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High-definition transcranial infraslow pink noise stimulation for chronic low back pain: protocol for a pilot, safety and feasibility randomised placebo-controlled trial

Divya Bharatkumar Adhia 1, Ramakrishnan Mani,2 John N J Reynolds,3 Sven Vanneste,4 Dirk De Ridder1

ABSTRACT

Introduction Chronic low back pain (CLBP) is a common disabling health condition. Current treatments demonstrate modest effects, warranting newer therapies. Brain imaging demonstrates altered electrical activities in cortical areas responsible for pain modulation, emotional and sensory components of pain experience. Treatments targeting to change electrical activities of these key brain regions may produce clinical benefits. This pilot study aims to (1) evaluate feasibility, safety and acceptability of a novel neuromodulation technique, high-definition transcranial infraslow pink noise stimulation (HD-tIPNS), in people with CLBP, (2) explore the trend of effect of HD-tIPNS on pain and function, and (3) derive treatment estimates to support sample size calculation for a fully powered trial should trends of effectiveness be present.

Methods and analysis A pilot, triple-blinded randomised two-arm placebo-controlled parallel trial. Participants (n=40) with CLBP will be randomised to either sham stimulation or HD-tIPNS (targeting somatosensory cortex and dorsal and pregenual anterior cingulate cortex). Primary outcomes include feasibility and safety measures, and clinical outcomes of pain (Brief Pain Inventory) and disability (Roland-Morris disability questionnaire). Secondary measures include clinical, psychological, quantitative sensory testing and electroencephalography collected at baseline, immediately postintervention, and at 1-week, 1-month and 3 months postintervention. All data will be analysed descriptively. A nested qualitative study will assess participants perceptions about acceptability of intervention and analysed thematically.

Ethics and dissemination Ethical approval has been obtained from Health and Disability Ethics Committee (Ref:20/NTB/67). Findings will be reported to regulatory and funding bodies, presented at conferences, and published in a scientific journal.

Trial registration number ACTRN12620000505909p.

INTRODUCTION

Chronic low back pain (CLBP) is a significant and growing health challenge, affecting individuals, the wider community and the healthcare system.1–3 Along with pain and impaired function, individuals with CLBP have significant psychological comorbidities and poor quality of life.1–3 Currently available treatments for CLBP demonstrate at best small effect sizes.4–6 Pharmacological interventions are not effective with a high risk of adverse outcomes.7–9 Thus, new, innovative, evidence-based, safer therapies are warranted for the management of CLBP.

Resting-state cortical activity alterations have been demonstrated in individuals with CLBP.10–13 The most notably involved cortical areas include the anterior cingulate cortex (ACC) and the primary somatosensory cortex (SSC), which are the central hubs of the pain processing brain networks.10–18 The ACC, particularly the pregenual region (pgACC), is part of the descending pain modulatory system (or anti-nociceptive system), the activation of which releases μ-opioids that act to modulate incoming nociception information from the hyperactive, spinal cord circuits, thereby alleviating pain.15 16 17 19 20 The SSC, along with the dorsal region of ACC (dACC), is part of...
ascending nociceptive (lateral and medial) pathways that are responsible for encoding the sensory (ie, painfulness) and the emotional components (eg, suffering) of the pain experience. Recent evidence suggests that alterations in the functional connectivity patterns between the pain processing regions (pgACC, dACC, SSC) are critical for maintaining chronic pain and are associated with its clinical and psychological outcomes.14–16 21–28

Neuromodulatory interventions targeted to alter activities in cortical pain processing areas may improve clinical outcomes. Transcranial electrical stimulation (TES), a non-invasive brain stimulation technique, can influence the electrical activity of targeted brain regions, promote cortical plasticity and improve the functional connectivity to/from the targeted area, thereby improving pain modulation. Recent systematic reviews and meta-analyses demonstrate positive effects of the TES techniques in chronic pain conditions (eg, fibromyalgia, migraine, spinal cord injury).29–32 However, the evidence for effect of TES for treatment of CLBP is limited (n=10 pilot studies, n=2 protocols33 42) and have demonstrated mixed results. Recent systematic reviews and meta-analyses suggests that there is very low-quality evidence that a single session of TES have short term effects for improving pain in people with CLBP.45 46

Previous TES studies targeted altering cortical electrical activity of a single superficial brain region (eg, Motor cortex or dorsolateral prefrontal cortex) using transcranial direct current stimulation (tDCS), except one study that targeted a deeper brain region (dACC). None of the studies has simultaneously targeted multiple brain regions (pgACC, dACC, SSC) responsible for the descending and ascending modulation of nociceptive sensory information. Further, the stimulation technique used in the previous TCS studies involved applying two large scalp electrode pads that deliver currents to diffuse areas of the brain, making focalised stimulation of targeted brain regions less feasible. Focal and simultaneous stimulation of multiple brain regions could help improve clinical outcomes with larger effect sizes, similar to invasive neuromodulatory interventions.47

