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4 **Criteria:**

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6 more than 600 words in length t Includes a summary statement of any conflict of interest, including  
7 financial support related to the issue addressed t Authors of the relevant manuscript discussed are  
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9 **Conflict of interest:**

10 No conflict of interest of all authors

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12 Text on next pages: 595 words.

13 A more extensive text available at: <https://schoudernetwerk.nl/page/update-nhg-standaard>

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15 **A response to the updated review of Pieters et al in JOSPT November 2019 (1).**

16 Recently we studied the effectiveness of conservative therapy in patients with subacromial  
17 pain (2). Our conclusions were: low evidence in favour of exercise therapy and low evidence  
18 against clinical relevant effectiveness of Manual Therapy (MT). Why is our interpretation  
19 about MT so different with Pieters et al (1)?

20 Unclear in the production of a SR can be the formulation of a recommendation based up on the  
21 available external evidence. An example: Bennell et al (3) published an RCT where 120 SP patients  
22 were 'treated' with the experimental intervention (Manual therapy and Exercise therapy) or with the  
23 placebo Ultra Sound. After the treatment period (11 weeks) was concluded: both groups improved  
24 but without differences between groups. In the Cochrane review (4) this study validated their  
25 interpretation: 'no clinically important differences between groups in any outcome' and thereby lead  
26 to a negative recommendation. On the other hand Steuri et al (5), referring to the same study,  
27 stated: 'Manual therapy plus exercise therapy was superior to sham ultrasound (1 study, n=120,  
28 SMD -0,48 with 95%CI -0,78 to -0,06)'. Bennell (3), Page (3) and NHG (2) concluded that there was no  
29 clinically relevant effect (difference is smaller than the MCID) and that the additional value of Manual  
30 Therapy is questionable.

31 Another point is the overlap between Manual Therapy (MT) and Exercise therapy (ET). Manual  
32 mobilisations are also used in ET. In the NHG standard the question about the additional MT value is  
33 mainly answered from the perspective of specific MT techniques. Do HVT's and SM's (High Velocity  
34 Thrust Techniques and Spinal Manipulations) have an additional effectiveness? In general we're  
35 negative about that; but we're positive about Hands-on mobilisations (6).

36 Pieters et al review (1) developed an own strategy for the strength of a recommendation: if the  
37 included systematic reviews have a satisfying quality the recommendation is strong. The normal  
38 applied GRADE strategy (7) with determination of the strength of the evidence and summary of  
39 findings table per outcome measure, is missing. Also disappointing is that they didn't answered

40 questions like: Is MT more effective than another (placebo) intervention, placebo MT and if so, are  
41 those differences clinically relevant. We did and interpreted negative about the effectiveness of MT  
42 (2, or website).

43 Pieters et al conclude: 'Four reviews (4 ,5 ,7 ,8) reported moderate and high level of evidence that in  
44 addition to exercises, manual therapy offered a short-term decrease in pain'. Nevertheless the  
45 highest quality review (4) is negative about the additional value of MT. Steuri et al (5) conclude:

46 'Although there was only very low quality evidence, exercise therapy should be considered for  
47 patients with shoulder impingement symptoms and tape, laser or manual therapy might be added'.

48 Haik et al (7) were wrong in scoring their evidence as high value (they incorrectly updated the level of  
49 evidence) and described about manual therapy including mobilisation techniques (also applied by  
50 PT's) and reported short-term positive effects. Desjardins-Charbonneau et al (8) found statistical  
51 significant differences but without clinical relevancy (mean difference 1 point on a 0-10 NPRS).

52 The effectiveness of spinal manipulations as additional therapy to exercise is questionable. Hands-on  
53 mobilisations have positive short term effects in pain relief and function improvement but these  
54 techniques are not reserved to MT.

55 Because exercise therapy is the key treatment and is the main PT therapy, specific referral of patients  
56 with subacromial shoulder pain to a MT is most of the time not indicated. We have no indication that  
57 MT's perform better on exercise therapy than PT's.

58 We don't agree with the interpretations of our colleague reviewers and consider their review  
59 outcome as preference based PT and not evidence based PT.

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