

## KEY PATIENT INFORMATION POINTS

### ◆ Simple Backache - give positive messages

- ◆ There is nothing to worry about. Backache is very common.
- ◆ No Sign of any serious damage or disease. Full recovery in days or weeks - but may vary.
- ◆ No permanent weakness. Recurrence possible -but does not mean re-injury.

Activity is helpful, too much rest is not.  
Hurting does not mean harm.

### ◆ Nerve Root Pain - give guarded positive messages

- ◆ No cause for alarm. No sign of disease.
- ◆ Conservative treatment should suffice - but may take a month or two.
- ◆ Full recovery expected - but recurrence possible.

### ◆ Possible Serious Spinal Pathology - avoid negative messages

- ◆ Some tests are needed to make the diagnosis.
- ◆ Often these tests are negative.
- ◆ The specialist will advise on the best treatment.
- ◆ Rest or activity avoidance until appointment to see specialist.

## PATIENT BOOKLET

The above messages can be enhanced by an educational booklet given at consultation. The back book is an evidence based booklet developed for use with these guidelines, and is published by HMSO.

(ISBN 011 702 0788)

These brief clinical guidelines and their supporting base of research evidence is intended to assist in the management of acute back pain. It presents a synthesis of up-to-date international evidence and makes recommendations on case management.

Recommendations and evidence relate primarily to the first six weeks of an episode, when management decisions may be required in a changing clinical picture.

These guidelines have been constructed by a multi-professional group and subjected to extensive professional review.

They are intended to be used as a guide by the whole range of health professionals who advise people with acute low back pain, particularly simple backache, in the NHS and in private practice.

## KEY AUDIT POINTS

- ◆ Consideration of "Red Flag" symptoms.
- ◆ Discourage bed rest.
- ◆ Recommendation to return to normal activities.
- ◆ Specific aims for physical therapy.

## KEY IMPLEMENTATION POINTS

- ◆ Local ownership is important. Guidelines should be placed in local context but not at the expense of changing the principle recommendations.
- ◆ Multiple methods of implementation are more likely to be effective than single methods. These can include peer groups, audit feedback, facilitators and educational outreach.

### Psychosocial 'Yellow Flags'

When conducting assessment, it may be useful to consider psychosocial 'yellow flags' (beliefs or behaviours on the part of the patient which may predict poor outcomes).

The following factors are important and consistently predict poor outcomes:

- ◆ a belief that back pain is harmful or potentially severely disabling
- ◆ fear-avoidance behaviour and reduced activity levels
- ◆ tendency to low mood and withdrawal from social interaction
- ◆ expectation of passive treatment(s) rather than a belief that active participation will help

### Further information and copies of the full evidence base for these guidelines are available from:

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We are grateful to:

Professor Gordon Waddell, NHS Executive, Clinical Standards Advisory Group, U.S. Agency for Health Care Policy and Research, Swedish SBU, NZ National Health Committee

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Clinical Guidelines for the management of

# Acute Low Back Pain

### Contributing Organisations

Royal College of General Practitioners  
Chartered Society of Physiotherapy  
British Osteopathic Association  
British Chiropractic Association  
National Back Pain Association

Waddell G, McIntosh A, Hutchinson A, Feder G, Lewis M, (1999) *Low Back Pain Evidence Review* London: Royal College of General Practitioners

# ACUTE LOW BACK PAIN

## DIAGNOSTIC TRIAGE

**Diagnostic triage is the differential diagnosis between:**

- ◆ simple backache (non-specific low back pain)
- ◆ nerve root pain
- ◆ possible serious spinal pathology (tumour, infection, inflammatory disorders, cauda equina syndrome, etc.)