We propose determining the feasibility and safety of a novel high-definition transcranial infraslow pink noise stimulation (HD-tIPNS) technique, targeting the pgACC, dACC and SSC regions simultaneously in people with CLBP. The HD-tIPNS technique was developed to specifically modulate the infraslow electrical activity (0.0–0.1 Hz) in the brain. The infraslow electrical activity, a fundamental frequency range of the brain, reorganises neurons and improves the electrical connectivity of the brain-wide functional networks.48–51 The infraslow frequency plays a profound role in modulating and synchronising high-frequency cortical activity that are known to be affected in chronic pain, and is also critically involved in mediating pain perception.55 Evidence from imaging studies also demonstrate alterations in the infraslow oscillations in individuals with CLBP in the pain processing brain regions (pgACC, dACC, SSC).56 57 The pink noise frequency spectrum resembles the naturally occurring signals in the self-organisation of the brain, thus can be more effective than standard tDCS electrical parameters used in previous studies.58 59 We, therefore, believe that specifically and simultaneously targeting the fundamental infraslow activity at key nodes of pain processing networks, using a novel HD-tIPNS technique, could normalise brain-wide electrical activity and functional connectivity between areas of interest, promoting better pain modulation and producing more meaningful clinical benefits. This protocol outlines the methods and analysis used in the pilot randomised controlled trial. The specific aims are to (1) evaluate the feasibility, safety and acceptability of the HD-tIPNS technique in people with CLBP, (2) explore the trend of effect of HD-tIPNS on pain and function, and (3) provide estimates of clinical outcome measures to support a sample size calculation for a fully powered trial should the trend of effectiveness be present.

METHODS AND ANALYSIS

The following guides have been used to prepare this study protocol: Standard Protocol Items: Recommendations for Interventional Trials statement,60 the template for intervention description and replication checklist61 and IMMPACT Recommendations.62–66 In addition, this trial has been prospectively registered (table 1).

Study design

The proposed study will be a triple blinded pilot randomised placebo-controlled parallel trial with two intervention arms. The outcome measures will be collected at baseline, immediately postintervention, and at follow-up periods: 1-week, 1-month and 3 months postintervention (figure 1).

Randomisation

A research administrator, not involved in other procedures, will randomise participants on a 1:1 basis using a computerised open-access randomisation software programme to:

► Group 1: HD-tIPNS.
► Group 2: Sham stimulation.

The randomisation schedule will be concealed in sequentially numbered, sealed opaque envelopes and provided to participants at their baseline measurements.

Blinding

Participants, outcome assessor, and treating researchers will be blinded to group allocation. Stimulation programmes on Starstim device will be designed and controlled by an independent researcher to allow blinding of the treating researcher. The success of blinding will be assessed after the completion of the intervention and follow-up phases. The participant, and the outcome assessor, and treating researcher will be asked ‘What type of treatment they believe that they/the participant
Table 1 WHO trial registration data set (V.1.3.1)

<table>
<thead>
<tr>
<th>Item Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary registry</strong>&lt;br&gt;and trial identifying no</td>
</tr>
<tr>
<td><strong>Date of registration in primary registry</strong></td>
</tr>
<tr>
<td><strong>Universal trial no</strong></td>
</tr>
<tr>
<td><strong>Source of monetary or material support</strong></td>
</tr>
<tr>
<td><strong>Primary sponsor</strong></td>
</tr>
<tr>
<td><strong>Contact for public queries</strong></td>
</tr>
<tr>
<td><strong>Contact for scientific queries</strong></td>
</tr>
<tr>
<td><strong>Public title</strong></td>
</tr>
<tr>
<td><strong>Scientific title</strong></td>
</tr>
<tr>
<td><strong>Country of recruitment</strong></td>
</tr>
<tr>
<td><strong>Health condition or problem studied</strong></td>
</tr>
<tr>
<td><strong>Interventions</strong></td>
</tr>
<tr>
<td><strong>Key eligibility criteria</strong></td>
</tr>
<tr>
<td><strong>Study type</strong></td>
</tr>
<tr>
<td><strong>Date of first enrolment</strong></td>
</tr>
<tr>
<td><strong>Sample size</strong></td>
</tr>
<tr>
<td><strong>Recruitment status</strong></td>
</tr>
<tr>
<td><strong>Primary outcomes</strong></td>
</tr>
<tr>
<td>Safety (measured as any adverse events that have a likely causal relationship with the intervention)</td>
</tr>
<tr>
<td>Acceptability of the intervention (assessed quantitatively as well as qualitatively)</td>
</tr>
<tr>
<td>Pain and disability: Brief Pain Inventory and Roland-Morris disability questionnaire. (Note: Feasibility measures and treatment acceptability are primary measures that are listed under secondary outcome section in the ANZCTR due to limit of the primary outcomes that could be included in the registry).</td>
</tr>
<tr>
<td><strong>Secondary measures</strong></td>
</tr>
<tr>
<td>Psychological measures: Depression, anxiety and stress scale, pain catastrophising scale, and pain vigilance and awareness questionnaire.</td>
</tr>
<tr>
<td>Pain measures: Pain unpleasantness and bothersomeness, global rate of change score.</td>
</tr>
<tr>
<td>Well-being: European quality of life-five dimensions, WHQ-five well-being index.</td>
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</tbody>
</table>

