

ROYAL COLLEGE OF ANAESTHETISTS

FACULTY OF PAIN MEDICINE

Technology Assessment Report commissioned by the NHS R&D HTA Programme on behalf of the National Institute for Health and Clinical Excellence: Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin

Response to NICE provisional recommendations by the Faculty of Pain Medicine, Royal College of Anaesthetists

The Faculty of Pain Medicine, Royal College of Anaesthetists is responsible for training, assessment, professional standards and continued professional development of specialist medical practitioners involved in the treatment of pain in the UK. It supports a multidisciplinary approach to pain services and research into improving treatments. The Faculty's response to the provisional recommendations is submitted in this context.

Thank you for the opportunity to comment on the above report. Our comments are listed below; we have serious concerns about some aspects of the recommendations, the emphasis of which seem to have changed compared with the last version.

Specific recommendations

This guidance provides recommendations for the use of spinal cord stimulation for the following chronic pain conditions: failed back surgery syndrome, complex regional pain syndrome, critical limb ischaemia and refractory angina.

Response:

We believe that it is absolutely essential that you make it clear that we are dealing with neuropathic pain after back surgery (see below). Strongly suggest inserting “neuropathic pain in” before “failed back surgery syndrome”.

1.1 Spinal cord stimulation is recommended as a treatment option for adults with failed back surgery syndrome who continue to experience chronic pain (measuring at least 50 mm on a 0–100 mm visual analogue scale) for at least 6 months after surgery despite adequate standard care, and who have had a successful trial of stimulation (as defined in recommendation 1.4).

Response:

Inclusion of unqualified “failed back surgery syndrome” is an unjustified extension that is not supported by the evidence. We very strongly believe you should go back to your original remit i.e. neuropathic pain after back surgery – there is only an evidence-base for this. Our views on this are such that the Faculty would not be happy to be seen to endorse this recommendation if it stands unchanged.

1.2 Spinal cord stimulation is not recommended as a treatment option for adults with complex regional pain syndrome, critical limb ischaemia or refractory angina except in the context of research as part of a clinical trial. Such research should be designed to generate robust evidence about the durability of the benefits of spinal cord stimulation (including pain relief and quality of life) compared with conventional medical management.

We agree with this but possibly it is rather too limiting. Perhaps you could say “in the context of research as part of a clinical trial or a nationally co-ordinated audit.”

1.3 Spinal cord stimulation should be provided only after an assessment by a multidisciplinary team skilled in chronic pain assessment and management.

Response:

We agree with this. Perhaps the recommendation could be made more clear if you said: “Spinal cord stimulation should be provided only after an assessment by a multidisciplinary team skilled in chronic pain assessment and management, including all conservative therapies and psychological methods.”

1.4 For the purposes of this guidance, a trial is defined as successful if the person can tolerate the spinal cord stimulation device and stimulation sensation, and their pain is relieved (a minimum of 80% of painful areas covered and a minimum of 50% pain relief achieved in that area).

Response:

We agree that trialling in all its forms is accepted clinical practice. However, we believe that insisting on external trials is too prescriptive and not supported by robust evidence.

1.5 When assessing the severity of pain and the trial of spinal cord stimulation, the multidisciplinary team should be aware of the need to ensure equality of access to the treatment. Tests to assess a trial of spinal cord stimulation should take into account a person’s disabilities (such as physical impairments), or linguistic or other communication difficulties, and may need to be adapted.

Response:

We agree with this.

1.6 If different spinal cord stimulation systems are considered to be equally suitable for a person, the least costly should be used. Assessment of cost should take into account acquisition costs for the lifetime of the device, including anticipated neurostimulator longevity, the stimulation requirements of the person with chronic pain and the support package offered.

Response:

We agree with this.

Important omission in recommendations

The evidence-base underlying your recommendations arises from studies where there was a team available to advise the patients and deal with any problems on a 24-hour basis. If this is not present, then your recommendations are invalid and potentially harmful. Therefore, we strongly believe that you should recommend that a back-up service must be available to all patients receiving this device; without this, there is a danger that single handed practitioners with no commitment to backup and support will insert the devices, thereby endangering patients and wasting resources.

We feel very strong about this; we would not be happy to be seen to endorse these recommendations if this point was not included in the final guidance.

Many thanks again for the opportunity to provide input to these provisional recommendations. Please don't hesitate to contact the Faculty if you require any further information or clarification.

Submitted by [REDACTED]

On behalf of the Faculty of Pain Medicine Royal College of Anaesthetists

Email: [REDACTED] July 4, 2008