dispute this and agree that this claim reflects generally accepted practice. However, the rationale of our study was to investigate diagnostic accuracy by eliminating as much as possible bias in the index test (provocation tests) as well as the reference test (intra-articular sacroiliac joint [SIJ] blocks). Fritz and Wainner[1] have stated that improper use of the reference standard in a diagnostic study may compromise the validity of the research. In our opinion, bias could be introduced in the study if after the first injection a selection is made: 1 group consists of patients who react negatively and decide not to accept a second injection and the other group reacts positively and decides to receive the second (confirming) injection. This will include recollection knowledge of the anesthesiologist and investigator and that are dealing with a potential "positive" group. Furthermore, patients have knowledge of the design of the study as a result of the informed consent procedure and may be willing to react more positively if they receive the second injection. Again, to overcome that bias, in our (blinded) design, some of the patients received a second injection, which could be regarded, in retrospect, as unnecessary, provided the first block was negative.

Selection of patients eligible for study purposes in relation to the SIJ is an actual issue. Laslett et al[2] combined the SIJ provocation test with the McKenzie procedure in a clinical reasoning process to eliminate (separate) patients with intervertebral disk problems from the patients suitable for an SIJ study population. In our study, we withdrew patients with disk pathology based on magnetic resonance imaging scans in combination with neurologic deficits. From a purely clinical viewpoint, we can understand that their algorithm will work in daily practice.

Regarding the comment of Laslett, Aprill, and McDonald on false-positive rates, we agree that there is a lack of data on the false-positive rate for the initial screening for the SIJ block.

We thank Laslett and colleagues for their suggestion to publish the data as such and will consider it in the near future.

Peter van der Wurff, PT, PhD
Evert J Buijs, MD
Gerbrand J Groen, MD, PhD
Div of Perioperative Medicine and Emergency Medicine
University Medical Centre Utrecht
Utrecht, The Netherlands

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doi:10.1016/j.apmr.2006.04.013

Systematic Reviews on Rehabilitation Interventions

I was impressed with the breadth of Tate's lecture[1] on the state of rehabilitation research, which provided evidence of encouraging progress in this area. However, the progress on the systematic reviewing of the rehabilitation interventions is sadly rather more modest than she has reported.[1] Specifically, her reported number of 5075 Cochrane reviews on rehabilitation for just 7 selected diagnostic groups in July 2005 exceeds the total of 2608 completed reviews in the Cochrane Database of Systematic Reviews (Issue 1, 2006). It may well be that her search results included "hits" from several of the other 7 databases also contained in the Cochrane Library. A search purely on *rehabilitation*, as probably used by Tate, yields 334 completed Cochrane reviews and 106 protocols for Cochrane reviews in the Cochrane Database of Systematic Reviews (Issue 1, 2006). This simple search strategy will, however, miss several relevant reviews and include other nonrehabilitation reviews.

Despite the far smaller number of Cochrane reviews, Cochrane and other systematic reviews of rehabilitation are still a growth area in terms of "number, scope, and quality" as concluded by Tate. By virtue of their being updated on a regular basis, Cochrane reviews are indeed particularly "valuable tools on which to continue to build a strong theoretical body of knowledge."[1(p164)] However, there is still considerably more to be done and, in particular, I urge rehabilitation specialists to contribute actively to this endeavor.

Helen H. Handoll, DPhil
University of Teesside
Middlesbrough, UK
h.handoll@tees.ac.uk

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doi:10.1016/j.apmr.2006.04.006