Table 1 Continued

<table>
<thead>
<tr>
<th>Item Information</th>
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</thead>
<tbody>
<tr>
<td><strong>Ethical review</strong></td>
</tr>
</tbody>
</table>

received respectively? and will be required to choose between three options: active, sham or don’t know. The confidence in their judgement will also be assessed on an 11-point Numeric Rating Scale (NRS) (0=not at all confident to 10=extremely confident), with the reason for their judgement being noted and whether the intervention was revealed to them. Unblinding will be permissible only in the case of an adverse event or any unexpected event.

**Study setting**

This study will be conducted in the Department of Surgical Sciences laboratory, Dunedin School of Medicine, Dunedin hospital, New Zealand.

**Participants and eligibility criteria**

Adults with CLBP will be eligible to participate.

**Inclusion criteria**

Capable of understanding and signing an informed consent form, age between 18 and 75 years on the day of the consent, pain in the lower back (the region between 12th rib and gluteal fold) that occurs everyday for ≥3 months, a score of ≥4 on an 11-point Numeric Pain Rating Scale (NPRS, 0=no pain to 10=worst pain imaginable) in the past 4 weeks prior to enrolment, a disability score of ≥5 on Roland-Morris Disability Questionnaire. These cut-off scores are used as an indication that CLBP significantly impacts daily functioning, are by International Association of Study of Pain guidelines and are in line with optimal Delphi definitions of LBP prevalence.

**Exclusion criteria**

Participants with the following self-reported health conditions will be excluded: Inflammatory arthritis, undergoing any therapy from a health professional (eg, physiotherapist or chiropractor), recent soft tissue injuries of the back in the last 3 months, history of surgery to the back region or waiting/scheduled for any procedures within the next 6 months, current intake of any centrally-acting medications or intention of taking new medications in the next 3 months, steroid injections to the back in past 6 months, history of surgery to the back region in the last 3 months, a score of ≥4 on an 11-point Numeric Pain Rating Scale (NPRS, 0=no pain to 10=worst pain imaginable) in the past 4 weeks prior to enrolment, a disability score of ≥5 on Roland-Morris Disability Questionnaire. These cut-off scores are used as an indication that CLBP significantly impacts daily functioning, are by International Association of Study of Pain guidelines and are in line with optimal Delphi definitions of LBP prevalence.

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Sample size

This proposed research is a pilot exploratory study, which will be executed to make a power estimate for a future phase II study should the intervention appear feasible, safe, acceptable and show trends of effectiveness. Hence a sample size calculation was not performed. Based on statistical advice, a sample of 40 participants (20/group) was considered enough to determine feasibility issues and obtain treatment estimates for designing a full trial.

Recruitment and study enrolment

Participants will be primarily recruited through broadcasting in the public media (e.g., newspapers and social media). Participants attending healthcare providers will also be invited to participate. The total recruitment period will be 1 year (June 2021 to May 2022). Advertisements will be placed in the local newspapers twice a month and social media once a month (Sponsored Facebook ad, for 1 week). Advertisement fliers will be placed around a tertiary hospital, regional healthcare practices and supermarkets. A recruitment email will be sent to the local tertiary educational university/polytechnic staff and students once every 2 months.

All volunteers will complete an online screening form. Potential participants will be contacted by a researcher with a health professional background (trained musculoskeletal physiotherapist) to undergo further screening over the phone to confirm eligibility prior to study enrolment. The study information sheet (online supplemental file) will be emailed to eligible participants. Written informed consent will be obtained before baseline testing.

At the baseline session, all participants will complete questionnaires to capture demographics, clinical characteristics of CLBP, including presence of central sensitization (Central Sensitisation Inventory), neuropathic pain quality (PainDETECT), pain personification, and treatment expectancy and credibility.

