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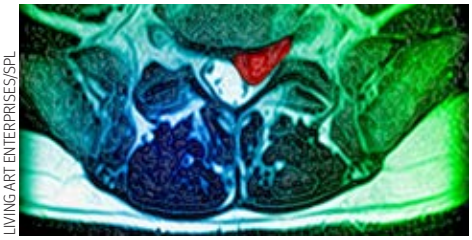
'LUMBOSACRAL RADICULAR PAIN

Comparative efficacy trials with no placebo group



LIVING ART ENTERPRISES/SPL

Cohen and colleagues' trial of epidural steroids versus gabapentin in patients with lumbosacral radicular pain found no significant difference in the primary outcome.[1] There are several problems with their conclusion that a trial with neuropathic drugs might be a first line treatment option.

Given the lack of a difference between treatment groups, there was no justification for endorsing one treatment over the other. In addition, the trial did not study first line treatment. All participants had experienced symptoms for at least six weeks; about 80% had chronic symptoms and 25% were taking opioids at baseline. More importantly, there was no convincing evidence that either treatment was efficacious against placebo.

In a meta-analysis we showed that epidural steroids have a significant short term effect on pain and disability compared with placebo.[2] However, the small effect size indicates that the treatment may not be clinically worth while. Epidural steroid injections are weakly recommended for lumbosacral radicular pain by guidelines.[3] Although the latest guideline recommends gabapentin as first line drug for neuropathic pain,[4] evidence comes from trials in other neuropathic pain conditions. Our systematic review found only limited direct evidence[5]—one small unregistered trial showed a moderate short term benefit for gabapentin versus placebo in people with lumbosacral radicular pain.[6]

In view of the limited evidence supporting the efficacy of epidural steroid injections or gabapentin and the lack of a placebo comparison, Cohen and colleagues' results do not suggest that these two treatments are equally effective—they could be equally ineffective or equally harmful (42.8% of participants withdrew from the study owing to negative outcomes after one month).[1] This comparative efficacy trial does not help clinical decision making because neither treatment has evidence of efficacy against placebo. The more urgent research question is whether either treatment, or another, is superior to placebo.

Chung-Wei Christine Lin senior research fellow and associate professor, George Institute for Global Health and Sydney Medical School, University of Sydney, Sydney NSW 2000, Australia
clin@george.org.au
Richard O Day professor of clinical pharmacology, St Vincent's Hospital Clinical School and Pharmacology, School of Medical Sciences, Faculty of Medicine, University of New South Wales, NSW, Australia
Ian Harris professor of orthopaedic surgery , South Western Sydney Clinical School, Faculty of Medicine, University of New South Wales
Chris G Maher professor, George Institute for Global Health and Sydney Medical School, University of Sydney, Sydney NSW 2000, Australia
Andrew McLachlan professor of pharmacy, Faculty of Pharmacy and Centre for Education and Research on Ageing, University of Sydney

1 Cohen SP, Hanling S, Bicket MC, et al. Epidural steroid injections compared with gabapentin for lumbosacral radicular pain: multicenter randomized double blind comparative efficacy study. *BMJ* 2015;350:h1748. (16 April.)

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Authors' reply

Lin and colleagues commented that because the differences between treatments were small we were unjustified in recommending one treatment over another.[1 2] In our conclusions we stated that it was reasonable to proceed with pharmacotherapy first, given the small differences seen. If physical therapy and surgery—which is associated with much higher costs and risks than physical therapy—were shown to be equivalent, would they still state that recommending one treatment over another was unjustified? Given the available information, the decision on which treatment to use initially should be individualised. A large multicenter study that compared conservative treatment (including gabapentin) with a series of epidural steroid injections for cervical radiculopathy found that the combination treatment fared best.[3]

The authors correctly state that a comparative effectiveness study without a true placebo group cannot be used to determine efficacy. The inclusion of a sham placebo group would have added considerably to the costs and practical barriers in implementing this study, and, more importantly, inclusion of a placebo group would have missed the point of comparative effectiveness research, which is to compare treatments.

