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Pressure ulcer resource guide

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TO THE EDITOR: Stacey, in his recent editorial on preventing pressure ulcers, stated that it is a major challenge to successfully implement guidelines in clinical practice and that a combination of strategies is required.[1] In this context, your readers may be interested in the new pressure ulcer resource guide, developed by the National Institute of Clinical Studies (NICS).[2] The resource guide provides health professionals and consumers with easy access to:

- the latest guidelines;
- literature reviews;
- health professional and consumer information resources;
- current Australian research activities, journal articles and papers; and
- links to a range of groups undertaking significant work in this area.

The guide was developed in consultation with leading experts and professional groups with a strong interest in the management of pressure ulcers in Australia.

This guide is an example of the efforts of NICS to help healthcare organisations and practitioners improve patient care by providing them with access to the best available evidence, proven strategies, tools and resources. The guide can be freely accessed from the NICS website www.nicsl.com.au (under "Quick Links").

1 Stacey MC. Preventing pressure ulcers [editorial]. *Med J Aust* 2004; 180: 316.
2 National Institute of Clinical Studies. Pressure ulcer resource guide. Available at: www.nicsl.com.au/knowledge_reports_detail.aspx?view=10 (accessed May 2004). ❑

Management of chronic low back pain

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TO THE EDITOR: Bogduk, in his recent clinical update on management of chronic low back pain, stated that "zygapophysial joint pain can be relieved by radiofrequency neurotomy (E2, E3), and techniques are emerging for treating sacroiliac joint pain and internal disc disruption (E2, E3, E4)".[1] (E2, E3 and E4 refer to the levels of evidence: E2 evidence is obtained from at least one properly designed randomised controlled trial; E3 from pseudorandomised controlled trials or comparative studies; and E4 from case series, either post-test or pre-test and post-test.)

I have two concerns about this statement. Both involve the fact that at least three systematic reviews (E1 level of evidence) have now been published on treatment of lumbar zygapophysial joint-mediated low back pain with radiofrequency procedures.[2-4] Together, these three reviews cast considerable doubt on Bogduk's claim about the role of radiofrequency neurotomy.

My first concern is that the earliest of those systematic reviews,[2] which came to a very different conclusion from that of Bogduk, was published in 2001, well before he submitted his clinical update to the Journal on 16 July 2003. Yet, he does not mention that review, even though he was obviously aware of it, as evidenced by his letter to the journal *Regional Anesthesia and Pain Medicine* expressing concern with the methods underpinning the review.[5] Even if Bogduk disagrees with the conclusions of that review, justification for excluding it from the evidence base of his recent clinical update seems warranted.

Secondly, two more recent systematic reviews[3,4] have come to conclusions very different from those of Bogduk on the role of radiofrequency neurotomy in treatment of lumbar zygapophysial joint pain.

The first of those two reviews, from the Cochrane Collaboration Back Review Group, concludes: "There is . . . conflicting evidence for its [radiofrequency denervation] effectiveness for lumbar zygapophysial joint pain. There is limited evidence suggesting that intradiscal radiofrequency may not be effective in relieving discogenic low back pain. Further high-quality randomized controlled trials are needed, with larger patient samples and data on long-term effects, for which current evidence is inconclusive."[3]

The second review concludes: "Current studies fail to give more than sparse evidence to support the use of interventional techniques [zygapophysial injections and radiofrequency denervation] in the treatment of lumbar zygapophysial joint-mediated low back pain. This review emphasizes the need for larger, prospective, randomized controlled trials with uniform inclusion and exclusion criteria, standardized treatment, uniform outcome measures and an adequate duration of follow-up period so that definitive recommendations for the treatment of lumbar zygapophysial joint-mediated pain can be made."[4]

In summary, authors who knowingly exclude important relevant evidence from clinical updates should at a minimum justify the exclusion of that evidence. Given the collective weight of recent relevant systematic reviews, considerable doubt now exists about the role of radiofrequency procedures in the treatment of lumbar zygapophysial joint pain.