Intervention procedures

The intervention will be administered five times a week (30 min/session) for 4 weeks by an assistant research fellow trained by the primary investigator experienced in neuromodulation techniques. A battery-driven wireless TES (Starstim-Home TES, Neuroelectrics, Spain) will be used to deliver stimulation while participants are comfortably and quietly seated (Figure 2). The HD technique uses arrays of multiple small electrodes whose configuration can be optimized for focaly targeting specific brain regions. Eight small
electrodes (~4 cm²) will be placed on a neoprene head cap following the International 10–20 electroencephalogram (EEG) system to simultaneously target pgACC, dACC and SSC (figures 2 and 3) (table 2).

For HD-tIPNS group, the stimulation will be delivered at a current strength of a maximum of 2mA for 30 min, with 60 s ramp up and ramp down at the beginning and end of each stimulation session, with continuous stimulation in between. The pink noise stimulation at a current strength of a maximum of 0.6mA will be superimposed on the infraslow (0.1 Hz sinusoidal) waveform of a current intensity of 1mA. The current strength at each electrode will never exceed the maximum safety limit of 2mA. The intervention dosage is chosen based on the previous TES studies in CLBP and follows safety guidelines.

For the sham stimulation group, to create an identical skin sensation to active stimulation, we will use the Actisham protocol created by the Neuroelectrics. The current will be applied for a 60 s ramp up and 60 s ramp down at the beginning and end of each stimulation session, without any current for the remainder of the session. The duration of the sham session will be like HD-tIPNS session to blind the procedure appropriately. Participants in both groups will be informed that they may or may not perceive any sensations during the stimulation treatment. The previous TES studies have used this sham procedure and are shown to effectively blind participants to the stimulation condition, as it can induce the same scalp sensations perceived during active stimulation, both in terms of intensity and localisation. Further, the Actisham protocol will prevent the currents from reaching the cortex, thus avoiding causing any brain excitability changes.

Treatment fidelity will be assessed by the principal investigator at each session, who will supervise that the treatment is delivered in a standardised manner as planned. The treatment delivered for each participant for each session will be saved on the NIC2 computer software.

Outcome measures

An assessor, blinded to the group allocation, will collect outcomes at baseline (T₀), immediately postintervention (T₁ᵢ) and at follow-up of 1 week (T₁ᵢwk), 1-month (T₁m) and 3-month (T₃m) postintervention. The chosen secondary measures have good psychometric properties, are used in clinical trials involving people with CLBP and are by recommendations.
Recruitment rate, the number of participants recruited per month. Participants will be recruited over 1 year, with no threshold placed on the recruitment rate for each month. The recruitment rate will be recorded every week since the release of the advertisements, as well as the number of advertisements and the time period required to achieve the desired sample size (n=40).

The proportion of participants eligible and recruited from the total number screened (with reasons for exclusion), expressed as a percentage.

Adherence to intervention measured as number of treatment sessions attended by each participant expressed as a percentage of total number of sessions. Adherence rates will be calculated once the treatment phase is completed.

Drop-out rates, measured as the number of participants who dropped out in each group, expressed

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**Table 2** Description of the HD-tIPNS intervention, as per the template for intervention description and replication

