

## COVID-19 and Its Implications for People with Chronic Back Pain: Diverging Opinions

To say that the world of back care is in a state of transition would be a huge understatement. A 90-year-old quote from an Italian political philosopher pretty much sums up the current state of affairs.

“The crisis consists precisely in the fact that the old is dying and the new cannot be born; in this interregnum a great variety of morbid symptoms appear,” according to Antonio Gramsci (See Gramsci, 1929.)

As a recent article in the *BackLetter* pointed out, the world is in the midst of the greatest disruption in pain care since the last world war. How long this pandemic-related disruption will last—or how it will impact people with chronic back and other forms of persistent pain—is anyone’s guess.

In other words, it is not clear how long it will take for the old system to die and a new pain-care system to emerge. Or what the new system will look like.

The *BackLetter* article suggested that this disruption could have a disastrous impact on particularly vulnerable groups: those with addiction and dependency issues, individuals with high-impact chronic pain, and people with specific spinal diseases and neurological problems. It also suggested that the major life disruptions—widespread unemployment, poverty, and social disadvantage—created by the COVID-19 pandemic can be expected to create and exacerbate pain problems.

But it also pointed out that a brief interruption in care might not have a negative effect on many patients with acute or persistent back problems. It may actually reduce overdiagnosis and overtreatment, especially in dysfunctional pain care systems such as those in the United States—where back care is notably ineffective and exorbitantly expensive.

### Chronic Back Pain a Varied Condition

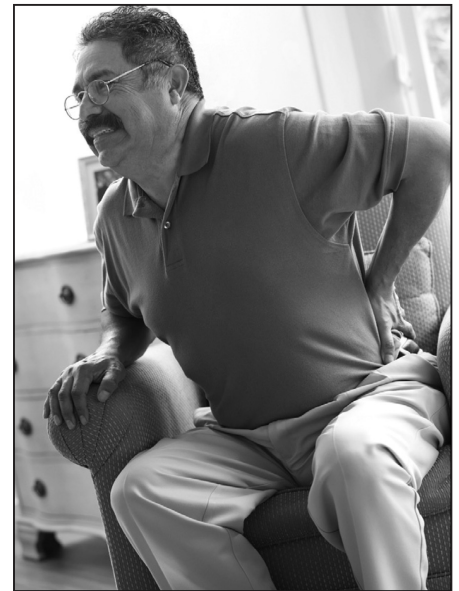
The *BackLetter* article did not identify all people with chronic pain as a vulnerable

group because the term “chronic back pain” embraces individuals with a wide range of pain and disability problems—from minor to severe. From pain that interferes minimally with life to pain that affects every aspect of human existence. Recent research suggests that chronic pain falls into a wide range of trajectories.

### Important Not to Conflate Different Forms of Chronic Pain

It is important to *avoid* viewing chronic back pain as a uniformly serious condition requiring continuous care. Research over the past quarter century suggests that chronic pain is a highly varied condition—in the general population, in primary care, and in specialty care.

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## Back Pain’s Huge Burden

At a time when the world is obsessed with corona virus disease 2019 (COVID-19), it is important not to forget other important health conditions.

A recent report from a collaborative team of Chinese and Australian researchers is a reminder of the huge burden of low back pain (LBP) worldwide.

Aimin Wu, MD, of Zhejiang Spine Surgery Centre in Wenzhou, China, and colleagues studied the impact of LBP from 1990 to 2017, employing data from the Global Burden of Disease studies. (See Wu et al., 2020.)

By way of background, they offered some undisputed characterizations. Low back pain is one of the most common musculoskeletal problems globally. “It is the leading cause of activity limitation and absenteeism from work, and results in a

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# Does Inactivity Lead to Disc Degeneration Over the Long Term?

A new study supports the idea the human spine needs motion and physical activity to stay healthy—and to withstand the slings and arrows of everyday life.

Elke Maurer, MD, and colleagues of Eberhard Karls University in Tuebingen, Germany, investigated the relationship between short- and long-term physical inactivity and degenerative changes of the thoracic and lumbar spine in a southern German cohort from the general population over a 14-year period. The study subjects were all participants in the prospective, population-based KORA study conducted in the region of Augsburg, Germany. (See Maurer et al., 2020.)

A total of 385 individuals (mean age 56 years at baseline) took part in the study. All participants completed a physical activity questionnaire at baseline in 1999-2001, another in 2006-2008, and a third in 2013-2014.

At the time of the third questionnaire, the subjects also underwent a full-body magnetic resonance scan performed on a 3-Tesla MRI scanner.

The researchers quantified thoracic and lumbar disc degeneration using the widely employed Pfirrmann score. They characterized physical activity as follows: (1) no physical activity; (2) irregular physical activity for one hour per week; (3) regular physical activity for one hour per week; and (4) regular physical activity for two hours or more per week.

For the purposes of this particular study, the researchers collapsed those categories into just two groups: (1) physical activity for one hour or less per week; or (2) regular physical activity for more than one hour per week.

They gathered information on specific types of exercise (e.g. walking and cycling), smoking, physical labor, obesity, blood pressure, and fasting glucose levels. They

also assessed the prevalence of acute back pain and grouped the study subjects into five exercise categories: none, little, moderate, strong, and very strong.

They found a strong correlation between physical activity and disc degeneration of both the thoracic and lumbar spine over the 14-year study span. Low levels of activity were associated with higher levels of disc degeneration.

“Disc degeneration was more apparent in those with irregular activity <1 hour compared to those with regular activity of  $\geq 1$  hour and more per week ( $p < 0.01$ ) and in those with no activity compared to those with regular activity of  $\geq 2$  ( $p < 0.001$ ) measured using exam 3. Less physical activity over a time period of 14 years correlated with an increase of disc degeneration of the thoracic and lumbar spine after adjustment for age, sex, BMI, hypertension and diabetes mellitus ( $p < 0.05$ ).

