the common diagnosis of lumbar degenerative disc disease the increasingly prevalent treatment of spinal fusion has indications which are unclear^{7,8}. The economic impact of low back pain is growing and “grave”⁹. We need more than a truce with the chiropractors; we need an alliance. If our collective resources were focused on educating the public, government, medical community, and third-party payers about the benefits of manual and mechanical treatments, then there would be more than enough patients for both professions. In the US, where the healthcare system is generally agreed upon as broken, manual and manipulative treatments are underutilized and undervalued. This is to the detriment of Americans and our economy. It is the mutual ethical responsibility of the physical therapy and chiropractic professions to reframe our adversarial relationship into one of mutual respect and collaboration.

W. Bryant Miller, PT, DSc, OCS, CMPT, FAAOMPT
516 Tremont Street
Chattanooga, TN 37405
Email: integrativerehabilitation@att.net

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LETTER TO THE EDITOR

Low Back Pain and Myofascial Trigger Points

This letter is concerning the article in Vol. 15#2 starting on page 111 by Pinto et al on “Management of Low Back Pain.” Their discussion started with the statement, “The origin of low back pain (LBP) is difficult to establish.” That is so true if you do as they did and base thinking only on symptoms with no regard or concern for the literature that clearly identifies its treatable cause, i.e., myofascial trigger points. I am referring here to the clear and rather complete presentation of the cause of LBP on pages 804–809 of the 1999 edition of the *Trigger Point Manual*¹ and the seven references of published articles provided below^{2–8} that describe its successful treatment by addressing skillfully the myofascial trigger point cause of the pain and dysfunction. Patients deserve and need to be examined for myofascial trigger points that are common and likely to be causing their LBP. How to identify those muscles and treat them is fully explained in the *Trigger Point Manuals*, volume 1 & 2^{1,9}.

David G. Simons, MD
Clinical Professor Rehabilitation Medicine, Emory University, Atlanta, GA
Adjunct Professor, School of Health Professions, Division of Physical Therapy, College
of Health and Human Sciences of Georgia State University, Atlanta, GA
loisanddavesimons@earthlink.net

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Authors' Response to Dr. Simons

We would like to thank Dr. Simons for his letter to the editor on our case series titled “Management of low back pain: A case series illustrating the pragmatic combination of treatment- and mechanism-based classification systems”. Recent literature has clearly identified the importance of classifying patients with low back pain (LBP) into subgroups^{1,2}. Classification provides a means of breaking down a larger entity into more homogenous subgroups of patients based on examination data³. The most common methods of classifying patients with musculoskeletal conditions are based on identifying the underlying pathology causing the condition⁴, however the pathology underlying the complaints of LBP is often difficult to identify⁵. Even if identified, the pathology is often of limited usefulness in selecting the most beneficial interventions⁶. Moreover, classification is most helpful for physical therapists when it is based on signs and symptoms that match interventions to the subgroup of patients most likely to benefit from them (i.e. treatment-based classification)^{7,8}. The goal of treatment-based classification is to improve decision-making in the determination of an individual patient's diagnosis, prognosis, and intervention strategy.

Dr. Simons seems to ignore the importance of sub-grouping patients when he states that myofascial trigger points are the “treatable cause” of LBP. We disagree with this as it has been reported that in 90% of patients with LBP a patho-anatomical cause cannot be identified⁵. Additionally, reviewing the references that Dr. Simons provided it appears that Kovacs et al⁶ also contradict Dr. Simons with the following statement, “Low back pain often is believed to be the result of degenerative disk syndrome, protrusion of intervertebral disks, strains, sprains, and other disorders associated with the position or movement of the spine, such as those caused by scoliosis or spondylolisthesis. In most cases, however, it is not possible to establish an organic cause.” In another reference provided by Dr. Simons we find that the first randomized controlled trial performed to evaluate the effectiveness of myofascial therapy clearly demonstrated that no significant differences existed for pain or activity between patients receiving myofascial therapy, joint manipulation, and back school in the management of sub-acute LBP¹⁰. We would argue that the lack of statistical significance may have been related to the failure of the authors to classify patients to receive interventions from which they are most likely to benefit. Nonetheless this provides no data to support the use of incorporating the treatment of myofascial trigger points into the management of LBP.

In our case series therapists categorized patients into subgroups and then delivered interventions that provided patients with the highest likelihood of recovery. In addition to the utilization of a treatment-based classification therapists also treated individual impairments. At this point in our case series it would have been appropriate for the clinicians to treat trigger points that they found, however none of the clinicians chose to do so. Despite not treating any trigger points, our patients' exhibited clinically meaningful improvements in all outcomes. Additionally, a number of trials^{1,2, 8,11-14} demonstrating the effectiveness of conservative interventions for the management of LBP have shown statistically significant improvements in pain and disability despite none of the patients receiving any treatments directed at myofascial trigger points. We agree with Dr. Simons that his textbook provides a detailed description on how to treat myofascial trigger points. However, the aforementioned references challenge the need to do so.

We have found little support for the use of soft tissue mobilization and treatment of trigger points in the (sub) acute LBP population^{15,16}. Within the limitations imposed by current best evidence for the (sub) acute LBP population it is our opinion that if clinicians choose to incorporate any soft tissue or trigger point techniques that these should be used within the context of a treatment-based classification system that is supported in the literature.

Daniel Pinto, PT, OCS

Joshua Cleland, PT, PhD, OCS, FAAOMPT