Author's response to reviews

Title: Exploring integrative medicine for back and neck pain - a pragmatic randomised clinical pilot trial

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Version: 3 Date: 30 June 2009

Author's response to reviews: see over
Cover letter, revision round 2, 30 June 2009

Dear Iratxe Puebla,

Thank you for your email received on 23 June 2009 and the second opportunity to revise and clarify our manuscript entitled “Exploring integrative medicine for back and neck pain – a pragmatic randomized clinical pilot trial” [MS: 7919351342550535].

Please find our replies below in a point-by-point format addressing each of the reviewers’ comments, all numbered for easier reference.

We thank for the valuable comments and feel that the manuscript is now more concise and clear. We look forward to your response. Thank you.

Sincerely yours,

Tobias Sundberg
Max Petzold
Per Wändell
Anna Rydén
Torkel Falkenberg

Reviewer's report
Title: Exploring integrative medicine for back and neck pain - a pragmatic randomised clinical pilot trial
Version: 2 Date: 12 June 2009
Reviewer: Suzanne McDonough

Reviewer's report:
I have am delighted that the authors found my comments helpful. I have had the opportunity to review the authors' comments and the revised manuscript and there is greater clarity in the paper. However I think that some further revisions are advisable.

Major Compulsory Revisions:

1) I think the research team may have misunderstood my comment about looking at clinically important differences as opposed to statistical change. By this I meant that they should explore defined minimally clinically important differences (MCID) between the groups, see the comment also by Dr Poitras (point 4) for the
SF36. So for example do any of the changes that you see in Table 2 for the SF36 exceed the between group MCID? At the moment it is difficult to interpret the findings, are the differences for some of the measures of the SF36 meaningful from a clinical perspective?

Reply: Thanks for clarifying your comment. We have now revised the figures in Table 2 to include the clinical differences between the groups as well as a measure of distribution based effect sizes (Cohen’s d) to make it easier for the reader to interpret the findings.

2) You should also explore the other validated outcomes that you used to see if they have a published MCID? The section in the results and subsequent discussion should be rewritten in light of this, so for example is your statement on page 19 true i.e. there are promising clinical differences?

Reply: There is no consensus on MCID for our set of “IM tailored” outcomes. We have rewritten the results and discussion in light of this and the MCIDs/effect sizes, please see the results page 12 last paragraph on “Clinical differences and effect sizes between groups” and the discussion page 18 lines 1-4 and page 19 lines 1-3. The conclusions have been revised and the sentence on “promising clinical differences” has been removed, please see last paragraph on page 20.

3) The team should also consider whether a different set of or additional validated outcome measures should be used in a main trial.

Reply: We have added a section in the discussion about outcomes and complementing perspectives of evaluating the effects of IM. Please see page 19, line 3-12.

4) The discussion then needs to reflect the findings in terms of MCID above

Reply: Please see reply 2 and 3.

5) One of the other reviewers highlighted the issue around the outcome measures used in this study, and although the SF-36 was used, it would seem that the other measures used were not fully validated. I think that the research team should seriously reconsider the outcomes that they might use in a main trial, it is not good practice to adapt any outcome measure without additional validity testing (particularly if it is going to be used as the primary outcome measure). I take on board the comment on page 7 about wanting to use tailored outcomes, and perhaps they could consider Mymop for a main trial. They need to address this in their results and discussion section, as in order for the results of a main trial to be taken seriously the choice of outcomes is very important.

Reply: We agree that the choices of outcomes and strategies for evaluation in complex interventions are very important and have added perspectives reflecting about our current results in relation to this, please see page 19 first paragraph. We have also taken onboard the suggestion of using SF-36 as the basis for a main outcome measure, please see the results page 13 second paragraph and the conclusions page 20, lines 11-13. Please also see reply 3.
6) Although these is now a more detailed description of the therapies used in the IM model. There is no real detail given on the treatments given in the conventional care group on pages 12/13, 25% were referred to physiotherapy, and of the 85% who received advice, 37% received this advice from a physiotherapist?? Can you please clarify exactly what you mean here?

➡ Reply: We’re sorry if this was unclear. The general practitioner, not a physiotherapist, gave advice. In 37% of the cases this was advice about physiotherapy, e.g. perhaps that physiotherapy might be an option if the pain would not subside. We have clarified this on page 13, last paragraph lines 3-5.

7) Also did you record exactly what the physiotherapist did with the patient, if not, this would need to be included for a main trial so that you know exactly what you are comparing between the groups.