<table>
<thead>
<tr>
<th>Item no and Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Brief name</td>
<td>HD-tIPNS</td>
</tr>
<tr>
<td>2. Why</td>
<td>The HD technique uses arrays of multiple small electrodes whose configuration can be optimised for focally targeting specific brain regions. The HD-tIPNS technique is developed to specifically modulate the infraslow electrical activity (0–0.1 Hz) in the brain. The infraslow electrical activity, a fundamental frequency range of the brain, reorganises neurons and improves the electrical connectivity of the brain-wide functional networks. Optimising the infraslow frequency can normalise the electrical activity in the higher frequency bands known to be affected in individuals with chronic pain. Recent imaging studies have also demonstrated alterations in the infraslow oscillations in individuals with CLBP in descending (pgACC) and ascending (dACC, SSC) pain pathways. Research shows that pink noise stimulation can influence the infraslow electrical activity (0–0.1 Hz) in the brain. The pink noise frequency spectrum resembles the naturally occurring signals in the self-organisation of the brain, thus can be more effective than standard tDCS electrical parameters. We, therefore, hypothesise that specifically and simultaneously targeting the fundamental infraslow activity at the key nodes of pain processing networks, using a novel HD-tIPNS technique, could normalise brain-wide electrical activity and functional connectivity between areas of interest, promoting better pain modulation and producing more meaningful clinical benefits.</td>
</tr>
<tr>
<td>3. What</td>
<td>A battery-driven wireless transcranial electrical stimulator (Starstim-Home TES, Neuroelectrics, Spain) will be used to deliver stimulation while participants are comfortably and quietly seated. Eight electrodes will be placed on a neoprene head cap following the International 10–20 EEG system to simultaneously target pgACC, dACC and SSC (figures 2 and 3).</td>
</tr>
<tr>
<td>4. Procedures</td>
<td>At each session, participant’s scalp will be cleaned with alcohol wipes. The treating researcher will place the neoprene cap with the eight electrodes attached to it on the participant’s head while they are comfortably seated in a chair. The reference electrode will be placed on the right ear. Electrogel will be applied to the scalp at the locations of the electrodes for reducing the impedance. The NIC2 software uses a traffic light signal indicator (red, yellow, green) for impedance. All electrodes will be prepared to have the lowest impedance (green colour). All the cables will be attached to the stimulating electrodes and the neckbox. The stimulator will be connected to the NIC2 software using its own firmware. The participant will be comfortably positioned in a half-laying position with their eyes closed. The participant will be asked to relax, and the stimulation intervention will be delivered for 30 min.</td>
</tr>
<tr>
<td>5. Who provided</td>
<td>Two independent researchers will be involved in the delivery of the intervention. A researcher (R1) with a health professional background (physiotherapist) will design and control the Starstim-Home device and set up the stimulation programmes in the NIC2 (neuroelectrics software), to allow blinding of the treating researcher (R2). The programme will be uploaded to the online portal and the treatment will be scheduled for each participant by R1. Another independent researcher (assistant research fellow, R2) with considerable experience in administering neuromodulation techniques will prepare the participants for treatment and administer the stimulation intervention using the iPad of the Starstim-Home TES system. During the stimulation period, the iPad screen presents only a green bar for indicating the duration of the stimulation session and no other stimulation parameters are presented. This allows for appropriate blinding of the treating researcher (R2).</td>
</tr>
<tr>
<td>6. How</td>
<td>All participants will receive individual face-to-face sessions.</td>
</tr>
<tr>
<td>7. Where</td>
<td>Interventions will be delivered at a clinical laboratory in the Otago Medical School, Department of Surgical Sciences, located in the Dunedin Hospital, Dunedin, New Zealand.</td>
</tr>
<tr>
<td>8. When and how much</td>
<td>All participants will receive the intervention (based on their randomised group) for a total of 20 sessions, five times a week for four consecutive weeks. Each stimulation session will last for 30 min duration.</td>
</tr>
<tr>
<td>9. Tailoring</td>
<td>The interventions will not be tailored to individual participant’s brain states. All participants in HD-tIPNS group will receive the same stimulation waveform, pink noise stimulation at a current strength of a maximum of 0.6 mA superimposed on the infraslow (0.1 Hz sinusoidal) waveform of a current intensity of 1 mA.</td>
</tr>
<tr>
<td>10. Modifications</td>
<td>Not applicable. This is a protocol for a pilot trial.</td>
</tr>
<tr>
<td>11. How well</td>
<td>Adherence to intervention will be one of the primary outcomes for the study and will be recorded by the treating researcher. Adherence rates will be calculated once the treatment phase is completed. The number of treatment sessions attended by each participant will be recorded and expressed as a percentage of the total no of sessions.</td>
</tr>
<tr>
<td>12. Actual: describe the extent to which the intervention was delivered as planned.</td>
<td>Not applicable. This is a protocol for a pilot trial.</td>
</tr>
</tbody>
</table>

**Primary outcomes**

**Feasibility measures**

- Recruitment rate, the number of participants recruited per month. Participants will be recruited over 1 year, with no threshold placed on the recruitment rate for each month. The recruitment rate will be recorded every week since the release of the advertisements, as well as the number of advertisements and the time period required to achieve the desired sample size (n=40).

- The proportion of participants eligible and recruited from the total number screened (with reasons for exclusion), expressed as a percentage.

- Adherence to intervention measured as number of treatment sessions attended by each participant expressed as a percentage of total number of sessions. Adherence rates will be calculated once the treatment phase is completed.

- Drop-out rates, measured as the number of participants who dropped out in each group, expressed
as a percentage of the total number of participants enrolled in the study. Drop-outs rates will be calculated once the follow-up phase is completed.

Safety measures
At each treatment and follow-up session, the treating researcher will record any adverse effects that likely have a causal relationship with the intervention. The following variables will be recorded:
- Qualitative description and intensity of each symptom on a Likert scale (0=none to 10=extreme).
- Relation of symptom to treatment, measured on a scale ranging from 1=unrelated to 5=strongly related.
- Duration and time taken for resolution of each symptom expressed in minutes.
- Worsening or improvement of symptoms: The Discontinuation-Emergent Sign and Symptom will be used to record worsening or improving side effects compared with status prior to previous session.
- Any drop-outs due to adverse effects and how the adverse effects were managed.

