<table>
<thead>
<tr>
<th>Severity group movement</th>
<th>No Change</th>
<th>74.4%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved</td>
<td>22.6%</td>
</tr>
<tr>
<td></td>
<td>Worsened</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Using the categories set out by Gatchel et al (2009) which remain the only published means of interpreting PDQ scores clinically we have a NNT of 3.3 and a Number Needed to Harm (NNH) of 40.

My feeling is that we have a lot of patients who initially engage with our service who never accept absolutely the chronicity of their pain problem and who as a result have perceived unmet needs and re-engage with the medical model. I would like to audit our results and determine what factors distinguish responders and non-responders. Plainly the size of the data set available and the high non-responder rate significantly compromise results. What the results do provide is an objective baseline measure which we can use to assess any future change to treatment approach or service delivery.

Editorial Note

It remains a problem that baseline results from units such as this have almost no outlet that makes them available for comparative analysis, a process that should be seen as constructive but appears to strike fear into the hearts of staff and managers. Of course a total lack of standardisation in clinical outcome measurement tools employed between departments further complicates this issue. Finally political issues now affecting the entire NHS mean that the sharing of information is often seen as a risk in case it is used by rival departments further complicates this issue. Finally political issues not only affecting the entire NHS mean that the sharing of information is often seen as a risk in case it is used by rival organisations in future Tender Bids. Can I thank Steven for being visionary enough to share results and for being willing to go through the process of gaining permission to do so.


specific lower limb symptoms and decreased mobility. The authors highlighted that these three items were not on any internationally recognised list of red flags. This body of work highlights the lack of consensus between clinical practice, research and clinical guidelines.

A further barrier to developing a standard screening tool is the lack of clear instructions to provide to clinicians after they have screened the patient. For example, how many positive responses to red flag questions are required to warrant referral for medical screening? Is one red flag enough or should a cluster of positive responses be required for medical referral? Additionally, are some red flags more important than others? Is Bladder dysfunction more important than a history or cancer? Or should we be referring all patients over the age of 50 for medical screening?

In this article I have attached a copy of a Red Flags Questionnaire I have developed from a non-systematic search of the literature (See Table 1). The questionnaire is something I routinely use in clinical practice. I have found it beneficial for two reasons. Firstly, as a screening tool and to facilitate the appropriate documentation of red flags. Secondly, as a psychological intervention to reduce patient anxiety that their pain is due to a serious spinal pathology. The majority of patients I see will complete the questionnaire and answer negatively to all 14 Red Flag questions included. I usually ask the patient the question and then circle yes/no as appropriate. Afterwards I provide visual feedback of the form with 14 negative responses. I discuss the questionnaire with patients and tell them that this indicates that the chance of their back pain being due to a serious or sinister condition is minimal and that they have what most people have – simple mechanical/ non-specific low back pain. Anecdotally patients report that this is good to hear and give the indication that they find it quite relieving.

The questionnaire attached is written in such a way as the patients could fill it out themselves if required using simple language (avoiding words like saddle anaesthesia) and a personalised writing style e.g. is your pain. However, it could be argued that the language is still relatively complex and I would be interested in hearing suggestions on how it could be simplified. There are a number of potential red flags I have not added e.g. failure to improve after one month. I have not added this as a question because I think there is a reasonable body of evidence that many episodes of back pain last longer than one month (Van Den Hoogen 1998; Hestbaek et al. 2003). Thus it would be quite likely that the majority of patients seen clinically would answer yes to this question, which may unnecessarily worry patients that they have a serious sinister pathology. This could negate the potential positive psychological effects of the reassuring message of 14 negative responses.

How to interpret the red flag questionnaire below is quite controversial. I will report here how I use it but I would stipulate that this is just my personal clinical opinion rather than information based upon research evidence. Many of the patients I see are over 50 years of age thus if this is their only positive red flag (Question 2) I note that it should be monitored but I reassure the patient that it is a minor finding. Indeed it is questionable as to whether this age criterion is a red flag in isolation. If any of the questions particularly relating to Cancer (Questions 3, 4, 6, 10, 11, 12, 13, and 14) are positive, I would refer the patient to their GP within the coming week if possible, the speed of referral being partly to reduce any anxieties the patient may have, but also of course if cancer is present that it be identified and dealt with promptly. If any of the questions directly related to Cauda Equina Syndrome are positive (Questions 8 & 9) I would immediately advise the patient to go to A&E considering that it is recommended that decompression surgery be undertaken, within 48 hours of onset (Ahn et al. 2000). For the remaining questions I would tend to simply monitor and if the patient did not improve with treatment but had one of more of these red flags I would then refer them to their GP for medical screening. For some questions I would ask additional supplementary questions if the patient responded positively. For example, if the patient responded yes to Q9 (bladder/ bowel issues) it would be important to identify if any incontinence issue was more likely to be related to stress incontinence rather than a serious or sinister pathology.

The most important thing to remember is that this questionnaire should not be used in isolation. Clinical Judgment is one of the most important elements in the identification of potential serious pathology (Henschke et al. 2007) and clinicians should be primarily guided by their judgement rather than simply acting upon the findings of the questionnaire. Additionally, of course, clinicians should also adhere/consider any locally developed polices and pathways that exist.

A key purpose of publishing this questionnaire is to ask for clinician’s feedback on it. Are there any questions that clinicians would suggest adding or removing? Or would anyone act upon the information in a different manner to what I have suggested. I would like to know if any departments use a similar questionnaire. If they do not and wish to use the attached questionnaire, or they do but want to start using the attached questionnaire instead, I would be happy for them to do so but I would appreciate if they could let me know that they are using it and whether they find it useful or not. Overall, I hope that this short paper sparks some interest in Red Flags, not just from a screening perspective but also from an intervention and reassurance perspective.

Acknowledgments
I would like to thank Fraser Ferguson for providing comments on the initial draft of this article.

References
to lumbar disc herniation. SPINE, Vol. 25: 1515-1522.


Table 1: Red Flags Questionnaire

To the best of your ability, please answer yes or no to the following questions. If there are any questions, which you are unsure about, please ask your physiotherapist during the consultation.

NAME_____________________ DOB _____________

1. Is your back pain the result of minor or major trauma, for example, a road traffic accident, a fall, or a strenuous lifting activity? Yes / No
2. Are you 50 years of age or older? Yes / No
3. Do you have a history of any type of cancer? Yes / No
4. Have you experienced any unexplained weight loss (>10 pounds in three months) not directly related to a change in activity or diet? Yes / No
5. Do you have a “band like” pain radiating into your chest or abdomen? Yes / No
6. Is your pain worse when you lie down? Yes / No
7. Does your pain keep you awake at night unrelated to movement or positioning? Yes / No

PPA Chairs Report for AGM 2011

The last twelve months has seen the PPA strengthen its position on a number of fronts through the hard work of the Executive Committees guided by constructive feedback from the membership. Reports from the Honorary Officers clearly and succinctly outline the progress both achieved and planned. At this point I am constitutionally obliged to remind the Executive and the Membership that I enter my final year of the three year term of office.