“There was no statistically significant association between physical labor, walking activity, or cycling activity with disc degeneration. Additionally, no significant correlations between degree of disc degeneration ( $p = 0.990$ ), degree of physical inactivity ( $p = 0.158$ ), and back pain were observed.”

This type of study, however, cannot prove a cause-and-effect relationship.

Disclosures: None declared.

## Reference:

Maurer E et al., Long-term effect of physical inactivity on thoracic and lumbar disc degeneration—a MRI based analysis of 385 individuals from the general population [published online ahead of print April 30, 2020], *The Spine Journal*; doi:10.1016/j.spinee.2020.04.016.

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# Could COVID-19 Offer Lessons on Back Care in the Future?

The tragedy of the COVID-19 pandemic may offer some unexpected lessons for the field of spine care. Even terrible events can lead to positive developments. Or as the old saying goes, “It is an ill wind that blows no good.”

Italian researchers Fabio Cofano, MD, and colleagues recently pointed out that the COVID-19 pandemic in Italy may offer insights on emergency care for low back pain. (See Cofano et al., 2020.)

In Italy, the United States, and elsewhere, emergency care for low back pain is common. And much of the back care dispensed in emergency departments is probably excessive and unnecessary.

Neurosurgeon Cofano and colleagues noted that some patients seeking emergency care for back problems do not have emergency conditions. They are consulting emergency services for convenience sake.

“Since emergency medicine can ensure a completely free-of-charge and prompt care, many patients with nonurgent pain syndromes improperly access EDs to skip waiting lists for the ordinary—and often congested—assistance for instrumental diagnostic services, outpatient consultations, and hospitalizations for surgical procedures,” according to these Italian physicians.

They reported on patterns of emergency consultations at a major Italian hospital in the city of Turin (Torino) during the COVID-19 crisis in Northern Italy.

Because of the crush of patients seeking healthcare—and fear about being inadvertently exposed to the coronavirus—the total number of visits for degenerative spine disease dropped dramatically.

In the three weeks before the COVID-19 lockdown in Northern Italy, this hospital documented 182 emergency visits for spine/back pain disorders. In the three weeks following the lockdown, only 32 individuals sought emergency care.

They noted that the 32 post-lockdown patients appeared to have serious back pain—in terms of traumatic injuries and cases requiring sophisticated diagnostic testing. This suggested to them that these patients were much more likely to “require” urgent care during the post-lockdown period than those seeking care before the lockdown.



They acknowledged that this evidence is anecdotal and fundamentally inconclusive. There is certainly the possibility that many patients stayed away out of fear of the virus. In the United States, for example, there has been a substantial reduction in emergency visits even for people with dire health conditions, such as heart attack and stroke.

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**Italian researchers believe the tragic COVID-19 crisis in Italy may offer some lessons for policy makers going forward. Many, perhaps most, patients seeking emergency care for low back pain could probably be best managed in outpatient rather than emergency settings. Policy makers may want to reconsider free and easy access to emergency departments.**

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And they suggested that there may be physical reasons for lower consultation

rates post-lockdown: a reduction in physical performance demands and a lessening in physical work tasks.

However, they believe that the pandemic also offers a lesson for policy makers going forward. Many, perhaps most, patients seeking emergency care for back pain could probably be best managed in outpatient rather than emergency settings. And that policy makers and healthcare administrators may want to reconsider easy and free access to emergency care. In other words, it may be possible to filter out some patients with routine back pain and direct them toward a different management strategy.

A *BackLetter* editor asked Cofano if he had any recommendations for reorganizing emergency spine care in Italy or other countries.

“It is our opinion that inappropriate emergency care for back problems represents a difficult issue that could be managed only with comprehensive strategies,” he responded. “To summarize, in increasing order of relevance:

- “Institution of discouraging financial policies or fees for improper access.” These “should be conceived according to the principles and concepts of different National Health Systems.
- “Education of the general public about the importance of emergency departments, emphasizing the necessity to reduce inappropriate access to maximize the quality of urgent services.

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# Nitrates Ineffective in Building Bone Among Women With Osteopenia: Fracture Prevention Remains Elusive

Postmenopausal women with diminished bone density often worry about the eventual development of osteoporotic fractures. And many are interested in treatments that might build bone or prevent further bone loss. And for good reason. Eighty percent of fractures occur among women who do not satisfy the criteria for osteoporosis.

Unfortunately, there are few proven strategies among postmenopausal women with moderate bone loss (i.e. osteopenia).

## Few Promising Treatments

There is no conclusive evidence that exercise or diet has a major preventive effect. Calcium and vitamin D are no longer recommended in guidelines—because of the poor risk/benefit profile for calcium and lack of efficacy for vitamin D.

Most osteoporosis medications are aimed at women and men at high risk of fracture. But there is little compelling evidence that bisphosphonates or hormone therapies provide any benefit for women with osteopenia.

Infusions of zoledronic acid have shown some promise in the treatment of osteopenia. However, many women have been scared away by potential adverse events—especially rare but serious side effects such as osteonecrosis of the jawbone and atypical femoral fractures.

So there are no evidence-based treatments for osteopenia that have a totally acceptable risk/benefit profile.

## Nitrates Widely Used in Cardiovascular Medicine

Researchers and healthcare providers had hoped that treatment with nitrates (such as nitroglycerine or isosorbide mononitrate) might fill this gap. The use of nitrates to increase bone mineral density (BMD) and prevent fractures would be an attractive strategy because they are inexpensive, readily available, and have a favorable safety profile in the treatment of cardiovascular disease.

And there were glowing early reports from clinical trials on nitrates for osteopenia. However, some of those early trials on nitrates for osteopenia were retracted because of research misconduct. However,

researchers are still investigating their potential benefits.

A new randomized controlled trial by Mark Bolland, MBChB, PhD, from the University of Auckland in New Zealand and colleagues tested three nitrate preparations and two different dosages. Unfortunately, the results dashed the hope that these drugs might be effective.