**Simple backache: *specialist referral not required***

- ◆ Presentation age 20-55 years
- ◆ Lumbosacral, buttocks & thighs
- ◆ "Mechanical" pain
- ◆ Patient well

**Nerve root pain: *specialist referral not generally required within first four weeks, provided resolving***

- ◆ Unilateral leg pain > LBP
- ◆ Radiates to foot or toes
- ◆ Numbness & paraesthesia in same distribution
- ◆ SLR reproduces leg pain
- ◆ Localised neurology

**Red flags for Possible serious spinal pathology: *prompt referral (less than four weeks)***

- ◆ Presentation age < 20 or >55
- ◆ Non-mechanical pain
- ◆ Thoracic pain
- ◆ PH-carcinoma, steroids, HIV
- ◆ Unwell, weight loss
- ◆ Widespread neurology
- ◆ Structural deformity

**Cauda equina syndrome: *immediate referral***

- ◆ Sphincter disturbance
- ◆ Gait disturbance
- ◆ Saddle anaesthesia

**The evidence is weighted as follows:-**

\*\*\* Generally consistent finding in a majority of acceptable studies.

\*\* Either based on a single acceptable study or a weak or inconsistent finding in some of multiple acceptable studies.

\* Limited scientific evidence which does not meet all the criteria of 'acceptable' studies.

## PRINCIPAL RECOMMENDATIONS

### ◆ Assessment

- ◆ Carry out diagnostic triage (see left).
- ◆ X-rays are not routinely indicated in simple backache.
- ◆ Consider psychosocial 'yellow flags'

### ◆ Drug Therapy

- ◆ Prescribe analgesics at regular intervals not p.r.n.
- ◆ Start with paracetamol. If inadequate substitute NSAIDs (e.g. ibuprofen or diclofenac) and then paracetamol-weak opioid compound (e.g. codydramol or coproxamol). Finally, consider adding a short course of muscle relaxant (e.g. diazepam or baclofen).
- ◆ Avoid narcotics if possible.

### ◆ Bed Rest

- ◆ Do not recommend or use bed rest as a treatment
- ◆ Some patients may be confined to bed for a few days as a consequence of their pain but this should not be considered a treatment.

### ◆ Advice on staying active

- ◆ Advise patients to stay as active as possible and to continue normal daily activities.
- ◆ Advise patients to increase their physical activities progressively over a few days or weeks.
- ◆ If a patient is working, then advice to stay at work or return to work as soon as possible is probably beneficial.

### ◆ Manipulation

- ◆ Consider manipulative treatment for patients who need additional help with pain relief or who are failing to return to normal activities.

### ◆ Back exercises

- ◆ Referral for reactivation / rehabilitation should be considered for patients who have not returned to ordinary activities and work by 6 weeks.

## EVIDENCE

- \* Diagnostic triage forms basis for referral, investigation and management
- \* Royal College of Radiologists Guidelines
- \*\*\* Psychosocial factors play an important role in low back pain and disability and influence the patients response to treatment and rehabilitation.

- \*\* Paracetamol effectively reduces low back pain.
- \*\*\* NSAIDs effectively reduce pain. Ibuprofen and diclofenac have lower risks of GI complications.
- \*\* Paracetamol-weak opioid compounds may be effective when NSAIDs or paracetamol alone are inadequate.
- \*\*\* Muscle relaxants effectively reduce low back pain.

- \*\*\* Bed rest for 2-7 days is worse than placebo or ordinary activity and is not as effective as alternative treatments for relief of pain, rate of recovery, return to daily activities and work.

- \*\*\* Advice to continue ordinary activity can give equivalent or faster symptomatic recovery from the acute attack and lead to less chronic disability and less time off work.

- \*\*\* Manipulation can provide short-term improvement in pain and activity levels and higher patient satisfaction.
- \*\* The optimum timing for this intervention is unclear.
- \*\* The risks of manipulation are very low in skilled hands.

- \*\*\* It is doubtful that specific back exercises produce clinically significant improvement in acute low back pain.
- \*\* There is some evidence that exercise programmes and physical reconditioning can improve pain and functional levels in patients with chronic low back pain. There are theoretical arguments for starting this at around 6 weeks