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EDITORIAL

Chiropractic Management of Chronic Low-Back Pain: Commentary on Wilkey et al.

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A new study by Wilkey et al. in this issue (pp. 465–473), "A Comparison Between Chiropractic Management and Pain Clinic Management for Chronic Low-Back Pain in an NHS Outpatient Clinic: A Preliminary Study," in which chiropractic care for chronic low-back pain (CLBP) significantly outperformed medical pain clinic care in an outpatient setting within the National Health Service (United Kingdom), may provide the basis for a breakthrough in the way large health care systems handle CLBP cases.

It comes at a moment when chiropractors' ability to provide adequate courses of care for CLBP is under fire on several fronts, including managed care and worker's compensation boards in the United States. The core question is whether chiropractic is judged to be effective (and therefore reimbursable) for acute cases only or for chronic cases as well. A corollary issue is whether chiropractic is being required to meet a higher standard of evidence than medical treatments for the same condition.

The first wave (1975–2005) of research on chiropractic treatment of low-back pain dealt primarily with acute cases and focused on comparing spinal manipulation to a comparison treatment or placebo. A strong majority of these studies (there are now over 40 randomized controlled trials[1] of spinal manipulation for low-back pain) found that manual manipulation outperformed competing options; in no study did a comparison treatment or placebo outperform manipulation. Moreover, not a single participant in any of the trials experienced a major negative reaction to chiropractic care. The evidence supporting spinal manipulation for acute low-back pain is broad and deep, leading government consensus panels in the United States, Canada, Great Britain, Sweden, Denmark, Australia, and New Zealand to recommend spinal manipulation in their low-back pain guidelines, as did recent guidelines jointly developed by the American College of Physicians and the American Pain Society.[2]

Chronic low-back pain has generally been seen as a separate clinical entity, reflecting the very real challenges posed by chronicity across the spectrum of human illness and across the range of treatments delivered by the various professions. In essence, the longer someone has suffered from a problem, the steeper the climb toward recovery. Overall, guidelines and reviews that endorse spinal manipulation for acute low-back pain have been more hesitant in their conclusions about its efficacy for chronic cases. This has also been true of guidelines evaluating other interventions for low-back pain.

We are now entering a second wave of low-back research related to chiropractic. Two major questions at the forefront of researchers' attention are:

1. How does chiropractic management of chronic low-back pain fare in comparison to standard medical care?
2. Which patients, or categories of patients, are most likely to respond to particular approaches? In other words, what are the relevant subsets of the "nonspecific low-back pain" category that is the currently accepted diagnostic dumping station for 85%–90% of low-back pain cases?

Wilkey et al. take a significant step toward answering the first question in their excellent paper. Their study features a head-to-head comparison of chiropractic care (pragmatically defined to allow all procedures the participating chiropractors would normally employ) versus medical care in the hospital's pain clinic (defined in similar pragmatic terms).

The chiropractic and pain clinic groups started at baseline with similar levels of pain, although the chiropractic group was on average a decade older than the pain clinic group, and chiropractic subjects had endured their pain for a mean of 3 years longer (7.34 versus 4.04 years) than the

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pain clinic group did. Nevertheless, improvement in pain intensity at week 8 was 1.8 points greater (on a 0–10 scale) for the chiropractic group than for the pain clinic group: a dramatic difference. Disability scores (which measure the impact of pain on daily activities) measured with the Roland Morris Disability Questionnaire also demonstrated a far greater benefit from chiropractic care, with a greater than 5-fold difference in the degree of improvement. These data measured effects through the end of the 8-week treatment period.

Prior studies[3–5] have demonstrated long-term sustained improvement in chronic low-back pain but have been criticized on methodologic grounds, for reasons described by Wilkey et al. in their paper. A follow-up to the current study (with a larger cohort and at least 6-month follow-up) could prove of major value not only for chiropractic but for the broader field of chronic pain management.

Chiropractors currently confront an ingrained mindset on the part of many insurers and medical physicians who demand that courses of chiropractic care be limited in duration, recognizing little or no difference between acute and chronic cases. Doctors and insurers who would never consider limiting chronic pain patients to a 6-week course of prescription anti-inflammatory or analgesic medication in many cases do not hesitate to place such limits on chiropractic management of chronic back pain. Full discussion of these issues should be holistic in scope and is not possible in this short editorial.

Wilkey et al. have made a major contribution to these much-needed discussions. Chronic low-back pain is disabling to many people and extraordinarily expensive to the health care system as a whole, particularly when both direct and indirect costs (such as time lost from work) are considered. It is in the interest of patients, doctors, and insurers that a level playing field be adopted for the evaluation of treatments for this condition. If the data provided by Wilkey et al. can be replicated in a larger study, chiropractic management should move to the forefront of chronic low-back pain care.

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