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**“Based on previous clinical trials, we had high hopes that treatment with nitrates might be a safe and highly effective treatment for preventing age-related bone loss and fractures. We assessed several different doses and forms of nitrates and our results show clearly that no preparation or dose had any effect on bone density or bone turnover.”**

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“Based on previous clinical trials, we had high hopes that treatment with nitrates might be a safe and highly effective treatment for preventing age-related bone loss and fractures. We assessed several different doses and forms of nitrates and our results show clearly that no preparation or dose had any effect on bone density or bone turnover, but they did cause significant side-effects for women,” said lead author Bolland in a statement accompanying the study. (See Bolland et al., 2020.)

Many of the women did not tolerate these medications well. A full 27% of potential study subjects dropped out during the run-in phase because of adverse effects such as headaches.

And 21% of women who participated in the trial dropped out over the yearlong study period, compared with just 2% of subjects randomized to placebo.

“Sadly, this research area has recently had several studies with strongly positive



results retracted because of scientific misconduct. We think our paper provides closure, with fairly definitive evidence that nitrates do not affect surrogate measures of bone health and thus there is no reason to think they would prevent fractures,” Bolland added.

## A Double-Blind Study of 240 Women

These researchers studied a total of 240 eligible women who tolerated low-dose oral nitrate treatment in a two-week run-in period. They were subsequently randomized to five different treatment groups or placebo.

“Over 12 months, there were no statistically significant between-group differences in changes in BMD at any site and no consistent differences in bone turnover markers,” according to Bolland et al. “When the active treatment groups were pooled, there were also no differences in changes in BMD or bone turnover markers between nitrate treatment and placebo.”

Disclosures: None declared.

## Reference:

Bolland MJ et al., Nitrates do not affect bone density or bone turnover in postmenopausal women: a randomized controlled trial [published online ahead of print May 5, 2020], *Journal of Bone and Mineral Research*; doi:10.1002/jbmr.3982.

# Reining in False Certainty About the Evidence on Back Pain

**H**ealthcare providers often display “certainty” in their communications to patients about their health problems. Unfortunately, in back care—as in many areas of medicine—much of the certainty is unwarranted and premature.

Failure to recognize the uncertainty often dooms patients and the general public to inferior health outcomes. And it often reduces motivation to conduct further research, according to a recent article in the *New England Journal of Medicine* by Gregory E. Simon, MD, and colleagues. (See Simon et al., 2020.)

According to some researchers, much of medical treatment is inappropriate and does not find conclusive support in the scientific evidence. One can observe this pattern across the spine field, where many popular treatments have only marginal impact or worse. Yet they are prescribed frequently and enthusiastically—for weeks, months, and even years.

The utilization and costs of these treatment have grown dramatically without having any discernible positive impact on pain and disability at a population-wide level. As a recent study in *JAMA* documented, the costs of treating back and neck pain in the United States grew from \$37 billion in 1996 to \$135 billion in 2016. Much of this treatment is unnecessary and wasteful. (See Dieleman et al., 2020.)

Back care, of course, is not the only area of medicine where common treatments are often inappropriate and/or excessive.

“Twenty to 50 per cent of all healthcare services delivered in the United States is inappropriate, wasting resources and/or harming patients. Much of this waste is due to overuse of medical interventions, resulting in an unknown amount of preventable harms. Underuse of effective and safe interventions further compounds the system’s failure to meet patients’ needs. While there are many causes for inappropriate care and waste, much of it may be attributed to the poor quality of information that clinicians and patients rely on to make decisions about the services they deliver or receive,” according to John Ioannidis, MD, and colleagues in a 2017 commentary. (See Ioannidis et al., 2017.)

And they noted that much of the evidence healthcare providers rely on—including major randomized controlled trials, system-

atic reviews, clinical guidelines, and articles in the mass media—is heavily flawed.

This pattern has been on display in the spine field for decades. The evidence supporting the use of long-term opioid therapy for chronic back and other forms of pain is a perfect example. A major intervention for chronic pain was based on tragically flawed evidence and led directly and indirectly to hundreds of thousands of unnecessary deaths.

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**A recent article in the *New England Journal of Medicine* by Gregory E. Simon, MD, and colleagues pointed out that it is a vital duty of healthcare providers to question and publicize false certainty about medical decisions. Otherwise there will be no motivation or incentive to produce better quality research—and a better foundation for clinical practice. As the old adage states, “The squeaky wheel gets the grease.”**

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The medical establishment in the United States was slow to recognize the dangers of opioids in the treatment of chronic pain. And it took nearly twenty years—and a huge human toll—to begin to rein in excessive opioid use for chronic back pain. Even now, opioids are still being prescribed excessively despite multiple guidelines documenting their poor risk/benefit profile.

There is a tendency in medicine to simply adopt the results of highly publicized clinical trials, systematic reviews, and clinical guideline recommendations from august professional societies and government organizations as if they automatically represent some kind of truth.

The article by Simon et al. pointed out that it is a vital duty of healthcare providers to question and publicize false certainty about medical decisions. Otherwise there will be no

motivation or incentive to produce better quality research—and a better foundation for clinical practice. (See Simon et al., 2020.)

“First, false impressions of certainty regarding common and consequential medical decisions undermine patients’ and clinicians’ motivation to develop necessary evidence. Honest acknowledgment of uncertainty and evidence gaps is necessary—in practice guidelines, clinician education, and communication with patients. Medical educators can consistently emphasize the weak evidentiary basis for most clinical decisions. Clinical training and continuing education can emphasize honest acknowledgment of uncertainty as a core competency for all clinicians. As clinicians’ and patients’ dissatisfaction with current evidence increases, motivation to participate in the development of new evidence may follow,” according to Simon et al. Or as the age-old adage goes, “The squeaky wheel gets the grease.”

However, it takes courage to point out that the evidence is flawed in many areas. It upsets the providers, administrators, and policy makers who support the status quo. And it can lead to vilification of those bringing attention to problems in the scientific evidence and in clinical practice. This has happened multiple times in the spine field. Major critiques of the evidence have sometimes resulted in intimidating threats by special interests.