1 Bogduk N. Management of chronic low back pain. *Med J Aust* 2004; 180: 79-83.
2 Geurts JW, van Wijk RM, Stolker RJ, Groen GJ. Efficacy of radiofrequency procedures for the treatment of spinal pain: a systematic review of randomized clinical trials. *Reg Anesth Pain Med* 2001; 26: 394-400.
3 Niemisto L, Kalso E, Malmivaara A, et al. Radiofrequency denervation for neck and back pain: a systematic review within the framework of the cochrane collaboration back review group. *Spine* 2003; 28: 1877-1888.
4 Slipman CW, Bhat AL, Gilchrist RV, et al. A critical review of the evidence for the use of zygapophysial injections and radiofrequency denervation in the treatment of low back pain. *Spine J* 2003; 3: 310-316.
5 Bogduk N. In defense of radiofrequency neurotomy [letter]. *Reg Anesth Pain Med* 2002; 27: 439-440. ❑

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IN REPLY: Although systematic reviews have identified three studies of lumbar radiofrequency neurotomy, they do not take into account technical errors in the procedure. Neither the study of Gallagher et al[1] nor that of Leclaire et al[2] used techniques that could coagulate the target nerves accurately, consistently, and thoroughly.[3] Therefore, these studies are not a measure of the efficacy of the procedure when performed correctly and have no place in a systematic review. Nor are systematic reviews permitted to include complementary, observational studies like that of Dreyfuss et al.[4] Yet, this study sets the benchmark for what outcomes can be achieved, if and when correct techniques are used.

The "conflicting" evidence reported by systematic reviews arises because inaccurate surgical techniques are used. When studies using inaccurate techniques are eliminated, there is no conflict. The literature reduces to one controlled study[5] and one complementary study.[4] These were the studies that I cited in the clinical update on chronic low back pain.[6] In the face of that literature, the conclusion that I proffered, and which Wen-

ban has quoted, is valid. Zygapophysial joint pain can be relieved by radiofrequency neurotomy. Perhaps the extra words that are required are *provided that correct techniques are used.*

1 Gallagher J, Petriccione di Valdo PL, Wedley JR, et al. Radiofrequency facet joint denervation in the treatment of low back pain: a prospective controlled double-blind study to assess its efficacy. *Pain Clin* 1994; 7: 193-198.
2 Leclaire R, Fortin L, Lambert R, et al. Radiofrequency facet joint denervation in the treatment of low back pain. A placebo-controlled clinical trial to assess efficacy. *Spine* 2001; 26: 1411-1416.
3 Lau P, Mercer S, Govind J, Bogduk N. The surgical anatomy of lumbar medial branch neurotomy (facet denervation). *Pain Med* 2004. In press.
4 Dreyfuss P, Halbrook B, Pauza K, et al. Efficacy and validity of radiofrequency neurotomy for chronic lumbar zygapophysial joint pain. *Spine* 2000; 25: 1270-1277.
5 van Kleef M, Barendse GAM, Kessels A, et al. Randomized trial of radiofrequency lumbar facet denervation for chronic low back pain. *Spine* 1999; 24: 1937-1942.
6 Bogduk N. Management of chronic low back pain. *Med J Aust* 2004; 180: 79-83. ❑

Metformin and serious adverse effects

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TO THE EDITOR: I refer to the recent editorial on "Metformin and serious adverse effects".[1]

I would like to highlight the position of the Royal Australian and New Zealand College of Radiologists (RANZCR) on the use of metformin hydrochloride when administering intravascular contrast media. The RANZCR has adopted an evidence-based approach in formulating its guidelines. The College guidelines on metformin hydrochloride and intravascular contrast media are available at <www.ranzcr.edu.au/open/policies/diagnostic_imaging/pol1_2.htm>.

The current guideline is that there is no need for patients to stop taking metformin hydrochloride for 24–48 hours before administration of an intravascular contrast medium. Stopping or continuing to take metformin depends on the patient's renal status, and the likelihood of inducing renal dysfunction when intravascular contrast is administered. If discontinuation is required, then the drug only needs to be stopped for 48 hours, commencing on the day of administration of intravascular contrast.

1 Nisbet JC, Sturtevant JM, Prins JB. Metformin and serious adverse effects [editorial]. *Med J Aust* 2004; 180: 53-54. ❑

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IN REPLY: Chong's letter highlights some important issues, and his points are well made. As we imply in our editorial,[1] the evidence base on which to base guidelines and decisions is poor, which is one of the reasons that the guidelines differ widely between countries and organisations. Specialty-specific guidelines must also take into account practicalities. We elected to follow the more conservative end of the guideline spectrum in our suggestions, accepting that, in many circumstances, these would be difficult or impossible to follow. From a radiological perspective, it would require a significant change in practice to implement guidelines such as those we suggested, and the evidence base supporting such a change does not exist.

Metformin is a short-acting drug and stopping it at the time of a potentially hazardous procedure will almost always be effective in preventing drug-related complications. Overall, the aim of our article was to raise awareness of the potential hazards of metformin use, and to encourage practitioners to follow available and relevant guidelines.

1 Nisbet JC, Sturtevant JM, Prins JB. Metformin and serious adverse effects [editorial]. *Med J Aust* 2004; 180: 53-54. ❑

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