In Reply: Contemporary Analysis of Minimal Clinically Important Difference in the Neurosurgical Literature

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To the Editor:

The authors’ raise an important point regarding the type of change that can and should be considered when determining the minimal clinically important difference (MCID) for a treatment and patient population. Although the primary examples highlighted in our publication focused on absolute values for the individual patient reported outcome measures (PROMs), percent change can also be used as an MCID. As noted, this can increase an MCID’s sensitivity, particularly for patients who score at the extremes of an outcome measure. However, anchoring patient satisfaction to an arbitrarily chosen percent change overlooks the “minimal” in MCID. Had the receiver operating characteristic (ROC) curve been run across the continuum, the MCID might have been 25%, or even 35%. The spinal cord stimulation literature, which long has referenced an arbitrary benchmark of 50% pain reduction, exemplifies the need to identify the appropriate threshold that connotes treatment value.

For the benefit of our patients, it remains important to find a balance between disease-specific PROMs and neurosurgical PROMs. Disease-specific PROMs such as the Health-Related Quality of Life Measure for Children with Epilepsy (CHEQoL) bring the patient’s daily concerns, such as a child’s fear of being treated differently, to the surgeon’s attention in a way that neurosurgical-specific PROMs may not. Similarly, the Chicago Chiari Outcomes Score (CCOS) is a neurosurgery-specific PROM that incorporates the impact of complications on patient outcome—a connection that may not be obvious to patients. As a field, we do not want to be short-sighted and trade one set of limitations for another. Rather, using and developing the appropriate complement of PROMs for specific neurosurgical situations will best serve our patients in the future.

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REFERENCES

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