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Dear Dr. Berliner:

The recent publication of the Agency for Healthcare Research and Quality’s (AHRQ) Technology Assessment Pain Management Injection Therapies for Low Back Pain has raised significant concerns for physicians who utilize injection procedures to treat patients suffering with pain and functional limitations resulting from spinal pathology. Representatives of 14 medical specialty societies representing both physicians who perform these procedures and those whose practices rely on them in determining appropriateness of more invasive surgical treatments have convened to discuss concerns and formulate an appropriate response. The medical specialty societies who participated in this review and critique share a common goal with the AHRQ: commitment to identifying pain management therapies that provide value to the patient and society through measurable improvements in pain and physical functioning with no or minimal adverse events.

We are fully cognizant of the issues of overutilization and inappropriate utilization, and therefore also wish to bring into focus which interventions are effective when treating the various causes of low back pain. We have concerns, however, that the methodology employed by the report’s authors cannot and does not make such determinations, and that the conclusions may lead to egregious denial of access to these procedures for many patients suffering from low back pain. We trust that due consideration will be given to the most critical comments made during the peer review/public comment period and that several aspects of the report will be revisited to ensure that the best available evidence is addressed scientifically in order to provide an accurate assessment of the procedures reviewed.

Our primary concerns fall into five main categories, and are best illustrated by the flawed epidural steroid analysis:

- Assertions Regarding the Nonspecific Nature of Axial and Radicular Pain
- Evidence Base Restriction to Randomized Controlled Trials (RCTs)
- Inadequate Analysis of Patient Selection
- Inadequate Analysis of Technical Procedural Performance
  - Subgroup Analysis by Image Guidance
  - Subgroup Analysis by Epidural Access
  - Failure to properly assess quality of trials by emphasis solely on research methodology
- Inadequate Data Analysis: Emphasis on Continuous, not Categorical Data
Nonspecific Nature of Axial and Radicular Pain

The authors begin with the assertion that injection therapies for “low back pain” are directed toward a nonspecific and un-diagnosable process. They used this fundamentally false assumption to justify their inclusion of trials with patient selection based on symptoms, not a specific diagnosis. The authors state in the draft report: “In the majority (>85%) of patients with low back pain, symptoms cannot be attributed to a specific disease or spinal pathology.” They cite their review paper from 2002 that contains no primary data. The original source of this statement was a synopsis of a workshop on idiopathic low back pain from 1982. (1) That article was not an original research study, contained no original data or further references, and appears to have been a piece of expert opinion at best. In that article from 1982, the authors noted that previous estimates of low back pain without definite etiology range widely from about 20% to 85%. Thus, in an effort to justify their approach to include trials that selected patients by symptoms rather than specific diagnoses, the authors of the AHRQ report misquoted a 30-year-old opinion piece. They relied on a manuscript that predates both modern MRI scanning and the current use of image-guided diagnostic injections, both of which have been repeatedly shown to be valuable in the diagnosis of spine pathology.

In the final, published report, the 85% figure remains, but the citation has been changed to a paper that addresses the lack of specificity of spine imaging, a well-known observation that is not relevant here. When challenged during peer review/public comment, the authors’ response indicated that the non-attributable nature of low back pain is acknowledged in the guidelines of the American College of Physicians, and no evidence is necessary, as there can be no evidence due to the lack of a pathoanatomic reference standard. The authors are correct that a pathoanatomic criterion standard is lacking for all studies ever conducted with pain as a primary variable. That nihilism, however, is not part of clinical practice. Systematic application of controlled anesthetic blocks or provocation procedures can achieve somewhat less sensitive, but far more specific diagnosis than simply relying on symptoms. Radiculopathy has specific observable physical examination and electrophysiologic findings. Radicular pain without radiculopathy can be diagnosed by a combination of physical exam (e.g. straight leg raising test) and controlled selective nerve blocks. Somatic axial pain experienced in the lumbar region can be specifically attributed to the facet joints (dual comparative medial branch blocks), the intervertebral disc (disc stimulation), paraspinal muscles and fascia (trigger point injections), or the sacroiliac joint (controlled intra-articular blocks and multi-site, multi-depth lateral branch blocks). Numerous studies over the past 20 years have established prevalence rates for these specific pain generators and their relationship to age and gender. (2-8) We feel it is inappropriate to ignore this body of evidence and accept trials whose inclusion criteria are mere symptoms. The authors of the technology assessment should not be allowed to use, as a foundation of their methodology, 85% as the level of non-attributable symptoms in low back pain, as this is based on either pure assertion or 30-year-old “expert” opinion.