Poet Carl Sandburg added six important words to the adage cited previously. “The squeaky wheel gets the grease but the quacking duck gets shot.”

Disclosures: None declared.

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## COVID-19 and Its Implications

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Many people with chronic pain—particularly chronic back pain—don't seek medical care at all. They manage it on their own. (See Ferreira et al., 2010.) Some patients with chronic symptoms who do seek medical care have high-impact pain that severely limits their ability to engage in key activities of daily life. But a larger group has chronic pain that does not interfere with normal function and activities.

For example, a population-based study published in 2019 found that about 40 million US residents reported having chronic pain. About ten million of those had high-impact pain, i.e. chronic pain accompanied by major activity restrictions. But triple that number had chronic pain without significant activity limitations, according to Mark Pitcher, PhD et al. (See Pitcher et al., 2018.)

Another 2019 review and commentary by Kelvin Jordan et al. estimated that about a third of the adult population has chronic or recurrent pain. But up to half of that group has “non-interfering pain” i.e. pain that does not interfere with daily life. Some of these individuals may have symptoms that progress to disabling pain. But some simply have benign pain trajectories. (See Jordan et al., 2019.)

It is vital to avoid conflating mild and severe forms of chronic back pain to make broad generalizations. Each major subgroup of chronic pain needs to be addressed separately in terms of treatment and prevention strategies.

One of the advantages of looking at these forms of pain separately is that better understanding of benign forms of chronic pain that do not compromise normal activity and function may give insights into the prevention of disabling chronic pain, Jordan et al. observed.

So it is difficult to imagine that the COVID-19 pandemic will have a consistent impact on all these groups. The disruption of pain care may be damaging to some patients with chronic pain but not to others.

### A Review in Pain

A review in a recent issue of the journal *Pain* expressed a different point of view. And there is plenty of room for disagreement in this area. This is an unprecedented healthcare emergency. And its overall

impact will only be clear once the pandemic plays out around the world.

Christopher Eccleston, PhD, and an international group of pain researchers recently conducted a superb and timely review of the potential of telehealth interventions to overcome some of the pain care disruptions created by the COVID-19 pandemic—particularly those affecting patients with chronic pain. However, this article appeared to address chronic pain in its more severe forms, the types of pain that fill pain clinics and pain services around the world. It is not clear that these observations apply to milder forms of chronic pain.

“All over the world people are closing the doors of their pain treatment centers. Not able to meet the demands of people with chronic pain, as valuable resources get reallocated to help fight the global pandemic caused by the spread of COVID-19,” said Eccleston in a video accompanying the review at the *Pain* website.

“In response to this, we, a collection of authors from Australia, the United States and Europe, wanted to put together a brief topical review looking at what the impact might be of the unfortunate shift and rapid adaptation in pain service delivery on the global population of people with chronic pain. And also to look at the evidence on what might help as people might try to look at alternative service provision in particular shifting to telemedicine solutions.”

The article suggested that the COVID-19 will have a negative impact on all types of chronic pain if the disruption of care continues.

“One of the things we know, and have known for some time, is that not treating chronic pain doesn't make it go away. Spontaneous recovery is incredibly rare. And, in fact, the consequences of not treating people with chronic pain can be quite severe. Work done looking at both adults and adolescents sitting on waiting lists for long periods of time show that they don't just stay at the same level of morbidity and need. They actually get worse and their needs increase. And, similarly, in populations where people have no [pain services] we see that the morbidity simply grows and the demands for need grow in line with that morbidity. Not doing anything is not an option, certainly not long term. Similarly, epidemiologically we have come to understand that it is exactly the patients who at the time of a pandemic are more likely to be affected by chronic pain and their risks of chronic pain increase,”

according to Eccleston. (See Eccleston et al., 2020.)

### Warnings About the Disruption in Pain Care

The authors repeated these warnings in the body of the review. Here are some direct quotes:

- “When people with chronic pain are denied assessment and treatment, their condition can worsen significantly; spontaneous recovery is rare.”
- “People waiting for assessment often report severe levels of pain that interfere with their ability to function, and reports of severe pain are associated with more severe levels of depression in 50% and suicidal thinking.”
- “Furthermore, people waiting over 6 months for assessment experience deteriorating health-related quality of life, increased pain, and increased depression.”
- “Not treating chronic pain will have consequences for individuals, health-care systems, and providers in the short- and long-term, increasing quantity, severity, and complexity of need.”

### Chronic Pain Has Multiple Trajectories

A *BackLetter* editor asked several people—pain researchers, clinicians, and patient advocates—to read this review. All felt that the warnings about disruption in chronic pain care applied mostly to individuals with severe and disabling back pain. They generally felt that these cautionary notes did not apply neatly to the broader population of patients with chronic back pain in primary care settings—or in complementary/alternative medical care.

They thought the review provided an eloquent endorsement of psychologically informed, evidence-based pain care delivered remotely. However, they felt that the review didn't acknowledge that this form of care is uncommon in many healthcare systems, particularly the United States.

The management of chronic back pain in the US generally doesn't align with the scientific evidence, is guideline discordant, and features widespread overuse of imaging, risky medications, and various treatments and procedures of limited effectiveness and cost-effectiveness.

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“You can find evidence-based, psychologically oriented care of chronic back pain in the United States but it is not widely available to patients,” said patient advocate Terry Corbin of HealthPartners in Minnesota. He is also a consumer representative at the Cochrane Back and Neck Group.

“It is most typically available in pain clinics and in the offices of clinical psychologists. Most patients with chronic back pain simply don’t have access to this form of care. Even when they do, reimbursement issues frequently come into play. And patients often end up with limited consultations with a mental-health professional—often just a session or two,” according to Corbin.

Corbin suggested that the United States is mired in an ineffective treatment model. “Transitioning to the type of remote care recommended in this article would require not only wholesale adoption of telehealth interventions but also a major paradigm shift in the treatment of back pain,” Corbin asserted.

