

Dear X

Thank you for your email/letter of X June. When we spoke about this, we agreed I would give you some general background information that may be relevant to the complaint you have received.

The GCC is aware of the legal action for libel brought by the British Chiropractic Association (BCA) against Dr Simon Singh, though this is not a matter in which the GCC is involved.

We understand that Dr Singh intends to mount a legal challenge to obtain leave to appeal against the decision of the court, and that his supporters have commenced a campaign 'Keep libel laws out of science'. Another associated strand of the campaign, I understand, is that complaints about the content of the BCA's members' websites may be made to more than 80 Trading Standards offices.

Moving now to the complaint in question, I've attached a copy of our patient information leaflet, in which we include the following statements

Chiropractors mainly treat

- *back, neck and shoulder problems*
- *joint, posture and muscle problems*
- *leg pain and sciatica*
- *sports injuries*

You may also see an improvement in some types of

- *asthma*
- *headaches, including migraine; and*
- *infant colic*

So I felt that the most appropriate way to respond to your enquiry is to provide details of our understanding of the evidence that underpins what we say.

It is important to emphasise that the GCC doesn't claim that chiropractors 'treat' asthma, headaches (including migraine) and infant colic. It is possible that chiropractic care may help to alleviate the symptoms of some of these conditions. Chiropractors are trained in differential diagnosis and would refer any patient for appropriate care from another health professional when necessary. It is important that, where appropriate, there is good co-management of patient care.

I'm not sure what level of detail to go into but as you may know there are a number of ways of measuring, or rating, evidence levels. One relevant example is Brønfort G. *Efficacy of Manual Therapies of the Spine*, Amsterdam: Thesis Publishers, 1997. This study rates the levels of evidence available at the time and provides a measuring tool to do it - I've cut and

pasted the 'ratings table' below for your information. If there's anything that's unclear please do get back to me.

The available evidence of the efficacy of the chiropractic contribution to the management of some types of asthma, migraine headache and infant colic is inconclusive (i.e. level D in the measuring tool used by Brønfort).

Further, with regard to some types of asthma:

- Brønfort concluded in 1997 that there is moderate evidence (Level B) that SMT is a non-efficacious therapy for chronic to moderately severe asthma in adults. There was insufficient data (Level D) to draw conclusions about the efficacy of spinal manipulative therapy (SMT) for other respiratory diseases (including childhood asthma)
- In 2001, Brønfort et al (see c. below) concluded that after three months of combining chiropractic SMT with optimal medical management for childhood asthma, the children rated their quality of life substantially higher and their asthma severity substantially lower. The observed improvements were thought unlikely to be as a result of the specific effects of chiropractic SMT alone, but other aspects of the clinical encounter that should not be dismissed readily.

So although some clinical trials had positive results there is insufficient data to make strong statements about efficacy. There is a higher level of available evidence (i.e. level B) with regard to some types of headache (such as tension-type and cervicogenic headache) and there appears to be a clinical advantage, of both SMT and exercises, both of which chiropractors use, compared to placebo and at least equivalence with commonly used therapies.

Other studies that you may find of interest and which appear to echo the evidence levels outlined in the paragraphs above are:

- a. Nielsen NH, Brønfort G, Bendix T. et al 1995. Chronic asthma and chiropractic spinal manipulation: a randomized clinical trial. *Clin Exp Allergy* Jan;25(1):80-8
- b. Balon J, Aker PD et al 1998. A comparison of active and simulated chiropractic manipulation as adjunctive treatment for childhood asthma. *NEJM* 339 (15): 1013-1020
- c. Brønfort G , Evans RL, Kubic P, Filkin P 2001. Chronic pediatric asthma and chiropractic spinal manipulation: a prospective clinical series and randomized pilot study. *JMPT* 24(6):369-77
- d. Brønfort G, Nilsson N, Haas M, Evans RL, Goldsmith CH, Assendelft WJJ, Bouter LM. Non-invasive physical treatments for chronic/recurrent headache. *Cochrane Database of Systematic Reviews* 2004, Issue 3 Art. No.: CD001878. DOI: 10.1002/14651858.CD001878.pub2
- e. Wiberg JMM, Nordsteen J, Nilsson N. 1999. The short-term effect of spinal manipulation in the treatment of infantile colic: a randomised controlled clinical trial with a blinded observer, *JMPT* 22 (8): 517-22.

This is not an exhaustive list but I do hope that this level of detail is helpful.

Please don't hesitate to contact me if you have any questions.

Yours sincerely

Margaret Coats

Chief Executive & Registrar

Levels of evidence (one definition of evidence ratings – there are others – but this one was used by Brønfort)

A	Strong evidence of efficacy <i>or</i> inefficacy	Must include two or more randomised clinical trials (RCTs) with a validity score of > 50 as well as clinically important and statistically significant results
B	Moderate evidence of efficacy <i>or</i> inefficacy	Must include one RCT with a validity score of > 50 as well as clinically important and statistically significant results
C	Limited evidence of efficacy <i>or</i> inefficacy	Must include one RCT with a validity score of 21-49 as well as clinically important and statistically significant results; <i>or</i> Must include two or more RCTs with a validity score of > 20 as well as clinically important and statistically significant results
D	Inconclusive evidence of efficacy <i>or</i> inefficacy	Minimal standards for classification as limited evidence were not met or the evidence was conflicting

Levels of evidence which do not form the basis for efficacy determination

- a. One RCT with a validity score of > 20 and absence of statistically significant results
- b. Non-randomised comparative studies between current patients who did receive the experimental intervention and other patients (e.g. historical controls) who did not or who received another form of therapy and where otherwise incomparable
- c. Clinical case series without controls. These studies provide information about the outcome of a treatment, and if promising, may form the basis for other studies that can address efficacy. These studies may contain useful clinical information, although they constitute the lowest level of evidence since favourable treatment responses are often based on

biased interpretation by the clinicians that provide the therapy and collect the data.