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REVIEWER'S COMMENT

This study confirms that the anatomical pattern of pain on a pain drawing corresponds reasonably well to reproduction of pain on discography and the diagnosis of a prolapsed disc on myelography. That is quite separate from the issue of psychological distress as measured by the Ransford score. It is important to emphasise that the underlying physical pathology and the patient's psychological state are quite separate issues. An individual patient may have both a discrete physical pathology and also varying degrees of emotional reaction. Physical pathology and psychological distress are not mutually exclusive but are different aspects of the illness. So the pain drawing, as any other aspect of the patient's clinical presentation, may provide information *both* about the patient's physical problem and about their psychological state.

The findings about the adjectives that patients use to describe their pain are much more tentative, and descriptions of aching and burning are only weakly related to a particular diagnosis. I would caution against attempts to diagnose pathology from such descriptions of the pain. That is likely to be unreliable and misleading.

We must remember that the pain drawing is only a screening test. It only gives the first crude hint of the anatomical pattern of the pain and the patient's reaction to the pain. Diagnosis of underlying pathology still depends on a detailed clinical history and examination, supplemented if necessary by appropriate investigations. Most patients with a high Ransford score on the pain drawing are distressed but up to 50% of distressed patients do not display this on a pain drawing, so there are many false negatives. We must remain alert to other signals of distress and illness behaviour. In conclusion, the pain drawing is a useful first step but it is no substitute for a thorough clinical assessment.

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