

Clinical Study

Sex life and the Oswestry Disability Index

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Received 13 July 2014; revised 6 January 2015; accepted 11 February 2015

Abstract

BACKGROUND CONTEXT: Despite the option to not answer, there is widespread anecdotal belief that the Oswestry Disability Index (ODI) Section 8 (ODI-8/sex life) is answered inaccurately (ie, in relation to psychosocial factors, not pain) or that it repels ODI participation. Oswestry Disability Index versions have therefore been created that omit ODI-8; however, no evidence base justifies this. Interestingly, one recent study reported an ODI-8 response rate (RR) of 97%.

PURPOSE: The aims of this study were to measure RR to sex life questions in patients with chronic low back pain (CLBP) and to validate that ODI-8 is answered appropriately and represents a specific measure of CLBP-mediated sexual inactivity.

STUDY DESIGN: Original.

PATIENT SAMPLE: Eighty-eight patients.

OUTCOME MEASURES: The outcome measures used in this study were the ODI, the Sexual Quality of Life Scale—version 2 (SQOL-2), the Short Form-12 version 2 (mental and physical), the Depression Anxiety and Stress Scale, the Coping Strategies Questionnaire, the Short-Form McGill Pain Questionnaire—version 2, the Opioid Risk Tool, and the Fear-Avoidance Beliefs Questionnaire (work and physical).

METHOD: Chronic low back pain patients older than 18 years attending a multicultural Western spinal clinic were prospectively offered the aforementioned questionnaires. Sex life disability questions—pain dependent (ODI-8) and pain independent (SQOL-2)—appeared first and fifth in every sequence.

RESULTS: Results were obtained in 65 patients (male 29, female 36). Despite expected response attrition with battery progression (RRs for the first and eighth questionnaires were 100% and 64.61%, respectively), RRs for ODI-8 (52.31%) and SQOL-2 (52.31%) were equal and significantly lower than others ($p < .001$). Nonresponders to ODI-8 (60.57 ± 13.3 years) and SQOL-2 (59.68 ± 13.34 years) were significantly older than responders (ODI-8: 47.82 ± 12.17 years, $p < .001$; SQOL-2: 48.27 ± 12.76 years, $p = .001$). Among ODI-8 or SQOL-2 responders, ODI-8 and SQOL-2 were not correlated ($r = -0.340$, $p = .104$). Although ODI-8 significantly correlated with prospectively identified pain-correlated questionnaires, ODI-8 did not correlate significantly with non-pain-correlated questionnaires.

CONCLUSION: Contrary to previous findings, 47.69% of CLBP patients specifically ignored ODI-8; however, 100% completed the ODI remainder. Among “responders,” ODI-8 was validated as having measured CLBP-mediated sexual inactivity. The ODI-8 was therefore treated consistently, as directed: It was either answered appropriately (ie, in relation to pain) or it was ignored (respecting the clause “if applicable”). No ODI modification therefore appears required for adults older than 18 years attending a multicultural Western CLBP clinic: One standard form including ODI-8 appears to yield appropriate ODI-8 response-treatment, with unaffected ODI participation. Multiple ODIs circumventing ODI-8 appear unnecessary and redundant in this population. Crown Copyright © 2015 Published by Elsevier Inc. All rights reserved.

Keywords:

Sex life; ODI; Pain; Psychosocial; Mental; Physical

FDA device/drug status: Not applicable.

Author disclosures: **MC:** Nothing to disclose. **LAGM:** Nothing to disclose.

Authors MC and LAGM significantly contributed to the article.

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EVIDENCE & METHODS

Context

The authors report is widespread belief that ODI section 8 (sex life) is inaccurately answered or limits participation in the survey. They sought to test this theory using a battery of tests administered to 88 patients.

Contribution

The authors report that, in their sample, nearly half of patients did not complete the ODI section specific to sex life. When respondents chose to answer ODI-8, answers were correct and accurately demonstrated the impact of their chronic low back pain on sexual activity. The authors advocate that modified ODI forms, eliminating section 8, are not necessary.

