participate in the interviews all of which were completed. This has been made clear in the text.

3. Results: Use of CAM and conventional treatments – at the end of this paragraph the authors talk about 28 further treatment names, 16 of which were CAM and refer to Table 2. This reference should be Table 1 where these extra 16 treatments are listed. There is no mention of these 16 treatments in Table 2. Why not show the numbers of these additional 16 treatments as well, unless they were all just mentioned once, in which case a footnote to this effect could be included.

Authors’ response: We will correct the mistake of referring to the wrong table. A note on the extent of use of these treatments has been added in the results section.

4. Results: The authors started with an open question about treatments before introducing a list of options. A couple of lines in the results about how much information came from the initial question and how much extra information came from the list would be interesting.

Authors’ response: This information has been added.

5. Discussion: The authors state that it has been shown that the prevalence of chronic pain varies widely across geographical areas and quote reference 24. However this study was conducted in one region in the UK and did not look at geographical variation. A more appropriate reference (e.g. Gureje, JAMA, 1998) should be given.

Authors’ response: We have changed the reference.

6. Discussion: Perceived helpfulness from using CAM – in the last part of this section the authors talk about the most favourable CAM treatment having higher ratings. I presume the authors mean most favourable in terms of helpfulness rather than in terms of numbers using it. I suggest they reword this slightly to make it clearer and say which CAM treatment(s) are perceived as better than paracetamol, ibuprofen and co-codamol to save the reader looking back at the graphs.
Authors’ response: This sentence has been rephrased and clarified.

7. Table 4: The numbers of ways/reasons given at the top of this table are presumably based on lists of ways/reasons given. Are the other ways/reasons given at the bottom of the Table also from prepared lists or were these other options participants came up with themselves? This should be clarified. Were the numbers reporting these other reasons small? 79 people appeared to give other reasons for stopping, but only 5 are listed. Are these examples or were only 5 given, in which case the numbers for each of these would be interesting since some of them must have been more commonly given than the reasons listed at the top of the table.

Authors’ response: A clarification footnote has been added to the table.

Discretionary Revisions (which the author can choose to ignore)
No such revisions to suggest
Accept after minor essential revisions What next?:
An article of importance in its field Level of interest:
Acceptable Quality of written English:
No Statistical review:
Declaration of competing interests:
I declare that I have no competing interests