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LETTER TO THE EDITOR

Letter to the editor on: Hanna B. Albert, Eva Hauge, Claus Manniche (2011) Centralization in patients with sciatica: are pain responses to repeated movement and positioning associated with outcome or types of disc lesions? Eur Spine J. doi:10.1007/s00586-011-2018-9

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I like to provide some clarifying thoughts on the interesting work of Albert et al. [1].

The main statements of the study are:

1. *If leg pain in radiculopathy patients can be changed during a clinical examination, these patients have a better prognosis than the ones whose distal pain cannot be changed—no matter whether the pain gets better or worse.*

At first glance, this conclusion seems to turn the "exceptional prognostic position" of the centralization phenomenon on its head. But if you are looking at this aspect closely, it can be put into perspective. Only 11 of 176 of the analyzed patients had been initially categorized as peripheralizers. Former research shows that not all centralizers are apparent in the initial assessment, some are identified in subsequent assessment sessions [6]. Thus, some of these peripheralizers on day 1 may have subsequently become centralizers and so may distort some of the conclusions on prognosis.

2. *The overwhelming majority of patients with a rather high risk for surgery can be treated with advice and a physical therapy intervention—even if only sham exercises are performed.*

The primary study [2] pointed out that the described patients showed significantly better outcomes in most aspects, if they are treated with symptom-guided exercises.

It surely stands out that the patients in the symptom guided had better outcomes despite having more faith in the efficacy of the sham exercises.

The symptom-guided approach even leveled the nocebo effect.

3. *Most LBP-patients with signs and symptoms of nerve root compression are able to centralize their pain with a very high prevalence rate of 84.8%.*

Unfortunately, Albert and colleagues add a new chapter to the deliberate confusion on centralization. Consistent operational definition is essential to make research on this topic comparable [5].

Albert's group "centralization instable" is a confusing addition and makes for a real "wishy-washy" category.

Research on the reliability for detection of centralization is based constantly on a certain standard of McKenzie-education [3, 4]. The main examiner in Albert's study had no formal McKenzie education. When it comes to statistical issues like reliability and prevalence, these facts must not be swept under the carpet.

4. *Also patients with a ruptured annulus can centralize their pain.*

If a barometer ascends, you usually expect nice weather. A barometer does not tell us the current temperature. If it is summer and currently 25°C warm, a hot day may be approaching. The barometer is a tool that supports us venturing a prognosis but it does not tell us about temperature, sunshine or wind speed. Just like the barometer, the centralization phenomenon fails, if you are misusing it.

Terms like directional preference and centralization help to define "movement in the right direction". Although McKenzie's idea behind derangement and centralization has always been the disc model, he emphasized from the beginning, that classification and treatment always depend on the patient and not on the structure.

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