

## Composition of Canadian Pain Society guideline development group?

The review of the Canadian Pain Society consensus statement on the pharmacologic management of chronic neuropathic pain in the November 2017 issue of *Canadian Family Physician*<sup>1</sup> does a good job of summarizing the recommendations in the guidelines.<sup>2</sup> However, aside from a statement that the Neuropathic Pain Special Interest Group of the Canadian Pain Society “is a multidisciplinary group of individuals with research and clinical expertise relevant to the pathophysiology and management of NeP [neuropathic pain],”<sup>1</sup> the review is silent about the composition of the committee that drafted the guidelines. This omission is important because the committee’s composition was contrary to at least 4 of the recommendations from the Institute of Medicine (IOM) in its 2011 report on the creation of guidelines.<sup>3</sup>

The IOM recommended that members with conflicts of interest (COIs) should represent not more than a minority of the guideline development group (GDG), whereas 13 of the 18 committee members had financial COIs with various pharmaceutical companies. The IOM recommended that the chair should not be a person with COIs. Dr Dwight Moulin, who is the first author of the guidelines, and presumably the committee chair, reported COIs with 5 pharmaceutical companies. The IOM recommended that the GDG should include a current or former patient, and a patient advocate or representative from a patient or consumer organization, but none appear to have been involved in the creation of this guideline. Finally, the IOM recommended that the GDG should be multidisciplinary and balanced, comprising methodologic experts and clinicians, but the committee appears not to have included any methodologic experts.

The importance of the points about COIs and methodologic experts are apparent in a study of clinical guidelines for the treatment of mild depression within the diagnostic category of major depressive disorder.<sup>4</sup> (I was one of the authors of this study.) Meta-analyses, re-analyses of antidepressant clinical trial data, and narrative reviews<sup>5-7</sup> have all explicitly concluded that because of the risk-benefit profile, antidepressants should not be used as a first-line intervention for mild depression. Four of 5 guidelines that recommended antidepressants as a first-line intervention for mild depression met the IOM’s criteria for financial COIs, compared with only 3 of 9 that did not recommend antidepressants as a first-line treatment. Similarly, none of the GDGs that recommended antidepressants had a methodologist or research analyst involved, whereas 7 of 9 that did not recommend antidepressants had a methodologist involved.

It is not just the content of guidelines that is important; equally important is how guidelines are created.

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### Competing interests

From 2015 to 2017 Dr Lexchin received payment from 2 non-profit organizations for being a consultant on a project looking at indication-based prescribing and on a second project looking at which drugs should be distributed free of charge by general practitioners. In 2015 he received payment from a for-profit organization for being on a panel that discussed expanding drug insurance in Canada. He is a member of the Foundation Board of Health Action International.

### References

- Mu A, Weinberg E, Moulin DE, Clarke H. Pharmacologic management of chronic neuropathic pain. Review of the Canadian Pain Society consensus statement. *Can Fam Physician* 2017;63:844-52.
- Moulin D, Boulanger A, Clark AJ, Clarke H, Dao T, Finley GA, et al. Pharmacological management of chronic neuropathic pain: revised consensus statement from the Canadian Pain Society. *Pain Res Manag* 2014;19(6):328-35.
- Institute of Medicine. *Clinical practice guidelines we can trust*. Washington, DC: National Academy of Sciences; 2011.
- Cosgrove L, Shaughnessy AF, Peters SM, Lexchin JR, Bursztajn H, Bero L. Conflicts of interest and the presence of methodologists on guideline development panels: a cross-sectional study of clinical practice guidelines for major depressive disorder. *Psychother Psychosom* 2017;86(3):168-70. Epub 2017 May 11.
- Fournier JC, DeRubeis RJ, Hollon SD, Dimidjian S, Amsterdam JD, Shelton RC, et al. Antidepressant drug effects and depression severity: a patient-level meta-analysis. *JAMA* 2010;303(1):47-53.
- Le Noury J, Nardo JM, Healy D, Jureidini J, Raven M, Tufanaru C, et al. Restoring study 329: efficacy and harms of paroxetine and imipramine in treatment of major depression in adolescence. *BMJ* 2015;351:h4320.
- Baumeister H. Inappropriate prescriptions of antidepressant drugs in patients with subthreshold to mild depression: time for the evidence to become practice. *J Affect Disord* 2012;139(3):240-3. Epub 2011 Jun 8.

## Estimating cancer risk from radiation

I appreciate Dr Vakil’s helpful summary of the attendant risks of radiologic imaging in the October issue of *Canadian Family Physician*.<sup>1</sup> Given the difficulty of determining the absolute risk of a given procedure from the radiation exposure alone, I usually find it helpful to use a calculator that takes into account a patient’s age and sex in addition to his or her radiation exposure. In this manner, it is possible to estimate a baseline cancer risk for a given patient, as well as the additional risk that might be expected from an x-ray or computed tomography scan. For example, using the calculator at X-RayRisk.com ([www.xrayrisk.com/calculator/calculator.php](http://www.xrayrisk.com/calculator/calculator.php)), I can estimate that a 50-year-old male patient who is considering a computed tomography scan of the abdomen can expect his future probability of cancer to increase by 0.04%. This translates into a number needed to harm of 2472.

When considering that the additional cancer risk posed by a radiologic procedure is likely to only manifest many years in the future, without a clear causal link to the inciting event, the individual patient might be more likely to undergo a necessary imaging test if they know the absolute numbers involved.

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### Competing interests

None declared

### Reference

- Vakil C. Radiation and medical procedures. How do we do no harm? *Can Fam Physician* 2017;63:774-5.

## Correction

In the article “First Nations hepatitis C virus infections. Six-year retrospective study of on-reserve rates of