Implications

The authors present useful information for physicians and researchers who utilize surveys such as the ODI to evaluate outcomes and physical function. That being said, the generalizability of this particular study's findings are highly dependent on how representative the sample of 88 patients is relative to the typical patient with chronic low back pain. Differences between the population under consideration here and patients with chronic low back pain as a whole (such as willingness to participate in a research study or take a survey) might mean that experiences in the clinical setting may not be comparable and response rates could be lower.

—The Editors

Introduction

The Oswestry Disability Index (ODI) [1] is widely used to assess chronic low back pain (CLBP). Despite the clause “if applicable,” there is widespread anecdotal belief that Section 8 (ODI-8/sex life) is answered inaccurately: that is, ODI-8 may be answered in relation to psychological or psychosocial factors and not pain. Furthermore, it is often perceived that the mere presence of ODI-8 may repel any form of ODI participation at all. Such concerns especially relate to certain cultures or to groups for whom questions relating to sex have been deemed inappropriate (eg, physically or mentally disabled patients). For these reasons, some ODI versions omit ODI-8 [2–4]; however, no evidence base justifies such action. Interestingly, one recent study reported an ODI-8 response rate (RR) of 97% [5], thus potentially quelling some concerns over ODI-8.

One distinct advantage of the ODI is that it comprises a one-page questionnaire applicable to all CLBP patients.

Multiple alternative ODI forms, catering for presumed distinct subgroups, therefore somewhat offset this advantage. We aimed to measure the ODI-8 RR and to validate ODI-8 as a specific measure of *pain-mediated* sexual inactivity. With this in mind, ODI-8 was to be initially compared with the Sexual Quality of Life Scale–version 2 (SQOL-2) [6], which primarily measures sex life in regard to psychological and psychosocial factors (not pain). However, ODI-8 responses were also compared with those obtained from other questionnaires, typically used in back or chronic pain clinics, which could be considered as either “pain correlated” or “not pain correlated.”

Because a potentially low RR to a sex life question could be dismissed as a generalized disaffection to questionnaire exposure, we placed sex life questions at regular separated intervals in a sequence of multiple questionnaires. Sex life questions (ODI-8 and SQOL-2) were always encountered first and fifth in each (identical) sequence.

Methods

The study was approved by the local hospital human research ethics committee. The setting was a multicultural specialist back pain clinic in a developed Western country. Patients were included if they had chronic low back pain (CLBP) on a daily basis for 3 or more months [7]. All patients attended the clinic after referral from either a primary health-care physician or secondarily from a health-care specialist. Chronic low back pain patients were prospectively approached between June and October 2011 and given an information sheet detailing the aims and methods of the study, that is, to test the value of various questionnaires in assessing functional and psychosocial impairment associated with CLBP. If they agreed to participate, patients signed a consent form and completed the questionnaire battery. An investigator remained nearby and accessible throughout. Only patients younger than 18 years were specifically excluded.

With the exception of SQOL-2, the battery comprised a variety of quality-of-life questionnaires commonly used in either back or chronic pain clinics, as well as a demographics questionnaire. The battery included the ODI (Fig. 1) [1], the Short Form-12 version 2 (SF-12v2: mental and physical) [8], the Depression Anxiety and Stress Scale (DASS) [9], the Coping Strategies Questionnaire (CSQ) [10], SQOL-2 [6], the Short-Form McGill Pain Questionnaire–version 2 (SF-MPQ-2) [11], the Opioid Risk Tool (ORT) [12], and the Fear-Avoidance Beliefs Questionnaire (FABQ: work and physical) [13].

Scores on the SF-12v2 are summed and transformed into a norm-based score with 50 as the mean: Higher scores indicate better function and less disability [8]. The DASS is a 42-item self-administered questionnaire assessing levels of psychological distress [9], with scores produced on three scales (depression, anxiety, and stress), and an overall score

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