Acceptability and satisfaction
Participant acceptability and satisfaction of the intervention will also be recorded quantitatively on an 11-point NRS (0=not at all acceptable/satisfied to 10=very acceptable/satisfied, respectively).

Clinical measures

Pain intensity and interference
Using Brief Pain Inventory (BPI), a standardised, validated questionnaire for CLBP.

Physical function
Roland-Morris Disability Questionnaire will be used to assess self-reported functional abilities.

Secondary outcomes
Measures of peripheral and central sensitisation
Quantitative sensory testing will be conducted and reported in accordance with the guidelines and our previous study (table 3).

> Mechanical temporal summation (MTS): will be assessed using a nylon monofilament (Semmes monofilament 6.65, 300 g). Brief 10 repetitive contacts will be delivered at a rate of 1 Hz, externally cued by auditory stimuli. The participants will be asked to rate the level of pain experienced on NRS (0=no pain to 100=extreme pain) immediately after the first contact and to rate their greatest pain intensity after the 10th contact. Three trials will be conducted for each of the two regions (ie, symptomatic low back and non-dominant wrist) in random order. The location of these areas will be recorded using bony

<table>
<thead>
<tr>
<th>Measure's domains</th>
<th>Constructs</th>
<th>Measurement tools</th>
<th>Timepoints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>Severity (primary clinical outcome)</td>
<td>Brief Pain Inventory Short form Severity subscale in the past 24 hours.</td>
<td>T_B, T_m, T_1wk, T_1m, T_3m</td>
</tr>
<tr>
<td></td>
<td>0–10 NRS of the worst pain in the past 24 hours</td>
<td>T_B, T_m, T_1wk, T_1m, T_3m</td>
<td></td>
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<tr>
<td></td>
<td>0–10 NRS of average pain in the past 24 hours</td>
<td>T_B, T_m, T_1wk, T_1m, T_3m</td>
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<tr>
<td></td>
<td>Unpleasantness</td>
<td>0–10 NRS of unpleasantness in the past 24 hours</td>
<td>T_B, T_m, T_1wk, T_1m, T_3m</td>
</tr>
<tr>
<td></td>
<td>Bothersomeness</td>
<td>0–10 NRS of bothersomeness in past 24 hours</td>
<td>T_B, T_m, T_1wk, T_1m, T_3m</td>
</tr>
<tr>
<td>Physical functioning</td>
<td>Pain interference (primary clinical outcome)</td>
<td>Brief Pain Inventory Short form Interference subscale in the past 24 hours.</td>
<td>T_B, T_m, T_1wk, T_1m, T_3m</td>
</tr>
<tr>
<td></td>
<td>Disability (primary clinical outcome)</td>
<td>Roland-Morris Disability Questionnaire</td>
<td>T_B, T_m, T_1wk, T_1m, T_3m</td>
</tr>
<tr>
<td>Global change</td>
<td>Global perceived change</td>
<td>Perceived change in the back region on an 11-point scale (−5=much worse, through 0=unchanged, to +5=completely), recovered</td>
<td>T_m, T_1wk, T_1m, T_3m</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>Extent of satisfaction</td>
<td>Perceived treatment satisfaction on a 0–10 NRS</td>
<td>T_m</td>
</tr>
<tr>
<td>Psychological functioning</td>
<td>Depression</td>
<td>Depression, Anxiety and Stress Scale</td>
<td>T_B, T_m, T_1wk, T_1m, T_3m</td>
</tr>
<tr>
<td></td>
<td>Catastrophising</td>
<td>Pain Catastrophising Scale</td>
<td>T_B, T_m, T_1wk, T_1m, T_3m</td>
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<tr>
<td></td>
<td>Attention to pain</td>
<td>Pain Vigilance and Awareness Questionnaire</td>
<td>T_B, T_m, T_1wk, T_1m, T_3m</td>
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<td>General health</td>
<td>Quality of life</td>
<td>European Quality of Life-5D</td>
<td>T_B, T_m, T_1wk, T_1m, T_3m</td>
</tr>
<tr>
<td></td>
<td>Well-being</td>
<td>WHO-Five Well-Being Index</td>
<td>T_B, T_m, T_1wk, T_1m, T_3m</td>
</tr>
</tbody>
</table>

NRS, Numeric Rating Scale; T_B, at baseline; T_m, immediately postintervention; T_1m, 1-month postintervention; T_3m, 3 months postintervention; T_1wk, 1-week postintervention.
Condition pain modulation (CPM) is the most essential technique used for assessing the effectiveness of pain modulation. Adhia DB, et al. BMJ Open 2022;12:e056842. doi:10.1136/bmjopen-2021-056842