➡ Reply: Unfortunately there were no possibilities to gather data from external physiotherapists or to track any other individual external treatments within conventional care due to logistical limitations. This has been addressed on page 14, last paragraph line 4-7. Hence, data on conventional care visits was only estimated from self reported use of health care in the “IM tailored” set of outcomes. We have added this as a limitation of the current trial, please page 19, last paragraph 2nd line from the bottom, and discussed the use of additional measures in this regard, please see page 17, second paragraph lines 4-8.

8) Other specific suggested corrections:
Page 2, last sentence: change to ‘Trends in clinically’
Page 3, line 9, change to ‘Trends in clinical’
Page 3, first sentence last paragraph, add in ‘few’ between ‘last’ and ‘decades’
Page 6, line 5, insert ‘the’ between fulfilled and inclusion
Page 10, 2nd paragraph, I don’t understand the use of the word ‘booted’
Page 11, 4th last sentence, remove this sentence on approaching statistical significance, it is either significant or it isn’t plus remove from page 16.
Page 12, 1st paragraph, change word ‘reversely’ to ‘conversely’
Page 12, 2nd paragraph, fourth line add ‘the’ between ‘applying’ and ‘same’
Page 14, 2nd paragraph line 1 change ‘recruiting’ to ‘recruitment’, line 5, reword to ‘may however be an over estimation due to logistical barriers which prevented us from making direct comparisons.’
Page 15, line 2, change ‘a’ to ‘one’
Last paragraph, first line, change advert to ‘adverse’

➡ Reply: Thank you for these details. All have been corrected or modified.

Level of interest: An article whose findings are important to those with closely related research interests
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
Reviewer's report
Title: Exploring integrative medicine for back and neck pain - a pragmatic randomised clinical pilot trial
Version: 2 Date: 8 June 2009
Reviewer: Stéphane Poitras
Reviewer's report:
The authors have satisfactorily addressed most of the points of concern in the revised version. However, certain elements need to be further addressed.

Major Compulsory Revisions

1. Comment #8. The authors should be applauded to have collected data to assess possible contamination between groups (table 3). However, results seem to demonstrate that there was extensive contamination in the conventional arm, which could partly explain the lack of difference between groups. More than a quarter (25.5-33.3%) of the subjects in the conventional arm appeared to have received complementary therapies. Although I agree with the advantages of a pragmatic trial, this contamination makes it difficult to isolate the effectiveness of the IM. This was partly discussed by the authors on p. 15 and 16, but contamination and its impact on the results should be further discussed.
   ➔ Reply: We have added a part to the issue of possible contamination in the discussion, please see page 18 last 5 lines from the bottom.

2. Comment #10. The authors have not convinced me on the psychometric properties and necessity of the proposed tailored outcomes, namely the 11 point scales for disability, stress and well-being. Particularly worrisome is that the stress and wellbeing scales were chosen based on face validity only. For disability, only one item of the Bournemouth questionnaire was chosen, and modified. However, the psychometric properties of the Bournemouth are for all of the combined items, not individually. There are numerous well validated instruments available to assess the dimensions of disability, stress and well-being. I would suggest that the main outcome measure would be the SF36. Power calculations could then be made with this instrument, of which there are numerous available data for SD and minimal important change for chronic LB and neck pain patients seen in primary care.
   ➔ Reply: We have revised the manuscript to suggest SF-36 as the basis for a main outcome measure. We have also done power and sample size estimates for the suggested use of SF-36 in a main trial. Please see page 14, second paragraph under “Statistical differences, power analysis and sample size”.

3. Comment #15. Why were non-parametric analyses used with the SF36 (QoL)?
   ➔ Reply: Due to the data type (ordinal data). This information has been added to the statistics section, please see page 10, second paragraph, lines 2-4.
4. Comment #16. The authors have analysed if there were differences with dropsouts on gender and age. However, the important difference to assess would be on baseline outcome measures. If drops outs tended to have significantly different baseline measures, this could partly explain results.

⇒ Reply: There were no significant differences in outcome measures between the dropouts. This information has been added to the text, please see page 12, first paragraph, last sentence.

Minor Essential Revisions

1. Comment #15. In logistic regressions, there is one dependant variable and several independent variables. This should be corrected on page 9.

⇒ Reply: Our co-author and statistician (MP: Max Petzold, PhD) has revised the text in the statistics section to provide more detail and clarity. Please see page 10, second paragraph.

Discretionary Revisions
None

Level of interest: An article whose findings are important to those with closely related research interests
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'

Reviewer's report
Title: Exploring integrative medicine for back and neck pain - a pragmatic randomised clinical pilot trial
Version: 2 Date: 7 June 2009
Reviewer: Heinz G. Endres
Reviewer's report: The concerns expressed by the reviewers have been adequately answered. No further comments.

Level of interest: An article whose findings are important to those with closely related research interests
Quality of written English: Acceptable
Statistical review: No, the manuscript does not need to be seen by a statistician.