Evidence Base Restriction to Randomized Controlled Trials (RCTs)

The efficacy of injection therapies for radicular pain has been the subject of a great deal of research effort that is totally ignored in this assessment. The inclusion criteria of the report select for research methodology: randomized controlled trials (RCTs) of injection therapies versus placebo, randomized comparative effectiveness trials, and large observational trials only with respect to harms. The exclusion of high quality observational studies of clinical effectiveness removes important information and context from a synthesis of the literature. The authors state
that there are ample RCTs for analysis, and examination of observational trials is unnecessary. However, many of the RCTs included patients selected only by symptoms or fail to utilize image guidance. These failings, further discussed below, make such trials irrelevant to current clinical practice and not unexpectedly show poor outcomes. Judging current practice of precise needle placement to a 1 - 2mm target zone in three dimensional space with confirmation of medication distribution by real-time observation of contrast flow by using data from blind injections into an unknown tissue compartment has no validity. There are very few RCTs that utilize current practice standards -- only the Ghahreman study is truly representative. (9) Hence examination of large observational studies adds important information that is relevant to current standards of practice.

**Inadequate Analysis of Patient Selection: Subgroup Analysis by Specific Diagnosis**

Many of the studies in the analysis fail to adequately specify the process under treatment. There is no physiologic process beyond systemic effect by which steroids delivered to the epidural space would be expected to affect axial back pain arising from nociception in the intervertebral disc, facet joints, sacroiliac joint, or supporting musculature. There is ample experimental and clinical evidence that radicular pain has an inflammatory basis and is potentially susceptible to targeted delivery of an anti-inflammatory agent to the interface of neural tissue and the compressive lesion. (10) Many of the included studies have treated an undefined mix of axial and radicular pain patients; heterogeneity of response is therefore expected, not surprising. The specificity of the diagnosis in the study populations was not included in the assessment of study quality.

An RCT without careful patient selection is of no clinical value and may be misleading, yet its RCT methodology tends to purchase it credence. Examining the 29 studies of “epidural steroid injection” versus placebo, radicular pain alone was specified in 22, a mixture of radicular and back pain in six, and back pain alone in one. A correlative imaging finding was required for inclusion in only 11 of 29 studies. The nature of the conditions being treated in this heterogeneous group of studies is thus largely unknown, and the degree of neural compression is completely unknown. Two independent studies have provided correlative data demonstrating the degree of neural compression is a predictor of successful clinical response to transforaminal epidural steroid injections (TFESI). (11,12) With minimal neural compression, the proportion of responders may be as high as 75%; with high grade compression, the response rate may be as low as 25%. The lack of diagnostic specificity in patient selection is unfortunately emphasized by the lack of clarity in the title of this technology assessment. Here “low back pain” is deemed inclusive of axial pain, radicular pain without radiculopathy, and true radiculopathy with a neurologic deficit. The definitions used by the authors are at variance with accepted medical terminology within neurology and pain management standards of care. (13)

