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LETTER

Prevalence, Activity Limitations and Quality of Life in Patients With Non-Specific Neck Pain in Burundi: A Cross-Sectional Study [Letter]

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Dear editor

Recently, the article titled "Prevalence, Activity Limitations and Quality of Life in Patients with Non-Specific Neck Pain in Burundi: A Cross-Sectional Study" by Ndacayisaba et al, published in the Journal of Pain Research,[1] has captured our attention. This cross-sectional study indicated the significant healthcare burden posed by non-specific neck pain (NSNP) in Burundi, giving insights into its prevalence, associated activity limitations, and impact on quality of life (QoL). We appreciate the remarkable contributions made by this study and would like to give some constructive feedback for consideration.

Firstly, this cross-sectional study bridges a critical knowledge gap by addressing NSNP's impact in Sub-Saharan Africa, an under-studied area of research. However, the causative link between anxiety and neck pain in the functional disability section is speculative due to the lack of longitudinal evidence imposed by the limitations of the design of a cross-sectional study.[2] Comparisons with high-income countries like Germany to justify the causative link may oversimplify findings, given significant contextual differences including cultural factors and healthcare accessibility between low- and high-income countries. Hence, we suggest that comparisons with Sub-Saharan countries be used to identify and compare regional trends. A longitudinal study, as mentioned by the authors, can also effectively elucidate the cause-effect relationship between NSNP and QoL.[3]

Additionally, the biopsychosocial framework adopted provides a holistic view of NSNP's impact on patients' lives. However, the implementation of the framework is constrained by several biases and limitations. Beyond the small sample size pointed out by the authors, the sample is disproportionately skewed towards highly educated individuals (52.9%), females (52.9%), and civil servants (88.2%), which is uncharacteristic of the broader Burundian population.[4] Compared to the rural population, the population studied is more likely to seek medical attention in urban centers, which are the recruitment centers for participants in this study. To improve generalisability, future studies may employ stratified random sampling to include variations in education levels, occupation, gender, and geographical location, for a more balanced representation of the Burundian population.

Finally, this study employs quantitative scales, such as SF-36[5] and HAD, which were developed in high-income countries, providing standardized and measurable metrics to quantify QoL. However, as stated by the authors, social-cultural factors, individual coping mechanisms, and other factors influencing QoL associated with NSNP were excluded from the study. These factors could be better captured through qualitative methods such as interviews and focused group discussions. Qualitative findings may also enhance the study's contextual relevance to a low-resource setting like Burundi. Thus, we suggest qualitative investigative methods to complement the quantitative data, substantiating and contextualizing the gravity of NSNP on patients' lives in Sub-Saharan Africa.

In conclusion, we deeply appreciate the efforts of Ndacayisaba et al in advancing understanding regarding NSNP in low-resource settings like Burundi. This work is a foundation for future public health interventions in the area. We

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sincerely hope that our comments and suggestions will be considered and we look forward to more invaluable research inputs into this field to further explore the multifaceted dimensions of NSNP.

Disclosure

The authors report no conflicts of interest in this communication.

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