Low-Intensity Physical Activity Promotion in Primary Care

Light-intensity physical activity (LPA) has been addressed as a public health importance in the last few years, alongside with the growth of evidence on its health benefits.[1] According to the 24-hour movement guidelines, LPA should be emphasized along with moderate- to vigorous-intensity physical activity (MVPA).[1] The current World Health Organization (WHO) recommendations on physical activity (PA) also encourage people to engage in more LPA in their daily lives.[2] However, only MVPA is counted to indicate sufficient PA (≥150 minutes/week of MVPA).[2] This represents a paradigm shift in the way to promote PA in primary care.

In primary care, promoting PA is still limited due to several barriers, including health care providers, patients, and health care systems.[3] Time constraints are considered the main factor preventing clinicians from discussing PA with their patients.[3] Providing systematic PA advice may require anywhere from a few minutes (<5 minutes for very brief PA advice) to a lengthy session (>30 minutes for extended PA advice).[4] Even offering very brief PA advice is challenging in some clinical settings. A systematic review and meta-analysis revealed that only 37.9% of patients in primary care received PA advice from health care providers.[5]

Due to the reasons mentioned above, LPA has the potential to be advised as a supplement or replacement of MVPA in some contexts. First, LPA is easier to communicate compared with MVPA. For example, discussing MVPA requires understanding the measurement of PA intensity (eg, percentage of maximum heart rate, metabolic equivalent, talk test).[3] Second, LPA can be an alternative for patients who are unable or not ready to perform MVPA. In addition, LPA can be recommended at the beginning of treatment courses before gradually increasing PA frequency, intensity, and duration. Third, LPA may be safer for susceptible populations. Higher intensity of PA may increase the risk of injuries and fatal harms (eg, sudden cardiac death, acute myocardial infarction).

Although the evidence supporting LPA is not as strong as that for MVPA, the benefits of LPA have been documented in recent years.[1,2] LPA has more roles in a wide range of populations from healthy individuals to clinical populations according to the WHO guidelines.[2] LPA is a potential connector to bridge the gap between the practice of PA promotion in public health and clinical settings. However, there are several gaps in knowledge to promote LPA in clinical settings. First, there is a need to establish strong evidence on the volume or amount of LPA that can improve health outcomes. Second, guidance for promoting LPA in clinical settings should be developed to align with clinical practices. Lastly, methods for measuring and monitoring LPA promotion in clinical settings should be justified.

In summary, the body of knowledge of LPA and health has been growing. LPA promotion is feasible in primary care. Health care providers are the key party to implement LPA promotion in their practices. Further evidence is required to support the benefits and safety of LPA among clinical populations. Clinical practice guidelines for LPA promotion and monitoring of their implication should be developed.

Apichai Wattanapisit, MD
Sanhapan Wattanapisit MD, MSc
From the Department of Clinical Medicine, School of Medicine, Walaialk University, Nakhon Si Thammarat, Thailand (AW); Family Medicine Clinic Walailak University, Nakhon Si Thammarat, Thailand (AW); Family Medicine Unit, Thasala Hospital Nakhon Si Thammarat, Thailand (SW)
E-mail: apichai.wa@gmail.com

To see this article online, please go to: http://jabfm.org/content/37/5/933.full.

References

1. Ross R, Janssen I, Tremblay MS. Public health importance of light intensity physical activity. J Sport Health Sci 2024;13:674–5.
2. Bull FC, Al-Ansari SS, Biddle S, et al. World Health Organization 2020 guidelines on physical activity and sedentary behaviour. Br J Sports Med 2020;54:1451–62.
3. Wattanapisit A, Wattanapisit S, Wongsiri S. Overview of physical activity counseling in primary care. Korean J Fam Med 2021;42:260–8.
4. Freene N, Barrett S, Cox ER, et al. The physical activity advice continuum-a guide for physical activity promotion in health care. J Phys Act Health 2024;21:311–5.
5. Wattanapisit A, Lapmanee S, Chaovalit S, Lektip C, Chotsiri P. Prevalence of physical activity counseling in primary care: a systematic review and meta-analysis. Health Promot Perspect 2023;13:254–66.

doi: 10.3122/jabfm.2024.240134R0

Re: Effectiveness of Long-Term Opioid Therapy for Chronic Low Back Pain

To the Editor: In Licciardone et al, attention is appropriately given to the important question of whether long-term opioid therapy (LTOT) has measurable benefits for those with chronic low back pain.[1] The primary finding in this observational study is that a cohort of individuals with chronic low back pain who are already taking LTOT have no better pain control or functioning over 12 months compared with a propensity score-matched cohort of individuals with chronic low back pain not taking opioids. Yet the authors conclude that their findings

add support to the notion that "clinicians should consider tapering opioid dosage among long-term opioid therapy users in accordance with clinical practice guidelines." While this is a reasonable statement on its own, the study design and results of this study do not support this conclusion.

