Correspondence

Colonoscopy in Rural Communities

To the Editor: The article by Drs. Edwards and Norris[1] in the September-October 2004 issue concluded that family physicians can provide safe and competent colonoscopy in a rural setting. Colonoscopy is increasingly being used as one of the screening options for colorectal cancer by many gastroenterologists. However, the number of gastroenterologists and other qualified endoscopists is not sufficient to meet the growing demand, especially in rural communities where there is an even greater shortage of specialists. Even though the sample size in the article is smaller than in the referenced studies, the results seemed to be comparably favorable. Even though the four endoscopists had different experience levels, with the number of endoscopies done before the study ranging from less than 50 to more than 500, the success rate for reaching the cecum was more than 90%. The authors concluded that "well-trained family physicians can safely provide diagnostic and therapeutic colonoscopy for their patients." Are the authors implying that family physicians who have done less than 50 colonoscopies during their training are well-trained and competent to do the procedure? The Gastroenterology Leadership Council[2] and the Accreditation Council for Graduate Medical Education[3] both recommend at least 100 colonoscopies with 20 polypectomies to achieve competency in performing colonoscopy. How can this training be incorporated into the 3-year family practice residency?

The shortage of well-trained colonoscopists may be reduced in the future by developments in new techniques of visualizing the bowel such as wireless capsule endoscopy[4] and computed tomographic colonography.[5] These emerging technologies may eventually reduce the number of colonoscopic procedures in the future, leaving the few gastroenterologists available to perform colonoscopies only on those patients who either have a positive result or who are not good candidates for wireless capsule endoscopy or computed tomographic colonography.

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Author's Reply

To the Editor: We appreciate the recent comments submitted regarding our article previously published in your journal.[1] We gave the concerns raised regarding the number of colonoscopies required to be "competent" much thought during the writing of the article and since publication. We believe this select group of physicians represents a minority of primary care practitioners. They are highly motivated procedure-focused family physicians at a rural facility. They all practice in this setting for that very reason. Before the study was begun, the objectives were well known to the participating physicians and it was clear that one of the critical goals for any colonoscopy was that the cecum be reached. In addition, as reported, our group of patients was considered "low risk," which may have led to a higher cecal intubation rate. The difference in training experience among the 4 study physicians was apparent in their reported cecal intubation rates, time to cecum, and total procedure time.

We greatly respect the recommendations of the Gastroenterology Leadership Council[2] and the Accreditation Council for Graduate Medical Education[3]; however, several others have already published successful reports regarding motivated rural family physicians performing colonoscopies with fewer than 100 procedures completed previously.[4–6] The largest prospective colonoscopy study to date included 13,580 procedures completed by surgeons.[7] This included 1368 procedures completed by surgical residents who had only completed between 11 and 49 previous cases. Wexner et al[7] reported, based on their results, that "no minimum number of cases can be mandated for credentialing to perform safe colonoscopies." Given the current shortage of physicians performing endoscopy in rural and underserved settings and the increasing demand for services, these studies support continued development of colonoscopy-trained primary care physicians.

We note that it was not the intent or purpose of our study to attempt to establish a minimum number of "in-training" colonoscopies that should be completed before privileging. It is our view that the setting of an arbitrary number of procedures to be done in training before privileging is inappropriate and unsupportable by evidence in the literature at this time. Resident and prac-

ticing physician skill in learning and performing new procedures varies widely, and we believe that the AAFP's policy of basing privileging on "documented training and/or experience, demonstrated abilities, and current competence"[8] is a far more prudent approach than assigning privileges based on completion of an arbitrary number of procedures. Thus, strategies to train family physicians in complex procedures will need to be individualized for each resident, and they should be based on the premise of training, followed by judging competence based on demonstrated abilities.

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Repeating Failed Policies Will Not Improve Outcomes

To the Editor: The recently published second edition of Gordon Waddell's *The Back Pain Revolution* starts out "Back pain was a 20th-century medical disaster and the legacy reverberates into the new millennium."[1] The article in the recent *JABFP Supplement* by Rives and Douglass advocates the same failing model.[2] Three unfortunately common errors pervert their understanding of the problem and thus prevent a useful conclusion. The errors are: misunderstanding the natural history of low back pain, looking for a diseased tissue instead of analyzing the system, and giving only a superficial look at psychosocial issues.