### What About Patients in Primary Care Settings?

Richard A. Deyo, MD, co-chaired the National Institutes of Health Task Force on Research Standards for Chronic Low Back Pain. (See Deyo et al., 2014.) In a recent e-mail interview, Deyo said that he also interpreted the recommendations in the review by Eccleston et al. as applying to patients at the more severe end of the symptom and disability spectrum.

“This is an interesting article from *Pain*. Despite the rather general title of ‘Managing patients with chronic pain during the COVID-19 outbreak . . .,’ it’s fairly narrowly focused on delivering psychologically oriented care using electronic resources for remote delivery. It appeared to explicitly focus on care for patients seen in pain specialty practices.”

“This report doesn’t address the large number of patients with chronic pain who are managed in primary care settings, nor does it address the widespread use of procedural services for many patients with chronic pain,” said Deyo.

“For patients with spinal disorders, many have argued that services such as spinal imaging, epidural injections, fusion surgery, and long-term opioids are over-

used. Selective declines or delays in initiating some of these services for some patients may not cause major hardships. We might hope *not* to return to full volume for some of these services.”

“Certainly, not all patients with chronic pain are the same, and those with high-impact chronic pain are often likely to be seen in pain specialty clinics,” according to Deyo.

“Like visits to pain clinics, primary care visits in many health systems have been sharply curtailed during the COVID-19 pandemic,” Deyo added. He pointed out that primary care providers treat a broad range of chronic pain problems, from serious disabling pain to symptoms that have less impact on daily lives. “Their management in primary care settings is really not addressed here.”

He suggested that some patients—those with addiction, dependency, and opioid tapering issues—will be sorely affected by disruption of usual care. “But other aspects of management for primary care patients with chronic back pain may not be severely affected by reduction in visit frequency,” he added.

Deyo agrees with the notion that effective back care will require a major transition away from usual care.

“I think, ideally, we’d evolve new strategies for chronic pain management after limitations from the coronavirus pandemic are lifted. For example, efforts to scale back on overused services, integration of mental health services with primary care, better resources for encouraging exercise, an emphasis on self-care, and substantial changes in opioid prescribing might all improve quality of care for chronic pain. Greater use of telemedicine might continue and help to improve access and maybe even adherence. So, we might hope not to return to business as usual in managing chronic pain, but to a more evidence-based, more effective, and more efficient model,” Deyo added.

### Do the Warnings About Care Disruption Apply Equally to Specialty and Primary Care?

A *BackLetter* editor asked lead author Eccleston via email about several of these issues. Eccleston is a psychologist and prominent pain researcher from the University of Bath in the UK—and a Coordinating Editor of the Cochrane Collaboration

Pain, Palliative Care, and Supportive Care Group.

“You mentioned that disruption of chronic pain care will have a negative influence over the ‘short- and long-term, increasing quantity, severity, and complexity of need.’ And you cited the adverse effects of waiting for care. Are those comments primarily aimed at the care of complex or high-impact chronic pain of the type seen in pain practices and specialty settings?” he was asked.

Eccleston said there may not be a clear distinction between primary and specialty care in many medical systems. And the observations in the *Pain* paper generally apply to both areas, he suggested.

“I think the distinction between specialist and primary care patients is often not a helpful one,” Eccleston responded. “A referral to a specialist provider in most systems means that the patient is still in primary care. Most of the studies of waiting lists in which patients are in primary care, show worsening.”

Eccleston is referring to the fact that specialty care is managed through a primary care provider in many medical systems around the world.

However, this is only partially true in the crazy quilt of medical systems in the United States. Over 30% of back pain cases result in a specialty referral, according to some US studies. (See Mafi et al., 2013.)

And once patients are referred to a specialist, they often become the patient of that specialist and no longer depend on the primary care provider for guidance and direction. In fact, many patients with chronic back pain acquire multiple independent providers.

This issue, however, is moot in many other societies around the world—particularly in low-income countries where there is literally no organized pain care. “In most systems in the world, usual care is no care,” according to Eccleston.

Eccleston suggested that many of the issues discussed in the *Pain* article will require further careful research. “What we don’t know yet—and perhaps won’t for a while—that we did not have space to discuss include:

1. Do people [with chronic pain] get worse through under-treatment?
2. Do people get worse through iatrogenic treatment, e.g., more liberal use of opioids, etc?

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# The Importance of Distinguishing Low-Impact from High-Impact Chronic Pain

The issue of distinguishing mild and severe chronic back pain is particularly relevant to pain management in the United States. Several major reports on chronic pain in the past have failed to differentiate high-impact and low-impact chronic pain.

For example, the influential 2011 Institute of Medicine report entitled “Relieving Pain in America” claimed that more than 100 million US adults—over 40% of the adult population—suffer from chronic pain, including low back pain. And in the language that it used, the report implied that 40% of adults suffer from serious or severe chronic pain. In fact, the report seemed to suggest that all chronic or recurrent pain is serious or severe. (See Pizzo et al., 2011.)

“People with chronic pain should be recognized by family, employers, health insurers, and others as having a serious disease,” the IOM report asserted.

However, that report employed a definition of chronic pain based on chronicity. In other words, chronic pain was defined solely by its duration—and not by its impact on life and work.

That 100 million estimate included people with all types of chronic pain, from barely bothersome to outright excruciating. But how many of those 100 million US residents have seriously *disabling* pain, i.e., chronic pain with a major impact on function? That was a key question in a country immersed in a terrible pain management crisis related to the opioid debacle.

In reaction to this and other reports, the authors of the 2016 National Pain Strategy recommended that researchers come up with more precise data on the prevalence of high-impact pain.

“Although about 40% of US adults report chronic pain, meaning present on at least half the days over an extended period of time (e.g., three or six months), the impact of chronic pain on people’s lives differs markedly,” noted Michael Von Korff, ScD, who co-chaired the committee that produced the National Pain Strategy. (See Von Korff et al., 2016.)