- Pressure pain threshold (PPT): A computerised, handheld digital algometer (AlgoMed; Medoc, Ramat Yishai, Israel) will be used to measure three trials of PPT over two regions (symptomatic low back and non-dominant wrist) in random order. Two familiarisation trials will be performed at dominant mid-forearm before formal trials. The 1 cm² algometer probe will be pressed over marked test site perpendicularly to the skin at a rate of 30 kPa/s. Participants will be instructed to press the algometer trigger button in the patient control unit when pressure sensation changes to first pain.94 If patients do not report pain at the maximum pressure level, the procedure would be terminated, and a score of 1000 kPa will be assigned for that trial. The average of three trials will be calculated and used for analysis.95

- Condition pain modulation (CPM): The most frequently administered procedure for exploring the endogenous pain modulatory system.94 96 CPM test procedure will be administered at least 15–20 min after the MTS and PPT procedures with the previously published recommendations of testing.94 96

Psychological measures
Will include Depression, Anxiety and Stress Scale,97 to measure those three psychological constructs, Pain Catastrophising Scale,99 to measure extent of catastrophic thoughts and feelings about their pain,100 and Pain Vigilance and Awareness Questionnaire101 to measure frequency of habitual ‘attention to pain’.

Secondary pain measures
Pain unpleasantness (affective component) measured using an 11-point unpleasantness NRS (0-not at all unpleasant to 10=most unpleasant imaginable).102 103 Pain bothersomeness: measured using an 11-point bothersomeness NRS (0-not at all bothering to 10=most bothering).102 103 A categorical question will also be used ‘In the last 1 week, how bothersome has your low back pain been?’ with five choices: ‘not at all’, ‘slightly’, ‘moderately’, ‘very much’ and ‘extremely’.104 105 The global rate of change:106 assessed using the question ‘Compared with the beginning of treatment, how would you describe your back at this moment?’ Participants will rate their perceived change on an 11-point scale (−5=much worse, through 0=unchanged, to +5=completely, recovered).

Quality of life and well-being
Will be assessed using European Quality of Life-5 Dimensions scale107 and WHO-Five Well-Being Index,108 respectively.

Measures of cortical electrical activity
Resting-state EEG (~10 min, eyes-closed) will be obtained in a quiet room while the participant is sitting upright in a comfortable chair by an independent researcher blinded to the treatment group. Participants will be asked to refrain from caffeinated drinks. EEG data will
be collected using the SynAmps RT Amplifier (Compumedics Neuroscan). The EEG will be sampled with 64 electrodes placed in the standard 10–10 International placement, and impedances will be checked to remain below 5 kΩ. The EEG data will then be resampled to 128 Hz, band-pass filtered (fast Fourier transform filter) to 0.01–44 Hz and re-referenced to the average reference using the EEGLAB function in Matlab. The data will then be plotted in EEGLAB for a careful inspection of artefacts and manual rejection.

Standardised low-resolution brain electromagnetic tomography (sLORETA) will be used to estimate intracerebral electrical sources that generate scalp-recorded activity in each of the following 10 frequency bands, that is, infraslow (0.01–0.1 Hz), slow (0.2–1.5 Hz), delta (2–3.5 Hz), theta (4–7.5 Hz), alpha1 (8–10 Hz), alpha2 (10.5–12 Hz), beta1 (12.5–18 Hz), beta2 (18.5–21 Hz), beta3 (21.5–30 Hz) and gamma (30.5–44 Hz). The following three analyses will be used to explore the specific (ie, at the targeted cortical regions) and non-specific (ie, other cortical regions) effects of the HD-tIPNS on cortical activity and connectivity:

- Whole-brain analysis: will be used to explore the overall (specific and non-specific) changes in the current density in the cortical regions. Comparisons will be made between pre-treatment and post-treatment measurements on a whole-brain by sLORETA statistical contrast maps through multiple voxel-by-voxel comparisons in a logarithm of t-ratio.109–111

- Region of interest analysis: will be used to calculate and compare the log transformed current density changes at the targeted brain regions (pgACC, dACC and SSC). The ROI maker 1 function in sLORETA will be used to define the region of interest. A seed point will be provided for each region of interest and all voxels within a radius of 10 mm will be averaged to calculate the current density.

