



Egregious Error: A “Narrative Opinion” Published as a “Clinical Practice Guideline”

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Dear Editor,

The recent guideline by Busse et al. advocating against interventional procedures for chronic spine pain suffers from critical methodological and analytical flaws that undermine its conclusions. (1)

1. Statistical Limitations

The entire body of work is based on a meta-analysis by Wang et al., which pooled **81 trials** with a **median sample size of 64 participants**—a cohort prone to **Type II errors** due to inadequate statistical power. (2) The authors acknowledge that **unblinded trials** reported significantly larger effect sizes (**-1.74 vs. -0.23 cm pain reduction, P = 0.005**) but still included these biased studies in primary analyses. This inflated **heterogeneity**, distorted effect estimates, and violated **PRISMA-NMA** standards. Furthermore, the **GRADE framework** was applied inconsistently, disproportionately downgrading certainty for interventional studies while maintaining equipoise for sham controls—a clear **double standard** that artificially favors null hypotheses.

2. Methodological Bias

The panel’s composition raises concerns regarding **specialty bias**, as it lacks sufficient representation from interventional pain specialists or procedural experts. The **lead author is a chiropractor**, the **second author a rheumatologist**, the **third a resident in internal medicine**, and the **last author specializes in health policy**. This composition likely undervalues the procedural nuances of interventional pain management. Similar specialty-driven biases have been documented in previous reviews, where different specialties evaluating the same data have reached **opposing conclusions**. (3)

Moreover, the guideline dismisses **clinically meaningful pain relief thresholds** (e.g., **≥2 cm on the VAS scale**) by redefining modest improvements as “little to no effect,” despite these values meeting **FDA benchmarks for minimally important differences** in chronic pain trials. This reframing minimizes **clinically significant benefits**.

3. Misleading Risk Assessment

The complication rates cited (e.g., **0.7% deep infection**) are derived from **low-certainty observational data**, while **catastrophic complications** like paraplegia were sourced from **case reports lacking denominator context**. By overemphasizing **rare harms** while downplaying the **well-documented**

risks of opioid alternatives, this guideline presents a **skewed risk-benefit analysis** that contradicts real-world clinical outcomes.

4. Restrictive and Flawed Recommendations

By issuing **strong recommendations** against interventional procedures based on **low-to-moderate certainty evidence**, the guideline effectively **denies patients access** to therapies that may benefit specific subgroups, particularly **those refractory to pharmacotherapy**. This **absolutist approach** is inconsistent with **JAMA Guidelines Trust criteria**, which advise **conditional recommendations** when evidence remains uncertain.

Additionally, we strongly oppose the **misinterpretation** of our **2022 American Society of Pain & Neuroscience (ASPN) guidelines** in the article. (4) The authors aggressively position their work as “trustworthy” while subtly discrediting opposing guidelines, revealing an **underlying agenda-driven purpose** rather than an objective scientific review.

5. BMJ's Role and the Need for Retraction

It is surprising that this article met **BMJ's rigorous acceptance criteria**, given its **methodological flaws** and lack of robust **biostatistical analysis**. At best, this publication represents a “**narrative opinion**” rather than an evidence-based **clinical practice guideline**.

The **BMJ editorial leadership** bears **immense responsibility** for ensuring that published content maintains **scientific integrity**. Disseminating **low-quality research** may have **far-reaching consequences**, including **restricting insurance coverage** for **non-opioid, evidence-based pain treatments**. In the midst of the **opioid epidemic**, such **misguided guidelines** may lead to **patient harm and medicolegal challenges**.

Conclusion

The **statistical errors, specialty bias, and unbalanced harms assessment** within this guideline **perpetuate the very inconsistencies** it claims to address. In the interest of **scientific integrity**, we respectfully urge **BMJ's editorial team** to **retract this article** and restore its legacy as a **trusted source of evidence-based medicine**. (5)

References

1. **Busse JW, Genevay S, Agarwal A, et al.** Commonly used interventional procedures for non-cancer chronic spine pain: a clinical practice guideline. *BMJ*. 2025;388:e079970. doi: 10.1136/bmj-2024-079970.
2. **Wang X, Martin G, Sadeghirad B, et al.** Common interventional procedures for chronic non-cancer spine pain: a systematic review and network meta-analysis of randomised trials. *BMJ*. 2025;388.
3. **Cohen SP, Bicket MC, Jamison D, et al.** Epidural steroids: a comprehensive, evidence-based review. *Reg Anesth Pain Med*. 2013;38(3):175-200.
4. **Sayed D, Grider J, Strand N, et al.** The American Society of Pain and Neuroscience (ASPN) evidence-based clinical guideline of interventional treatments for low back pain. *J Pain Res*. 2022:3729-3832.

5. **BMJ Group.** Journal retracts six further articles and corrects two others authored by former editor. Available at: <https://bmigroup.com/journal-retracts-6-further-articles-and-corrects-2-others-authored-by-former-editor>.