For perspective, consider a hypothetical systematic review of prescription medication for the treatment of cough, a common symptom like low back pain. Studies may show beneficial effects from antibiotics in a group of patients with bacterial pneumonia, a specific diagnosis, whereas pooled data from heterogeneous groups of patients with cough – including viral bronchitis, chemical pneumonitis, asthma, lung cancer, etc. – would produce different effects. If these pooled effects showed that many different medications had minimal impact on cough from various sources, would we abandon prescription antibiotics for pneumonia?
Additionally, the identification of the underlying etiologies of pain is essential as different pathologies not only have varying responses to treatment, but also have different natural histories, impacting prognosis. Thus, the time frame of follow-up to determine clinical utility becomes imperative. Some conditions, such as intervertebral disc herniation, can result in debilitating pain, but have an overall favorable natural history. This would be in contrast to neurogenic claudication due to central canal stenosis, which is less likely to resolve spontaneously with time. Thus short-term relief, as noted by the authors of the AHRQ report, would be very appropriate and expected for a disc herniation. To evaluate the long-term effects in this population would be as flawed as evaluating the long-term effectiveness of antibiotics for pneumonia. Again, should we withhold all antibiotics for pneumonia given the largely favorable natural history, or should we state antibiotics are ineffective because all subjects were better at 1 year follow-up? Similarly, should we withhold pain medications from patients with fractures or after orthopedic surgery, as these conditions only result in pain and have favorable natural histories?

**Inadequate Analysis of Technical Procedural Performance: Image Guidance and Contrast Confirmation of Epidural Spread**

The techniques utilized in the administration of epidural steroids are also critical. No randomized studies examined the use of image guidance as a variable. This has, however, been well examined in non-randomized studies demonstrating that up to 74% of “epidural” steroid injections performed without image guidance either deposit medication external to the epidural space or do not reach the targeted pathology within the ventral epidural space. (14-17). Examining the 29 studies used to assess efficacy of epidural steroid injections versus a placebo, there were 15 interlaminar or presumed interlaminar epidural steroid injection (ILES) studies, of which only one used fluoroscopic guidance. There were nine caudal injection studies, of which only a single study reported fluoroscopic guidance. Five transforaminal epidural steroid injection (TFESI) studies all utilized fluoroscopic guidance. Hence, with the exception of the five TFESI trials, the studies of “epidural steroid injections” deposited an anti-inflammatory agent into an unknown tissue space from which the agent was unlikely to reach the site of inflammation. Although there were no randomized studies with image guidance as a primary variable, it is reasonable to compare explanatory trial data. Data from explanatory trials of non-image guided injections yields a number needed to treat (NNT) greater than 90. (18-22) In contrast, a high quality explanatory trial of image-guided TFESI yields a NNT of 3. (9)

It is the position of the Multisociety Pain Workgroup that image guidance is absolutely essential for the safe and efficacious performance of epidural procedures, based on a large body of non-RCT evidence. It is, in fact, impossible to affirm the successful performance of a TFESI without image guidance. The AHRQ report’s sole reliance on RCTs and failure to acknowledge the context provided by the past 20-30 years of well-performed observational studies places AHRQ in the absurd position of denying the relevance of image guidance, which is the basis for a large body of medical practice. It also places AHRQ in conflict with the Food and Drug Administration’s Safe Use Initiative, which recommends image guidance for epidural steroid injections of all types. (23)

