Is a videotape to change beliefs and behavior superior to a standard videotype in acute low back pain? A randomized controlled trial

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***Morbidity:*** Acute low back pain

***Type of study***: prospective RCT

***Interventions:*** Videotape designed to change beliefs and behaviors, standard videotape

***Outcomes***: Oswestry Disability Index, Pain and Impairment Relationship Scale, Fear-Avoidance Beliefs Questionnaire, medical costs related to LBP and total medical costs incurred over 1-year of follow-up

***Cohort***: 138 subjects

***Inclusion***: 18-70 years with acute LBP defined as maximal pain between L1 and the gluteal folds lasting for < 3 months.

***Exclusion***: Current malignancy, osteoporosis, a spondyloarthropathy, previous lumbar surgery, a neurologic deficit on examination suggestive to nerve root compression or cauda equine syndrome, systematic disease causing LBP, pregnancy, multiple musculoskeletal problems, no access to videocassette recorder.

***Overall Evaluation:***

This may not meet the evidence for criteria. The participation rate was low with a 38 percent of subjects not completing the initial questionnaire and another 19 percent dropping out by the end of the 1- year study period. Assessors and analysts were not blinded. The study may not be sufficiently powered to detect clinically important differences in outcomes.

May not meet criteria for evidence.

Green: 8/27

Yellow: 7 /27

Red: 7/27

Not Applicable: 5 /27

**EW: Non-participation is high for both groups; a null result for the comparison does not constitute evidence for or against the comparison.**

**Inadequate for evidence, but adequate for a general information statement that giving a video is no sufficient for patient education.**

| **Criterion**  | **Green** | **Yellow** | **Red** | **Comments** |
| --- | --- | --- | --- | --- |
| Randomization | X |  |  |  |
| Concealment of allocation |  |  | X | Not addressed |
| Participant recruitment and eligibility  | X |  |  | Patients presenting to institutional centers of origin |
|  Blinding of patients and caregivers |  | X |  | Caregivers blinded, patients not aware of contents of other video  |
| Blinding of assessors of outcome and of data analysts  |  |  | X | Assessors not blinded |
| Blinding success |  |  | X | Not discussed |
| Participant follow-up | X |  |  | Figure 1 |
| Length of follow-up | X |  |  | Followed for one year |
| Baseline comparison |  | X |  | Demographic data and other co-variable data not presented. |
| Primary outcome  |  | X |  | Primary outcome not specified |
| Analysis of results  |  |  | X | Not addressed |
| Adverse effects |  |  | X | Not addressed |
| Attrition |  | X |  | 19% loss |
| Co-interventions (performance bias) | X |  |  | Through a questionnaire |
| Presentation of outcome data | X |  |  |  |
| Sample size and precision of results |  | X |  | Not discussed, study may not be sufficiently powered to observe clinically significant differences. For example, study is powered to see a 8.9 difference for Oswestry Disability Index and 10.45 difference for Fear-avoidance beliefs. |
| Description of interventions | X |  |  |  |
| Psychosocial variables |  |  | X |  |
| Dose-response relationships |  |  |  | NA |
| Sponsorship and funding |  | X |  | Not fully disclosed. |
| Protocol availability  |  |  | X | Not available |
| Baseline symptoms | X |  |  |  |
| Crossover trials |  |  |  | NA |
| For nonrandomized cohort studies with accurate measurement of treatment and outcome, and adjustment for measured confounders, a large treatment effect is observed  |  |  |  | NA |
| For nonrandomized cohort studies, there is a clear dose-response gradient, especially if there is a rapid response to treatment  |  |  |  | NA |
| For nonrandomized studies, adjustment for plausible confounders are expected to increase confidence in the treatment effect  |  |  |  | NA |
| Medical and biological plausibility and coherency |  | X |  |  |