“Chronic pain statistics that do not adequately differentiate persons with high-impact chronic pain from those with mild chronic pain conditions can be misleading,” according to Von Korff, who is an epidemiologist at the Kaiser Permanente Health Research Institute in Seattle.

“Differentiating persons with high-impact chronic pain from those with chronic pain with lower impact is essential in research studies and also for prioritizing treatment services that may help persons with high-impact chronic pain resume normal activities,” said Von Korff in a 2018 article in the *BackLetter*. (See Schoene, 2018.)

Two subsequent studies found that fewer than half of individuals with chronic pain in the United States had high-impact pain. “In 2016, an estimated 20.4% of US adults (50.0 million) had chronic pain and 8.0% of US adults (19.6 million) had

high-impact chronic pain, with higher prevalence associated with advancing age,” according to James Dahlhamer, PhD, and colleagues from the National Center for Health Statistics at the Centers for Disease Control and Prevention. (See Dahlhamer et al., 2018.)

A second study by Mark Pitcher, Von Korff, and colleagues came to broadly similar results. As mentioned in the feature article of this edition of the *BackLetter*, they concluded that about 40 million US adults reported some form of chronic pain. But only about 10 million—or 4.8% of the adult population—suffered from high-impact chronic pain. (See Pitcher et al., 2019.)

And that group is clearly bearing an excruciating pain burden. The vast majority (83.2%) reported being unable to work outside the home. Many were unable to finish school, engage in key social activities, or even work around the house. And poverty often looms for patients with high-impact pain problems.

These and similar studies should eventually allow researchers and healthcare providers to target healthcare interventions more effectively, lighten the pain burden for these people, and perhaps even reduce the overall level of back pain-related disability in the United States.

However, that won’t happen any time soon. The COVID-19 pandemic has put most of those goals and dreams on hold.

## COVID-19 and Its Implications

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3. What is the impact of COVID-19 on those with musculoskeletal disorders? and
4. What are the long-term effects of COVID-19 in creating future pain patients. We are just starting to see that now.”

He noted that some observers hold the opinion that patients with chronic pain may do better with sparing medical care. “Theoretically, there may be some people who do better because they are not over-medicalized.” He said he has not seen definitive evidence on this question.

This may be a crucial issue regarding the progression from acute to chronic pain problems. However, in the back pain area there is still lively debate over the factors that influence the transition to chronicity. And how that transition might be prevented.

A *BackLetter* editor posed another key question to Eccleston: “The system of chronic pain care in the United States is dysfunctional. There is no evidence in the back pain realm that the current management approach is reducing the prevalence of chronic pain or related disability. It is hard to imagine that a transition to telehealth services alone will address those

problems. In transitioning to remote care, would you also like to see a paradigm shift towards more rational and evidence-based chronic pain care?” he was asked.

“Fair point,” he replied. “Of course, we want better treatments, and better organization of treatments. They go hand in hand. We would not want better organization of treatments that speed access to low-quality treatments. So, absolutely: [we need] evidence-based care. But then I would say that as the editor of the Cochrane pain group.”

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# Telemedicine for Chronic Low Back Pain in Nigeria

Some low- and middle-income countries may have an advantage over rich countries because of greater experience with telemedicine and telehealth programs. Some have had to develop expertise to serve geographically remote areas—along with regions that lack abundant healthcare resources. This experience may help expand the use of telehealth services during the COVID-19 pandemic. However, huge challenges remain.

Researchers from Nigeria recently tested a telehealth intervention in a small randomized controlled trial. Physical therapist and health economist Francis Fatoye, PhD, of Manchester Metropolitan University in the UK and colleagues from Nigeria compared a telehealth rehabilitation program to a clinic-based program in the Osun State of Nigeria. (See Fatoye et al., 2020.)

## Telehealth Intervention Via the McKenzie Protocol

They wanted to compare a telehealth intervention featuring the McKenzie protocol to a similar program in a hospital-based physical therapy clinic—in terms of effectiveness and cost-effectiveness.

They randomly allocated 47 patients with long-term, chronic nonspecific low back pain to one of the two programs. The interventions took place three times per week for eight weeks. They analyzed disability, health-related quality of life, and costs, with follow-up assessment at four and eight weeks. Outcome assessors were blinded to treatment allocation.

“The findings of the present study showed that telerehabilitation was associated with greater health benefit and lower costs, suggesting it was a cost-saving therapy compared to clinic-based

therapy,” according to Fatoye and colleagues.

## Effective and Cost-Effective?

“Telerehabilitation-based McKenzie therapy (TBMT) was approximately 50% cheaper than clinic-based McKenzie therapy (CBMT); this is due to the less requirement of clinic-based [facilities] and less contact with the physiotherapist for its delivery. In other words, there is an opportunity to implement telerehabilitation programs across numerous geographic locations if needed. In low-income countries like Nigeria, access to physiotherapy services is a challenge due to shortage of physiotherapists and limited access to clinic-based programs. Unlike CBMT, TBMT could overcome barriers to accessing physiotherapy services and could deliver numerous bene-

*Continued on page 83*

## COVID-19 and Its Implications

*Continued from page 80*

Disclosures: None declared.

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## Back Care Lessons

*Continued from page 75*

- “Different organization of triage [services], which should provide different paths for pain syndromes in order to avoid crowding of urgent services
- “Above all, territorial health services should be strengthened: a global reinforcement of non-urgent services and outpatient assistance would probably be required to promote more responsible habits.

A *BackLetter* editor also asked Cofano about the harrowing experience of Italian healthcare providers and the population of Italy during the recent COVID-19 crisis there. Many providers put their lives on the line there to help society at large (as is happening in many other regions of the world. He responded simply, “I hope the emergency we just had will be left behind and never happen again.”

Disclosures: None declared.

### Reference:

- Cofano F et al., Back pain and accesses to emergency departments during COVID-19 lockdown in Italy [published online ahead of print May 1, 2020], *Neurosurgery*; doi:10.1093/neuros/nyaa174.

