

Letters

I wanted to congratulate Nicholas Zwar on his excellent article, 'Smoking cessation' (*AJGP* August 2020).¹ The article discusses groups with a high prevalence of smoking and mentions people with mental health problems. I wanted to add an additional group: people with substance use disorders. This group has an extremely high prevalence of tobacco smoking. Published articles give a prevalence of up to 98%,² while in some recent work we undertook in Sydney, NSW, we found rates to be 64.7% in a group of patients in the general practice setting and 91.7% in a group of patients in the public specialist alcohol and other drug (AoD) setting. Like people with enduring mental health issues, this group may be considered by practitioners to be uninterested in smoking cessation. My experience is that they would like to give up but find this difficult and need additional support over a longer period to cease smoking. The gains from this change are huge, and supporting patients who also experience significant drug and alcohol issues to cease smoking is a highly valuable task.

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Reply

Thank you for this letter. I agree that people with substance use disorders are an important group who have a high prevalence of tobacco use and who may be motivated to quit. There is a section on supporting cessation in people with substance use disorders in the second edition of The Royal Australian College of General Practitioners' publication *Supporting smoking cessation: A guide for health professionals*.¹ Key points in that section are that monitoring and support are needed and that smoking cessation efforts may assist long-term drug and alcohol abstinence.

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Non-radicular back pain

Among the many useful points made by Parr and Askin in their recent article on non-radicular back pain (*AJGP* November 2020),¹ there were several about which we felt sceptical.

First, the authors advocate imaging for patients with red flags, and 'age >40 years' is included as a red flag for malignancy. This is a concerning low threshold. A recent systematic review has called into question the predictive strength of many traditional red flags.² It found that even an age threshold of 50 years was not predictive of malignancy; the only significant red flag for this was a patient's history of cancer. Only in patients older than 64 years was age somewhat predictive of fracture, and not to an extent that routine imaging would seem mandated. With costs, exposure to ionising radiation, lack of evidence and low likelihood of benefit in mind, we believe that routinely ordering imaging for all patients over the age of 40 years with back pain would be an unwise choice.

Second, while the authors correctly list various risks of prescribing opioids for back pain, their preferential treatment of tapentadol is open to question. While there is some modestly promising evidence for tapentadol, the relevant Cochrane review cautions that most evidence derives from studies of only 12 weeks' duration, and notes that the single study with a one-year follow-up was unblinded and thus at high risk of bias.³ If there is evidence that tapentadol is safer or more effective than other opioids in the long term, we have yet to see it, and the authors have not cited it.

Finally, despite appropriately relegating lumbar spinal fusion surgery to last-line status, the authors rely on evidence from the late 1980s and early 1990s when quoting surgical success rates. Several more recent systematic reviews have found that there is no convincing evidence of effectiveness of such surgery

when compared with non-operative approaches, and that surgical complications are reasonably common.⁴ It is this contemporary level 1 evidence that has led to the recent Choosing Wisely campaign recommendation: ‘Do not refer axial lower lumbar back pain for spinal fusion surgery’.⁵

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Reply

Firstly, red flags for lower back pain are notoriously inaccurate.¹ Age guidelines to predict malignancy or fracture are no exception. We do not believe that all

patients above 40 years of age with back pain should receive advanced imaging. Instead, it should guide a differential diagnosis in conjunction with additional symptoms or signs. We believe the nature of pain to be very important. Constant, activity-independent or nocturnal pain should be considered significant.

Secondly, in low back pain not responding to first-line treatment, the use of tapentadol may be appropriate. While there is no perfect treatment, the evidence for tapentadol is promising.² Ideally this medication would be used for exacerbations of low back pain. Longer-term treatment should prompt referral to chronic pain services.

Finally, we agree there is a limited role for fusion in lower back pain. However, a blanket statement condemning surgery fails to recognise the nuance of spinal pathology. Lower back pain is **not** a diagnosis. Treatment should be patient focused. It would be rare for a patient with multilevel spondylosis to undergo surgery. However, severe unremitting pain secondary to a single-level pathology, such as a high-grade spondylolisthesis, may benefit from surgery. Möller and Hedlund conducted a randomised controlled trial examining patients with spondylolisthesis; fusion versus non-operative.³ The operative group had significantly greater improvement in pain and disability when compared with the non-operative group, with a good outcome in 74% versus 43% of patients, respectively. The article by Harris et al focuses on surgical fusion for the treatment of degenerative spinal conditions.⁴ As stated in the article, there is a paucity of high-quality evidence in spinal surgery, with most articles being low or critically low quality. While the article is ‘contemporary’, it also relies on reviews of pre-2000 research. Harris et al conclude by suggesting spinal fusion for back pain should ideally be performed in the context of a trial, **not** that surgery is contraindicated in all cases. With the implementation of the Australian Spine Registry, we would hope these patients can be closely monitored to determine surgical outcomes from modern surgical techniques.

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