- Lagged phase connectivity: will be used as a measure of coherence and will be calculated between all the regions of interest for all the 10 frequency bands as described above.109–111 Comparisons will be made between pre-treatment and post-treatment measurements using sLORETA statistical contrast maps through multiple voxel-by-voxel comparisons in a logarithm of t-ratio.109–111

**Statistical analysis**

SPSS V.27.0 will be used for all statistical analyses. Descriptive statistics will be used to analyse feasibility, safety and acceptability measures. As this is a feasibility study, tests for significance to compare clinical or secondary measures between study groups will not performed, but descriptive statistics will be calculated.

All measures will be analysed based on intention-to-treat principle and as per the originally assigned groups. Last observation carried forward methodology will be used to compute missing data. Mean±SDs and mean differences (95% CI) will be calculated from baseline to each interim and primary endpoint (T₃mₜ).

Percentage change to baseline will be calculated for primary pain (BPI) and functional (RMDQ) measures as below (eg, for T₃mₜ):

\[
\text{PercentChangeToBaseline} = \frac{\text{T₃mₜ} - \text{Bₚ}}{\text{Bₚ}} \times 100
\]

A≥30% decrease will be considered as a meaningful clinical important difference (MCID). Proportion of participants with changes ≥MCID will be calculated and descriptively compared between groups.

**A nested qualitative study**

We will include a nested qualitative study to explore participants’ experiences and acceptability of intervention procedures. Semi-structured in-depth interviews will be conducted by a researcher, blinded to treatment allocation, immediately post-intervention. All participants will be invited to participate. The aims of this study are explorative in nature and will evaluate participant’s experiences, exploring difficulties and barriers faced, perception towards intervention/research process, acceptability of intervention, perceived value and positive aspects of the study, and any other issues that arise during interviews. Table 4 presents the questions that will be used as a guide for the interview. The interviews will be audiorecorded and fully transcribed. The analysis will be guided by General Inductive Approach,112 113 which provides a pragmatic framework for identifying shared and individual experiences and embraces findings derived from both research objectives (deductive) and those arising directly from analysis of raw data (inductive). A constant comparison process will be used; researchers will reflect on and discuss completed interviews and revise the questions schedule accordingly to ensure a broad capture of new important information. The results of qualitative study will be published separately.

**Patient and public involvement**

Patients or the public were not involved in the design, or conduct, or reporting, or dissemination plans of our research.

**DISCUSSION**

To date, there are only a limited number of studies evaluating the TES interventions in people with CLBP.45 46 A recent meta-analysis demonstrates that there is moderate quality evidence suggesting that neither repeated sessions of non-invasive brain stimulation nor its combination with other treatments significantly improves pain or disability in people with CLBP.45 As most studies evaluating tDCS of single brain region demonstrated little success in improving pain and disability in people with CLBP, future trials focusing on different TES techniques, targeting multiple cortical areas, using various parameters are warranted and recommended. The proposed research will be the first randomised placebo-controlled pilot study.
to explore a novel HD-tIPNS technique targeting multiple brain regions simultaneously in individuals with CLBP.

This pilot research will provide preliminary evidence on feasibility, safety, and acceptability of the novel HD-tIPNS technique for treatment of CLBP. Assessment of feasibility and acceptability of new interventions and study procedures is essential to determine parameters required to inform the study design of a future fully powered randomised controlled trial. Further, to the best of our knowledge, none of the previous studies have assessed the acceptability of the TES in people with CLBP. Our study will incorporate detailed mixed method approach to assess the feasibility and the acceptability of the HD-tIPNS technique and help inform interventions, study procedures and refinements and the planning of a future definitive randomised controlled trial. Additionally, although our study is not powered to test effectiveness, it will provide treatment estimates to design the sample characteristics and numbers for a fully powered randomised controlled trial in future.

ETHICS, DATA SAFETY AND DISSEMINATION

Ethical approval has been obtained from Health and Disability Ethics Committee (Ref: 20/NTB/67), who may also audit the study investigators during or after the study. Any deviations from protocol will require Ethical amendment and will be updated in the registry. To protect participant confidentiality, any personal information collected will be destroyed at the end of the project. Each participant will be given a unique identification code, and the data will be linked to that code only. All study data will be securely stored in a locked filing cabinet or electronically with password protection, such that only those involved in the research programme will have access to it. As required by the University’s research policy, any unidentified raw data on which the results of the project depend will be kept in secure storage for 10 years, after which it will be destroyed.

An independent data and safety monitoring committee will monitor the safety of the study. A serious adverse event (SAE) is defined as any untoward medical occurrence or effect that results in death, is life-threatening, requires hospitalisation, results in persistent or significant disability or incapacity. The study will be discontinued if there is any unexpected SAE, other unexpected events or if funding is completed/insufficient.

Study findings will be reported to the regulatory and funding bodies, presented at the local, national, and international conferences, and disseminated by peer-review publication in a scientific journal.

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