# Crisis for Hospitals in the United States—Raising Questions About Continuing Surgical and Nonsurgical Care

Many hospitals in the United States face possible financial ruin because of the COVID-19 pandemic, according to a recent study in *JAMA*. This raises questions about the future of both surgical and nonsurgical care for spine problems.

“The COVID-19 pandemic represents an unprecedented medical and economic challenge for the US health care system. In the absence of robust and sustained governmental support, almost all hospitals will experience financial difficulties. But hospitals that are smaller, independent, rural, and have critical access status are particularly at risk. Policymakers should provide dedicated support to these hospitals to access CARES Act funds and consider allocating additional funding to them during the COVID-19 pandemic,” according to a commentary by Dhruv Khullar, MD, and colleagues. (See Khullar et al., 2020.)

These researchers pointed out that elective admissions to US hospitals account for more than 30% of total inpatient hospital revenue. And outpatient revenue now equals inpatient revenue, they noted.

Spine surgery is one of the major revenue producers for many hospital systems. In fact, some have argued that spinal fusion surgery is the single most expensive common surgical procedure. “Elective procedures, especially orthopedic and cardiac surgical procedures, are among the most profitable services for hospitals,” according to Khullar et al. Several other areas of spine care—physical therapy, occupational therapy, pain interventions, addiction services, and rehabilitation programs—are also commonly based in hospital settings.

Some are hoping that the COVID crisis will reduce the overtreatment of back problems in the United States. However, it is possible that the hospital crisis will drag down essential spine surgery and back pain interventions.

This is a particular worry for rural hospitals—and in hospitals in disadvantaged areas. Even before the COVID crisis, one in five rural hospitals in the United States was at risk of closure because of financial problems.

Hospitals give the impression of being rich institutions with guaranteed revenue flow. However, Khullar et al. pointed out that many hospitals have limited financial reserves. According to their analysis the median US hospital had 53.4 days of cash on hand before this crisis.

Disclosures: None declared.

## Reference:

Khullar D et al., COVID-19 and the financial health of US hospitals [published online May 4, 2020], *JAMA*; doi:10.1001/jama.2020.6269.

## Back Pain’s Huge Burden

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huge medical burden and economic cost. It is consequently one of the major global public health problems,” according to Wu et al.

They found that the estimated number of people with LBP grew from 377.5 million in 1990 to 577 million in 2017. Globally, the point prevalence (i.e. the number of people with back pain at any given time) fell slightly from 8.2% in 1990 to 7.5% in 2017. The prevalence of back pain was higher among women than among men.

The prevalence of LBP increased with age from childhood up until the age of 80 years or so. Then it dipped slightly in older age.

Low back pain was the leading cause of “years lived with disability” (YLDs) in both 1990 and 2017 for 13 of the 21 world regions covered in the study.

“The global YLDs for LBP were 42.5 million (95% UI [uncertainty interval]: 30.2 million–57.2 million) in 1990, and increased 52.7% to 64.9 million (95% UI: 46.5 million–87.4 million) in 2017. YLDs were higher for females than males in both 1990 (23.3 million, 95% UI: 16.6 million–31.2 million, compared to 19.2 million, 95% UI:

13.7 million–26.2 million, respectively) and 2017 (35.5 million, 95% UI: 25.4 million–47.7 million, compared to 29.5 million, 95% UI: 21.0 million–40.0 million, respectively). The age-standardized YLD rate (per 100,000 population) decreased slightly from 892 (95% UI: 637–1,195) in 1990 to 810 (95% UI: 582–1,089) in 2017, although this was not statistically significant at the 0.05 level. The age-standardized YLD rate was also higher in females than males.”

The review revealed a changing pattern of low back pain-related disability. Total years lived with disability peaked at 35–39 years of age in 1990 before decreasing. In 2017, years lived with disability peaked at 45–49 years of age. Males and females demonstrated similar patterns.

Despite the huge burden of LBP, many countries and public health authorities give short shrift to LBP. They continue to prioritize communicable diseases over noncommunicable diseases such as LBP. The *Lancet* Low Back Pain Series recently made a call for action on the management of LBP burden from governments, policy makers, and society at large. However, there continues to be a gap between evidence for effective management of LBP and current practice and policy, as outlined in the *Lancet*

Series. Greater attention is needed to bridge this gap.

“The recent *Lancet* series documented high levels of inappropriate investigations and treatments that are contributing to the LBP burden for both individuals and society. Key recommended principles for LBP would be to reduce unnecessary imaging and treatment, support people to be active and stay at work, and to only use medication, imaging, and surgery prudently. For high-risk cases, prevention and early intervention could be considered. Linton *et al.* reported a stepped, stratified, and matched care approach might reduce wastage of clinical time and resources,” according to Wu et al.

Disclosures: None declared.

## Reference:

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# MEETING CALENDAR

## ■ **Scoliosis Research Society 53rd Annual Meeting**

September 9-12, 2020  
Phoenix, Arizona

Contact: Scoliosis Research Society  
555 East Wells Street, Suite 1100  
Milwaukee, WI 53202  
Tel: 414-289-9107  
E-mail: [meetings@srs.org](mailto:meetings@srs.org)

## ■ **Cervical Spine Research Society**

December 10-12, 2020  
Las Vegas, Nevada

Contact: Cervical Spine Research Society  
9400 W. Higgins Road, Suite 500  
Rosemont, IL 60018-4976  
Tel: 847-698-1628  
Fax: 847-268-9699  
E-mail: [csrs@aaos.org](mailto:csrs@aaos.org)

## ■ **Eurospine 2020**

October 7-9, 2020  
Vienna, Austria

Contact: Eurospine, Spine Society of Europe  
Attn: Judith Reichert  
Schild Seefeldstrasse 16  
8610 Uster-Zurich,  
Switzerland  
Tel: 41-44-994-1404  
[www.eurospinemeeting.org](http://www.eurospinemeeting.org)

## ■ **International Association for the Study of Pain 2020 World Pain Congress**

June 27-July 1, 2021

Amsterdam, The Netherlands

Contact: IASP  
1510 H Street NW, Suite 600  
Washington, DC 20005  
Tel: 202-856-7400  
Fax: 202-856-7401

## ■ **NASS 2020: Annual Meeting of the North American Spine Society**

October 7-10, 2020  
San Diego, California

Contact: North American Spine Society  
7075 Veterans Boulevard  
Burr Ridge, IL 60527  
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- **The Prevalence of Anxiety and Depression is Soaring**

### ***Telemedicine for Back Pain***

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fits to the patients with reduced cost in Nigeria. However, the key challenges to its implementation strategies are the existence of effective internet services and patient reluctance to engage," they explained.

