

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 The Stationery Office (ISBN 011 702 0788).

These brief clinical guidelines and their supporting base of research evidence are intended to assist in the management of acute low 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. However, the guidelines may also be useful in the sub-acute period.

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.

◆ 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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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

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A C U T E L O W B A C K P A I N

DIAGNOSTIC TRIAGE

Diagnostic triage is the differential diagnosis between:

- ◆ Simple backache (non specific low back pain)
- ◆ Nerve root pain
- ◆ Possible serious spinal pathology

Simple backache: *specialist referral not required*

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

Nerve root pain: *specialist referral not generally required within first 4 weeks, provided resolving*

- ◆ Unilateral leg pain worse than low back pain
- ◆ Radiates to foot or toes
- ◆ Numbness & paraesthesia in same distribution
- ◆ SLR reproduces leg pain
- ◆ Localised neurological signs

Red flags for possible serious spinal pathology:
consider prompt investigation or referral (less than 4 weeks)

- ◆ Presentation under age 20 or onset over 55
- ◆ Non-mechanical pain
- ◆ Thoracic pain
- ◆ Past history - carcinoma, steroids, HIV
- ◆ Unwell, weight loss
- ◆ Widespread neurological symptoms or signs
- ◆ Structural deformity

Cauda equina syndrome: *emergency 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' (see over).

◆ **Drug Therapy**

- ◆ Prescribe analgesics at regular intervals, not p.r.n.
- ◆ Start with paracetamol. If inadequate, substitute NSAIDs (eg ibuprofen or diclofenac) and then paracetamol-weak opioid compound (eg codydramol or coproxamol). Finally, consider adding a short course of muscle relaxant (eg diazepam or baclofen).
- ◆ Avoid strong opioids 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 the 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 patient's response to treatment and rehabilitation.

S I M P L E B A C K A C H E

- ** 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.