There is more evidence demonstrating efficacy for epidural steroid injections than for almost any other back pain treatment. Although the authors cite their own review as evidence that the treatment "may not be clinically worth while,"[4] they fail to mention other, more inclusive reviews that reached diametrically different conclusions.[5] For gabapentin, although the evidence is mixed, we would interpret the positive controlled and uncontrolled trials as indicative of some efficacy.[6-8] The question that patients and physicians want answered is not whether epidural steroids are superior to epidural local anaesthetic or intramuscular saline, but whether they provide better relief than current treatments, including other drugs.

Steven P Cohen physician, Johns Hopkins School of Medicine, Baltimore, MD, and Walter Reed National Military Medical Center, Bethesda, MD, USA
scohen40@jhmi.edu
Yakov Vorobeychik director of interventional pain medicine, Penn State-Hershey Medical Center, Hershey, PA, USA

1 Cohen SP, Hanling S, Bicket MC, et al. Epidural steroids compared with gabapentin for lumbosacral radicular pain: multi-center, randomized, double-blind, comparative-efficacy study. *BMJ* 2015;350:h1748. (16 April.)

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CHOOSING WISELY IN THE UK

Prescrire: France's Choosing Wisely initiative

We welcome the Choosing Wisely initiative in the UK.[1] For more than 30 years the non-profit making organisation Prescrire has helped healthcare professionals and patients choose treatments that minimise the risk of adverse effects on the basis of strong evidence. And to do that wisely, Prescrire editors lack any conflicts of interests with drug companies, government agencies, or payers.

Many drugs are approved despite a lack of solid evidence that they are any better than existing treatments, or despite being less effective or more harmful than current options.

Each month Prescrire editors identify the few new drugs that provide an advantage compared with the majority of new products that are useless or risky, as shown in our annual review.[2] From the 87 drugs and indications reviewed in 2014 only three "offered a real advance," five

"offered an advantage," and 15 were "possibly helpful." But 35 drugs provided "nothing new" compared with existing treatments and 19 were "not acceptable."[2]

Prescrire also publishes an annual list of "drugs to avoid." The 2015 list identified 71 drugs on the French market that are more harmful than beneficial.[3] They include drugs with adverse effects that are disproportionate to their benefits, older drugs that have been superseded by drugs with a better harm-benefit balance, recent drugs that have a less favourable harm-benefit balance than current options, and drugs without proved efficacy that expose people to serious adverse effects.

Globally we must make better use of existing treatments. That means we need to choose, discard, and deprescribe.

Bruno Toussaint publishing director, Prescrire, Paris Cedex 11, France
contact@prescrire.org

1 Malhotra A, Maughan D, Ansell J, et al. Choosing Wisely in the UK: the Academy of Medical Royal Colleges' initiative to reduce the harms of too much medicine. *BMJ* 2015;350:h2308. (12 May.).

Cite this as: *BMJ* 2015;350:h3325

A TEST OF OUR HUMANITY

How Hong Kong helped Vietnamese refugees in 1979

I worked as a health officer in the midst of boatloads of refugees who started to come to Hong Kong in 1979, a few years after the reunification of Vietnam.[1] We had no choice but to accept them, making use of whatever space was available. The reason? Humanitarian. Clearly they needed help, and so did Hong Kong.

The then British prime minister, Margaret Thatcher, called an international meeting, urging Western countries to accept these refugees while Hong Kong remained the "first port of call." Our population of refugees swung from tens of thousands to peak at 100 000 and declined slowly only when countries like the US, Canada, and Australia started to resettle them. None of them wished to stay in Hong Kong for good. Most aspired to go to California or Florida. Some refugees turned down the offer of rescue by Scandinavian ships and waited for the US instead.