Primary care clinicians face 2 distinct questions surrounding LTOT for chronic pain. The first question is whether starting opioid-naive individuals with chronic pain syndromes on LTOT will result in benefit compared with nonopioid therapies. The authors note the small but growing body of literature that suggests only modest, if any, benefit of this approach over the long-term for pain control and functioning.[2,3]

A second, separate question is whether tapering or stopping LTOT in opioid-dependent individuals will result in benefit. To our knowledge, there are no randomized trials assessing this question. Observation data from multiple studies find associations of increased harms with tapering.[4,5] These studies have notable limitations and should not stop clinicians from discussing with patients the issue of tapering LTOT, as there remain risks associated with LTOT continuation.[6] Neither should they dissuade considerations to transition from full agonists to buprenorphine, an approach that is likely to reduce risks associated with continuation or tapering of full agonists.[7] This question is not addressed by the study design in Licciardone et al, yet the authors conclude that their findings indicate that clinicians should consider tapering opioid dosage among long-term opioid therapy users in accordance with clinical practice guidelines. This statement risks adding unmerited confidence to a clinical scenario that remains nuanced.

Whether to initiate LTOT in opioid-naive individuals with chronic pain seems increasingly clear: the limited benefits with noted risks make this pathway one that should be rarely taken, and when done so, guidelines suggest buprenorphine as the safest opioid.[8] The data presented by Licciardone et al do not offer signals to suggest otherwise. Yet the questions of whether and when to recommend tapering LTOT or transitioning full agonist LTOT to buprenorphine are not addressed in Licciardoneet al, are ones in need of more evidence, and for now, should be approached with careful nuance and individualization by primary care clinicians.

Richard C. Waters, MD, MSc
Claire B. Simon, MD
From the Downtown Emergency Service Center, Seattle WA (RCW); Department of Family Medicine University of Washington, Seattle, WA (CBS)
E-mail: watersr@uw.edu

To see this article online, please go to: http://jabfm.org/content/37/5/934.full.

References

1. Licciardone JC, Rama K, Nguyen A, Prado CR, Stanteen C, Aryal S. Effectiveness of long-term opioid therapy for chronic low back pain. J Am Board Fam Med 2024;37:59–72.
2. Busse JW, Wang L, Kamaleldin M, et al. Opioids for chronic noncancer pain: a systematic review and meta-analysis. JAMA 2018;320:2448–60.
3. Chou R, Hartung D, Turner J, et al. Opioid treatments for chronic pain. Agency for Healthcare Research and Quality (US); 2020.
4. James JR, Scott JM, Klein JW, et al. Mortality after discontinuation of primary care-based chronic opioid therapy for pain: a retrospective cohort study. J Gen Intern Med 2019;34:2749–55.
5. Agnoli A, Xing G, Tancredi DJ, Magnan E, Jerant A, Fenton JJ. Association of dose tapering with overdose or mental health crisis among patients prescribed long-term opioids. JAMA 2021;326:411–9.
6. Hallvik SE, El Ibrahimi S, Johnston K, et al. Patient outcomes after opioid dose reduction among patients with chronic opioid therapy. Pain 2022;163:83–90.
7. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC clinical practice guideline for prescribing opioids for pain - United States, 2022. MMWR Recomm Rep 2022;71:1–95.
8. Veteran Affairs/Department of Defense Clinical Practice Guideline: Use of Opioids in the Management of Chronic Pain. 2022.

doi: 10.3122/jabfm.2024.240154R0

Response: Re: Effectiveness of Long-Term Opioid Therapy for Chronic Low Back Pain

To the Editor: In a letter regarding our publication,[1] Waters and Simon contend that our study design and results did not support the conclusion that clinicians should consider tapering opioid dosage among long-term opioid therapy (LTOT) users in accordance with clinical practice guidelines.[2] Our study was conducted to address the scant evidence from randomized controlled trials on the long-term effects of opioid therapy.[3] Given that there are known harms with opioid therapy, the performance of long-term trials is limited both by methodological issues and ethical concerns. When randomized controlled trials are not feasible, cohort studies are generally considered the best alternative for deriving evidence to drive clinical decision making. Beyond conducting long-term follow-up, our cohort study used propensity score matching of treatment groups to control for potential confounders. This matching included several variables not often measured in clinical trials involving low back pain, such as pain catastrophizing, pain self-efficacy, widespread pain, health-related quality of life, wage replacement benefits, and litigation.[3]

Our results consistently demonstrated that LTOT was not associated with any benefits pertaining to pain intensity, back-related disability, or pain impact, including in analyses that also considered the duration of opioid therapy, dose response, and complete treatment adherence over 12 months (analogous to per-protocol treatment in a clinical trial). Thus, it is unclear why Waters and Simon believe that these cohort study results do not further support Recommendation 5 of the Centers for Disease Control and Prevention (CDC) Guideline for