I wish to make a couple of comments about matters raised on the last meeting of the XPG on Chronic Pain as I was unable to attend.

I am concerned that the hard work of members of the Group especially in the areas of implementation of the GRIPS Report and the development of a SIGN guideline for non-medicinal treatments of pain might suffer the same fate as the 5 previous reports on the subject - meaning that, after a lot of work is put in, people suffering from pain might not notice much difference in the amount of pain and length of time they suffer. I think that the yardstick we need to use to measure our success, is the increase in number of patients who directly benefit from the actions of our Group e.g. patients who have less pain, who become more functional in their lives, who have equal access to the most effective treatments for their particular pain condition regardless of how affluent they are or which area they live in the country and so on. I haven't seen any numbers measuring any of those possible markers since we were established in 2002.

Assuming that SIGN will include the use of 'sequential therapies' in the guideline for non-medicinal intervention (as implied by Shona Robison in a reply to Andy Kerr's letter on my behalf) and assuming that SIGN reach the conclusions that sequential therapies should be used for the treatment of some types of pain (as NICE did in 2009, QIS in 2008 and the Chronic Pain Briefing in 2002), pain sufferers would still be unable to access those therapies through the NHS when/if those treatments are deemed suitable for the following reasons.

In 2010 the Department of Health in England instigated the creation of the Complementary and Natural Health Council (a national organisation) funding it until it became self-sufficient. This gives GPs and other medical practitioners the confidence to be able to refer patients to CAM when they think this may be beneficial (the Dept of Health wrote to GPs encouraging them to refer patients to CNHC-registered therapists). As the Scottish Government currently does not support the CNHC and have stated that they have no intention of creating a Scottish equivalent, Scottish GPs will not be able to refer patients to drug-free (as they will not know who to refer to and where). There are organisations in Scotland that could take up a role similar to that of the CHNC but it seems that the current government considers it unnecessary.

Another issue preventing the access of pain patients to drug-free therapies is the fact that, even when guidelines recommending drug-free interventions are published and appropriate referral pathways are in place, GPs may be resistant to adhering to those guidelines as it is currently happening in England (as reported by the College of Medicine in May of this year).

Practical issues like these need to be addressed in parallel to the world-class work already being done.

Regarding Mary Scanlon's concerns about possible negative effects of chiropractics, regrettable as they are, I think that we need to keep them in the context of overall adverse effects of current pharmaceutical pain management interventions.

Some pain killers and anti-inflammatories have been shown to cause extreme adverse effects which can include even death (there are around 65,000 gastrointestinal haemorrhage emergencies a year in the UK[1] as adverse effects from NSAIDs (Ibuprofen, aspirin, etc); Vioxx killed at least 60,000 people before it was withdrawn; in September 2011 it was discovered that Diclofenac and other common pain killers/anti-inflammatories increase the risk of stroke and serious heart problems by 40% (just 5% below the risk associated with Vioxx); the FDA have just ordered lower doses of Acetaminophen in prescription painkillers (used for headaches, aching muscles and sore throats) as it has been the leading cause of liver failure in the USA being estimated to be directly responsible for some 120 deaths a year; and opioids lead to the problem of prescribed drug addictions. Although medication is necessary and often essential,

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1 NSAIDs and adverse effects: Bandolier http://www.medicine.ox.ac.uk/bandolier/booth/painpag/nsae/nsae.html

all pain management interventions need to be weighed in the context of harm-benefit balance.

We also need to define what it is meant by 'manipulation' as there are many types of 'manipulation' therapies. In the case of the discussion at the last meeting, it seems to mean 'chiropractics'. There are different types/schools of chiropractic techniques, some are so gentle that the patient can hardly feel what is being done (such as McTimoney, Palmer, Craneo-sacral, etc) and individual practices can vary within the same disciplines e.g. some chiropractors and osteopaths provide soft tissue work such as massage before they begin manipulation.

Normally what *can* cause harm is the use of what are called 'high velocity thrusts'. Also chiropractics does not necessarily equate with spinal manipulation as it is some times believed. I understand that chiropractors use a range of treatments including postural advice, reassurance and exercise. Again, I am not defending chiropractics but merely pointing out common misunderstandings which can get in the way of clearer assessments of pain management tools.

Incidentally, the lack of differentiation between therapies and their modalities is one of important issues underlying the paucity of conclusive evidence for so-called 'alternative therapies'. We also need to take into consideration the fact that lack of evidence does not constitute lack of effectiveness – but that's another issue.

Best regards

Paulo