



Cervical cancer screening

(FEBRUARY 2005)

TO THE EDITOR: The review article on cervical cancer screening in the February issue of *CCJM* by Dr. Jin et al was nicely written, with one major exception. The authors suggest that HPV testing in addition to the conventional Pap or ThinPrep cytology testing is recommended by the American Cancer Society (ACS) and American College of Obstetricians and Gynecologists (ACOG). The day after I read the article I approached one of my partners and asked if she had been employing this strategy. She had not heard about this “recommendation,” which is surprising given that she spends most of her time providing care to women and keeps up to date on the current literature. When I visited the Web site for the ACS, it states that HPV testing is optional, which I think is quite different from what the authors implied. The same “optional” status holds true for the ACOG guidelines as well. Perhaps this will change in the future, but for the time being both groups appear to suggest that either Pap or ThinPrep without HPV testing is reasonable. I think your readers should be made aware of this.

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IN REPLY: Following the US Food and Drug Administration (FDA) approval of HPV testing for use as an adjunct to cytology for primary cervical cancer screening, the National Cancer Institute (NCI), American Society of Colposcopy and Cervical Pathology (ASCCP), and the American Cancer Society (ACS) cosponsored a workshop and reached consensus based on a literature review, expert opinion, and results from large screening studies.¹ The conclusions of the workshop were that HPV DNA testing may be added to cervical cytology for screening in women age 30 and older.

Our article focused mainly on the new recommendations from the ACS and the American College of Obstetricians and Gynecologists (ACOG) following the FDA approval of HPV DNA testing as an adjunct to cervical cytology screening in women age 30 years and older, and we assumed that readers were familiar with the traditional approach of Pap test alone. Indeed, screening with Pap test alone is still an acceptable option according to ACS and

ACOG guidelines. In our article, we intended to highlight Pap and HPV testing as a new screening strategy recommended by the ACS and ACOG. We did not state that it was the only strategy. We apologize if there was confusion, as we have no motivation to intentionally mislead our readers.

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Physical therapy for back pain

(JANUARY 2005)

EDITOR'S NOTE: *The regular section, Patient-Oriented Evidence that Matters, or POEMs, that appears in the Cleveland Clinic Journal of Medicine is produced, written, and edited by medical experts at an independent company called InfoPOEMs. Each month, members of InfoPOEMs write synopses of important new clinical research. The following letter to the editor is written in response to a POEM, “Physical therapy adds little to back pain treatment” that appeared in the January 2005 issue of the CCJM. The response was written by the InfoPOEMs representative who authored that POEM.*

TO THE EDITOR: The recent headline titled “Physical therapy adds little to back pain treatment” in the *Cleveland Clinic Journal of Medicine* quickly reviewed an abridged version of a study by Frost et al recently published in the *British Medical Journal*.¹ It offered a synopsis of the full article and was bold enough to conclude, “At 1 year, disability and quality of life were no different with physical therapy than without.” It adds, “Other research has also not shown a benefit of physical therapy for low back pain,” citing an article in *Spine*.² Upon critical review of the articles cited, it is absurd to make these blanket statements without commenting on the obvious flaws in study design, methodology, and data analysis.

The original study, titled “Randomised controlled trial of physiotherapy, compared with advice for low back pain” attempted to compare two groups of patients: a group receiving hands-on treatment and another receiving advice only. The researchers chose strict parameters for physical



therapy intervention. “The physiotherapists chose a treatment strategy based on their (physical examination) findings but agreed to treat according to a standardized protocol reflecting routine [National Health Service] practice.” The main interventions were general mobility exercises for the lumbar spine, joint mobilizations, and abdominal strengthening.

The problem is that not all back pain patients are the same and should not be treated the same. Assessment of evaluation findings and choice of treatment approach is an integral role of the physical therapist. This obvious flaw in methodology ignores a well-documented finding in relation to the variability in back pain presentation and the success of individualized physical therapy treatment as opposed to general, nonspecific exercise programs.² If this clinical decision-making is taken away, you essentially nullify the role of physical therapy.

There is some concern regarding the use of the Oswestry Disability Index. Although this index is known to be a valid measurement tool, it is designed to measure functional gains. Unfortunately, the study by Frost et al failed to include any functional training in its treatment protocol, ignoring the principle of specificity of training. Physical therapists play a large role in recovery of function, whereby training is functional in nature. Without functional training to address prophylactic management of low back pain, such as body mechanics and postural retraining, one would not expect to see measurable changes on the Oswestry index 12 months after treatment.

The study also deemphasizes the significant improvements reported at the 2-month and 6-month intervals, which is a better indicator of the direct effects of physical therapy. If patients are not instructed on the proper lifestyle changes to prevent recurrence, it is highly probable they will return to the same lifestyle that originally caused the problem. At the 1-year mark, what are you really testing: the effects of physical therapy or how well patients have adhered to the advice given to modify their lifestyle?

The physical therapy treatments were administered by a total of 76 different therapists of “varying levels of expertise,” which calls into question the reliability and consistency of the treatments administered.

Statistically, the power of a test is the likelihood that it will detect a difference when one exists. The researchers were trying to attain a 90% power, which required 224 patients to participate. Since only 70%

of the participants provided data for the main outcome at 12 months (200 patients), they did not meet their own criteria. Furthermore, “missing data [were] replaced using last value carried forward.”

It is disheartening and alarming to realize that an agency purported to provide “Patient-Oriented Evidence that Matters” can review a journal article so poorly. Unfortunately, in this day and age most people don’t read literature on their own but rely on others to do the thinking for them. The title “Physical therapy adds little to back pain treatment” is a gross misstatement of the reviewed article, does not take into account the inherent flaws of the study, and is very misleading to the general public and health care professionals. Clearly, more research is needed to classify back pain patients and study the effects of specific treatments for specific disorders.

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2. Fritz J, Delitto A, Erhard R. Comparison of classification-based physical therapy with therapy based on clinical practice guidelines for patients with acute low back pain. *Spine* 2003; 28:1363–1372.

IN REPLY: The study we summarized showed that, on average, patients did not benefit from physiotherapy. This type of therapy may indeed be effective for some patients, but we currently do not have the tools or techniques available to determine who these patients are. Until these techniques are developed, the bottom line, as summarized in our Patient-Oriented Evidence that Matters (POEM), is that we have better proof of effectiveness with other treatments for low back pain: advice to stay active, nonsteroidal anti-inflammatory drugs, cognitive behavioral therapy, and perhaps muscle relaxants.

Both patients and their doctors will welcome new evidence that shows that physical therapy is effective for a particular subset of patients with back pain. Until we have that information, we have to “go with what we know.”

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