**Inadequate Analysis of Technical Procedural Performance: Subgroup Analysis by Epidural Access**

While image guidance is essential, the technique of delivery is equally important. Most of the ILESI and caudal injection studies cited in the technology assessment suffer from the lack of image
Continuous population health implications for patients previously requiring opioids ceased opioids. These significant outcomes restored to normal or near normal function and reduced their need for other health care. All patients previously requiring opioids ceased opioids. These significant outcomes with direct population health implications were concealed in the AHRQ’s assessment by inclusion only of continuous data (group means).
Another controlled trial used surgical sparing as the primary outcome. Only 29% of patients required surgery after treatment with transforaminal steroids injections compared with 67% treated with transforaminal local anesthetic. (28) The effects were durable in a 5-year follow-up study of these patients. (29) A recent supportive observational trial studied patients awaiting surgery for radicular pain; 56% (95% CI: 46-66%) avoided surgery after a successful TFESI. (30) A randomized, controlled comparative effectiveness trial of TFESI with two steroid formulations showed that 70% of patients with radicular pain due to disc herniation had greater than or equal to 50% pain relief that was durable at 6 months. (31) Clinical effectiveness of epidural injections was further supported by a large observational study of prospectively collected data on more than 2000 consecutive patients receiving a single TFESI for radicular pain due to disc herniation, fixed lateral recess, or foraminal stenosis. (32) In this study 46% were responders for pain relief (95% CI: 43-49%) and 41% (95% CI: 38-44%) for functional recovery. When patients were segregated by duration of pain syndrome, those with sub-acute pain (< 3 months duration) had 62% (95% CI: 56-68%) responders for pain relief and 59% (95% CI: 53-65%) responders for functional recovery, significantly better than patients with chronic pain. This important, clinically relevant information cannot be derived from the small RCTs included in the AHRQ assessment. The important clinical question of the effectiveness of repeat epidural steroid injections is not addressed by any study with methodology that would qualify for inclusion in the assessment. However, a recent observational study of prospectively acquired data on over 2000 TFESI in 933 patients demonstrated that repeat TFESI are less effective than an index TFESI, although not by a clinically relevant amount. More responsive sub-acute pain patients recovered all prior benefit in pain relief from an index injection that had since waned; early repeat injections for incomplete responders provided cumulative benefit. (33) A systematic review synthesized all the evidence from six explanatory trials, 11 pragmatic trials, and 20 observational studies of lumbar TFESI and concluded that up to 70% of patients with radicular pain due to disc herniations achieve 50% pain relief at 1-2 months after treatment and 30% achieve complete relief. Between 25% and 40% of patients have relief that lasts 12 months. (34)

Inadequate Data Analysis: Emphasis on Continuous, Not Categorical Data
In addition to image guidance and injection technique, another neglected study characteristic is the method of reporting outcomes data. Many studies included in this analysis report only continuous data as a comparison between group means in reference to a minimum clinically important difference. However, pain and functional disability data are not normally distributed. Rather, responses are often bimodal, with segregation into responder and non-responder populations that will be concealed by evaluating group means. Categorical outcomes that define the proportion of patients reaching a predefined responder status are critical to meaningful interpretation. (35) The authors recognized this and included categorical outcomes when available, but such data often cannot be extracted from the manuscripts, leaving less useful continuous data. In the five trials comparing TFESI and ILESI, only continuous data were analyzed.

Summary
It is imperative to recognize that study methodology is meaningless unless the procedures being assessed are performed on appropriately selected patients with appropriate indications using accurate and current technique. An RCT with sound randomization, excellent blinding, and no losses to follow-up is of no value if the patients did not have the condition under investigation and/or the therapeutic procedure was not conducted accurately. Stratification of studies by acceptable, technical performance of the procedures is critically important and must be
considered in parallel with, or even precede, evaluation of study design in assigning value to a study. The Ghahreman trial applied such technical rigor in procedural performance, as the procedures were performed in accordance with the very specific Practice Guidelines for Spinal Diagnostic and Treatment Procedures of the International Spine Intervention Society. (9) This study alone, of all the RCTs addressing epidural steroid injections, reasonably reflects current clinical practice. It is supported by a large body of prospectively acquired data in outcomes studies ignored by this report that also utilized well selected patients and careful control procedures.

Thank you for considering our comments, which are offered in the spirit of collaboration to ensure an accurate assessment of the injection procedures that can be effective tools in the treatment of appropriately selected patients.

Sincerely,

American Association of Neurological Surgeons
American Academy of Pain Medicine
American Academy of Physical Medicine and Rehabilitation
American College of Radiology
American Pain Society
American Society of Anesthesiologists
American Society of Neuroradiology

American Society of Regional Anesthesia and Pain Medicine
American Society of Spine Radiology
Congress of Neurological Surgeons
International Spine Intervention Society
North American Neuromodulation Society
North American Spine Society
Society of Interventional Radiology
References:


