

Correspondence

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.

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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