The authors state that up to 90% of patients with low back pain will recover within 12 weeks. The reference to this was a National Institutes of Health grant guide that did not give a source for this data. We know that approximately 90% of patients with low back pain will not continue to consult a medical practice after 3 months, but this does not mean that they are recovered.[3] In fact, a recent review of 36 studies reveals that at 1 year, between 42% and 75% of patients with low back pain continue to have pain.[4] Two more recently published studies showed that 52% of patients with low back pain and 53% of patients with sciatic pain still had pain and back-related disability at 5- and 4 year follow-ups, respectively.

Although the authors did note that the recurrence rates are high, they did not note the most relevant aspect of this. All episodes are not created equal. Evidence suggests that chronic low-back pain causes neurologic remodeling, leading to centrally mediated pain.[5] With each recurrent episode, the intensity, disability, duration, and peripheralization of symptoms tend to increase and eventually not resolve.[6] Time is of the essence. A recent study showed that waiting even 6 weeks for treatment prevented improvement in psychosocial variables with symptomatic improvement.[7] The failure to notice these factors falsely casts a shadow of triviality over episodes of low-back pain, leading one to the false conclusion that timely treatment is not important.

Rives and Douglass state that "An exact diagnosis and anatomic pain generator may not always be evident." That is certainly true, but this implicit assumption that we should search for an anatomic pain generator is misguided. Not to feign omnipotence, but I am unaware of a case in which this has been fruitful—aside from pathology or a clear-cut herniated nucleus pulposus with a predominance of anatomic leg symptoms. Bogduk has shown that painful tissues can be found in most cases,[8] but what have we gotten from this? Our affection in previous years for the disk—an undoubtedly painful tissue in many cases—was a complete and utter failure.

The Quebec Task Force said that "the inability to find diagnostic subgroups is the fundamental source of error in low-back pain management." Emphasis should be on functional classifications that can find relevant—if not yet perfect and complete—low back pain subgroups. As just one example, a McKenzie assessment can provide an excellent predictor of outcomes.[9] Most physical therapists and many chiropractors know this. However, the generals (medical doctors) are not talking to their soldiers (physical therapists and chiropractors). Any guidelines or review that hope to positively effect outcomes must address this.

Further, we see that when the pain is effectively treated, the psychosocial issues tend to resolve as well.[10] These psychosocial variables are not simply a result of lawyer-induced greed, as the authors implied with their reference to a 31% reduction in claims when pain and suffering settlements were eliminated. Litigation is not a great predictive factor—Waddell's book has an excellent

discussion of this.[1] A more reasonable—or at least as reasonable—hypothesis for the 31% reduction in claims is that their treatment was ineffective, so without a monetary settlement, they had no incentive to stay in the system! Nonorganic signs do not indicate psychogenic pain. Evidence is mounting that central hypersensitivity may account for the presence of Waddell's signs.[11]

As we have seen, the natural history of low back pain is not a rosy as our authors have led us to believe. Effective and timely treatment is essential to preventing chronicity. To treat effectively, we must have a meaningful diagnosis. Currently the best tools we have are functional analyses. It would be profitable to our patients to have increased interdisciplinary communication so that the gatekeepers are truly aware of the treatment options available. And while psychosocial issues such as comorbid depression do indicate a more complicated case, they do not indicate greed, malingering, or psychosis.

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Author's Reply

To the Editor: Our article was designed as an evidence-based review of the diagnosis and management of low back pain in the primary care medical setting, with emphasis on treatments supported by level A and B evidence.

In response to the main points in Dr. Jones' letter:

1. We believe a robust body of medical evidence supports the prompt resolution of most episodes of acute low back pain. Although the exact percentage of patients whose symptoms resolve within a given period of time will continue to be debated, we do not believe that the recent literature quoted by Dr. Jones substantially changes our assertion.

2. As we point out in our article, physical modalities play an important role in the treatment of low back pain. However, we are unaware of any high-quality evidence supporting Dr. Jones' assertion that "effective and timely treatment is essential to preventing chronicity" or that recurrent episodes of low back pain necessarily lead to permanent neurological changes.

3. Dr. Jones is correct in pointing out that a precise anatomic pain generator is not always found in patients with low back pain. We do not, implicitly or otherwise, advocate an aggressive search in every patient. However, in our view, ignoring the possible presence of a treatable lesion in deference to functional assessment is not in the best interest of patients.

4. In our opinion, the literature strongly supports the view that psychosocial variables play a significant role in the persistence of low back symptoms. These issues were explored in depth within our article.

In summary, although we acknowledge Dr. Jones' points of view, we stand by the approach to diagnosis and treatment of low back pain outlined in our article.

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