### **Rapidly Expanding Healthcare Crisis**

This study was conducted before the COVID-19 crisis. However, parts of

Nigeria have subsequently been devastated by the coronavirus.

So there may be a critical need for transitioning to remote healthcare via telemedicine in this populous African country—for pain care and other healthcare services. However, scaling up telehealth services takes time and the investment of millions of dollars in communication infrastructure. Low- and middle-income countries around the world face similar challenges when it comes to providing remote healthcare—and grappling with this worldwide crisis.

Disclosures: None declared.

### **Reference:**

Fatoye F et al., Clinical and cost-effectiveness analysis of a telerehabilitation intervention for people with nonspecific chronic low back pain [published online ahead of print January 24, 2020], *JMIR mHealth and uHealth*; doi:10.2196/15375.



# BACKPAGE

## US Healthcare System Not Offering Pain Patients Life-Saving Treatments

The US healthcare system was all too eager to overprescribe opioids for chronic pain over a 25-year period, causing millions of people to develop opioid dependence and addiction problems—and hundreds of thousands to overdose and die. Yet the same system seems unable to treat opioid use disorders effectively, either through ignorance or lack of attention.

Researchers from Oregon Health and Science University recently studied more than 12,000 patients in 109 hospitals in the Veterans Affairs healthcare system in 2017. The study subjects all had an opioid use disorder and varied conditions, which led to hospitalization.

Only 2% of the patients received a medication to treat opioid use disorder before or immediately after the hospitalizations.

Yet medications such as buprenorphine and methadone can effectively treat opioid disorders and save lives. They help relieve withdrawal symptoms and pain—and aid in normalizing brain function.

This is a major disappointment. “It paints a really bleak picture of the current state of affairs regarding the treatment of people with opioid use disorder,” said lead author Kelsey Priest, PhD, in a statement accompanying the study.

“This a huge missed opportunity,” according to coauthor Honora Englander, PhD. “Hospitalization is a reachable moment to initiate and coordinate therapy to treat substance use disorders. This study shows that in the VA—which most likely outperforms other US hospitals—

life-saving, evidence-based treatment is rarely prescribed.”

It is not an exaggeration to conclude that many innocent patients will die as a result. (See *Journal of General Internal Medicine*, April 14, 2020. doi: 10.1007/s11606-020-05815-0.)

## Lack of Access to Telehealth Back Care Services

As pain care providers transition from in-person visits to telehealth consultations, it is important to remember that large sections of the population will not

- Children in low-income households are much less likely to have a computer at home than their affluent classmates.
- Fifty-two million Americans do not know how to use a computer.
- Those who lack digital literacy tend to be older, less educated, and black or Hispanic.
- Many residents, particularly those in rural areas, do not have access to high-speed internet (which facilitates telehealth consultations).

“We must not forget about our vulnerable populations who suffer from the effects of their digital

Improvement made this point in a recent commentary on the “New Normal” in *JAMA*.

“COVID-19 has unmasked many clinical visits as unnecessary and likely unwise. Telemedicine has surged; social proximity seems possible without physical proximity. Progress over the past 2 decades has been painfully slow toward regularizing virtual care, self-care at home, and other web-based assets in payment, regulation, and training. The virus has changed that in weeks,” according to Berwick.

“Will the lesson persist in the new normal that the office visit, for many traditional purposes, has become a dinosaur, and that routes to high-quality help, advice, and care, at lower cost and greater speed, are potentially many? Virtual care at scale would release face-to-face time in clinical practice to be used for the patients who truly benefit from it,” he observed.

Berwick is familiar with the ins and outs of population-based medical care, having been the Director of the Centers for Medicare and Medicaid Services—the world’s largest healthcare payer—during the Obama administration.

However, the medical delivery system likely will not improve back and spine care unless there is also shift away the ineffective and disabling care that has warped this field. In other words, there has to be a paradigm shift in spine care—a movement away from overdiagnosis, overtreatment, overuse of expensive services, and resulting exorbitant costs.

Simply rerouting current management approaches through digital communication methods will not in itself lead to a major improvement in care or outcomes. The whole system of back care needs reform. (See *JAMA*, May 4, 2020; doi:10.1001/jama.2020.6949.)

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be able to access this form of care. And they should not be left behind.

“In a time of urgency, it is easy to forget the people far removed from our technological society,” according to Harvard researchers David Velasquez and Ateev Mehrotra.

They pointed out in a recent article at the *Health Affairs* blog that the switch to telehealth services may exacerbate healthcare inequities in modern societies. They offer some worrisome statistics regarding access in the United States:

- More than one a third of US households headed by individuals older than 65 years do not have a computer and more than half do not have a smartphone.

divide. Policy makers, public health officials, and other community leaders should work together to ensure that health care access is not compromised because of the shift to virtual care,” according to these researchers. (See *Health Affairs* Blog, May 8, 2020; [www.healthaffairs.org/doi/10.1377/hblog20200505.591306/full/](http://www.healthaffairs.org/doi/10.1377/hblog20200505.591306/full/))

## Will Face-to-Face Back Care Become a Rarity?

The coronavirus disease 2019 (COVID-19) pandemic is making it clear that much of low back and spine care does not require a face-to-face visit. And the current transition to telemedicine and telehealth services may be a turning point for the entire field.

Donald Berwick, MD, from the Institute for Healthcare