Comment on "Internet Cognitive-Behavioral Therapy for Painful Chronic Pancreatitis: A Pilot Feasibility Randomized Controlled Trial"

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We read with great interest the recently published study by Palermo et al. (1) concerning Internet cognitive-behavioral therapy (CBT) for painful chronic pancreatitis (CP). However, we found some points needed to be improved.

First, 1 month was set as the time window for pain assessment in the inclusion criteria; however, the period of pain evaluation after enrollment was only 1 week. The difference of time windows for pain assessment between enrollment and postrandomization could cause inaccuracy of the results. Generally, pain pattern of CP was subdivided into A and B types. A-type pain pattern is characterized as an intermittent pain with short pain episodes of a few days and alternated long pain-free episodes of several months to more than 1 year. B-type pain pattern is featured as prolonged periods of pain and/or clusters of recurrent severe pain exacerbations (2). According to the present trial design, this study was more applicable to patients with CP with B-type pain pattern. As for patients with CP with A-type pain pattern, they might have several episodes of pain in 1 month before enrollment, but no pain attack in 1 week before pain assessment during this trial. In this situation mentioned above, the absence of abdominal pain could not be considered as the effect of CBT. Therefore, setting the same time window for pain assessment would make the results more accurate.

Second, according to Table 2, nearly half of patients enrolled in this trial underwent moderate to severe symptoms of anxiety, depression, and/or sleep disturbance. However, whether these psychiatric symptoms had improved was not shown in the results. It would be better if the authors could exhibit the detailed changes of these psychiatric symptoms. In addition, if there were some improvements, it would be a good choice to make a subgroup analysis to figure out which psychiatric symptom had more improvement than others.

Third, both the Internet CBT group and the control group continued to receive usual medical care for CP. Up to now, it has been confirmed by multiple studies that medication, endoscopy and surgery could relieve patients with CP of pain to varying degrees (3). Meantime, these therapies have been recommended by many clinical guidelines (4,5). We would question whether the improvement of pain in this study was because of usual medical treatments, the Internet CBT, or the combination of these 2 therapies. Therefore, it would be better if a subgroup analysis could be conducted to compare the treatment outcomes of patients with CP with different usual medical cares.

In conclusion, the Internet CBT to treat painful CP is innovative and meaningful, but this study could be improved in pain assessment and data analysis.

CONFLICTS OF INTEREST

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