This problem lingered on until the 1980s, when we had to "absorb" those not granted immigrant status by the West into our local population. We did not turn anyone away until the Vietnamese government agreed to help the refugees economically. After tackling this problem at source, the tide of refugees gradually waned. The slow resettlement of the existing refugees by the major recipient countries meant we were left with a substantial number (about 20 000) until the late 1980s. During these years, we provided housing, food, healthcare, and employment (during the earlier period) to the refugees.

I hope this account provides an example of how affluent and developed countries should help refugees.

Tze Wai Wong professor, School of Public Health and Primary Care, Chinese University of Hong Kong, Hong Kong twwong@cuhk.edu.hk

1 Ladher N. A test of our humanity [Editor's Choice]. *BMJ* 2015;350:h3031. (4 June.)

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WESTERN DEMOCRACIES AND REFUGEES

Silence of advanced nations on the refugee crisis is shameful

Indonesia and Malaysia have just announced the provision of assistance to 7000 desperately stranded migrants. The offer to provide temporary shelter before resettlement and repatriation needs to include resettlement to advanced economies, such as Australia, the US, and the UK. The silence of these nations, which have yet to offer substantial assistance, is shameful and should be condemned.[1]

Malaysia and Indonesia have rightly emphasised that the international community has a responsibility to help them deal with the crisis. That regional governments and commercial shipping companies have agreed to help pinpoint the locations of migrant boats and provide these boats with directions to landing points in Malaysia and Indonesia, or rescue them if necessary, has been lauded by the UN High Commissioner for Refugees as vital for saving lives.

We, in Australia, have much to learn from Indonesia and Malaysia's agreement to rescue and care for stranded migrants. Not only has this clarion call not been sounded in Australia, but our already errant moral compass has been cast further adrift with reduced financial assistance to Indonesia. This has been incited by strained diplomatic relations caused by Australia's "push back the boats" policy and its moral objections to the execution of two citizens on drug charges in Indonesia.

Politicians encourage voters to be motivated by self interest rather than any meaningful engagement with the social conscience that should shape people's response to the welfare of imperilled human beings. There is no room in that ambition for a humane and moral approach to lost souls at sea and the world at large. Duelling politicians tell us what they think we want to hear and tempt us with what we desire.

Joseph Ting physician, Mater Health Services, Brisbane, Australia jysting@uq.edu.au

1 Berger D, Abbasi K. Refugees: time for moral leadership from the Western democracies. *BMJ* 2015;350: h2907. (28 May.)

Cite this as: *BMJ* 2015;350:h3354

CO-LOCATING PRIMARY CARE WITH A&E

Evidence for co-locating

We at Greenbrook Healthcare were delighted that the recent Royal College of Emergency Medicine (RCEM) report recommends co-locating GP services with emergency departments, but we believe that the RCEM's view that 22% of patients can be managed by a primary care team to be a serious underestimate.[1] As a provider of four primary care led urgent care centres (UCCs) co-located at large emergency departments in London, we have found that 50-60% of all patients attending emergency departments can be safely managed by GPs and nurse practitioners in our centre.

Our experience suggests that using primary care trained clinicians to manage the primary care related problems that present to emergency departments allows our emergency medicine colleagues to focus on the more seriously ill patients.

The RCEM report states that many patients chose to go to the emergency department even though they were offered a same day appointment at their GP practice. This reflects our experience, and we believe that managing that 24/7 demand at the point of presentation (the UCC) using primary care clinicians is the safest and most efficient option.

As urgent care models evolve we urge commissioners to take the next step and explore combining GP out of hours base services with primary care led UCCs. This will reduce multiple access points to out of hours care, which are confusing for patients and are an inefficient use of the workforce.

We look forward to working with the RCEM, commissioners, and the Patients Association to develop models of urgent care that meet patients' needs, support the training requirements of staff, and ensure ongoing patient education on appropriate use of services within the limited financial resources available.

Sally J Johnson medical director, Greenbrook Healthcare, UK sallyjohnson3@nhs.net

1 Wise J. Report calls for co-location of primary care with A&E. *BMJ* 2015;350:h3011. (4 June.)

Cite this as: *BMJ* 2015;350:h3352