Management of acute mechanical low back pain

Introduction

Acute low back pain is common but rarely due to serious pathology.

This desk aid summarises current guidance on the management of acute mechanical low back pain – i.e. within six weeks of onset.

Clinical features

Back pain presenting in patients aged 20 to 55 years which is:

- Located in the lumbosacral area, buttocks and thighs
- Worse in the back than in the legs
- Of less than six weeks duration
- Exacerbated and/or relieved by mechanical factors
- Not associated with systemic upset.

Principles of effective healthcare

Having excluded serious pathology, manage patients by giving:

- **Reassurance** (to reduce anxiety)
  - No sign of serious disease
  - Good natural history of recovery
- **Advice**
  - Maintain normal daily activity including work if possible
  - Avoid bed rest, if possible, as this actually delays recovery
- **Analgesia** – preferably to be taken at regular intervals. Options include:
  - Paracetamol (first choice); NSAIDs (if no contra-indications); combination of two analgesics

Consider a short course of muscle relaxants and/or manipulation for the small proportion of patients whose pain does not settle with advice and analgesia.

Managing occupational issues

- Encourage patients to stay in work if possible
- Consider suggesting work adjustments rather than signing the patient off work
- Consider issuing a Med 3 as 'You need **not** refrain from work' with specific advice to the employer written in the 'remarks' section
- Advise patients initially unfit for work to go back as soon as possible – **they do not need to wait until they are pain free.**

DON'T TAKE BACK PAIN LYING DOWN

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Patient presenting with back pain

History
Site of pain +/– radiation
Duration of pain and nature of onset
Precipitating/relieving factors
Other symptoms

Examination
Observation – gait
Spine – structural abnormality/tenderness
Straight leg raising
Neurology if symptoms dictate

Diagnostic triage (divides patients into three broad categories):

Serious pathology (around 1%)

Cauda Equina Syndrome:

- Sphincter disturbance
- Gait disturbance
- Saddle anaesthesia……

ADMIT as an emergency

Possible serious pathology suggested by 'red flags'

- Presentation under age 20 or over age 55
- Non-mechanical pain
- History of trauma
- History of carcinoma
- Systemically unwell
- Weight loss
- Systemic steroids
- IV drug use/HIV
- Structural deformity
- Widespread neurological symptoms or signs
- Pulsating abdominal mass

If clinical assessment suggests that serious pathology is possible:

URGENT investigation and referral

Acute mechanical low back pain (95%)

Initial Management:

Information:
- No sign of any serious disease
- No need for X-rays
- Good prognosis
- If movement causes pain this does not indicate 'harm'

Advice: – Stay active – continue normal daily activities including work if possible

Analgesia: – preferably taken regularly to relieve pain and allow continued normal activity
- First choice – paracetamol
- Other options include:
  - NSAIDs – if no contra-indications
  - Combinations e.g. paracetamol/codeine

If pain not controlled:
- Consider short course of muscle relaxants (diazepam): Advise on side effects; give for < 7 days only

If failing to return to normal activities:
Reassess to exclude serious pathology
- Consider a short course of manipulation
- Address beliefs/behaviours that may be delaying recovery

Nerve root pain (around 4%)

- Unilateral leg pain worse than low back pain
- Radiates to foot or toes
- Numbness and paraesthesia in same distribution
- Single Leg Raise reproduces leg pain
- Localised neurological signs

REFER if:
- Progressive neurological deficit (weakness, anaesthesia) – **URGENT**
- Pain not resolving after three to four weeks – **SOON**

Addressing beliefs/behaviours that may delay recovery

Patients who fail to resume normal activity may have certain beliefs and behaviours that are delaying recovery. These include:

- A belief that back pain is harmful or potentially seriously disabling
- A reluctance to remain active for fear of pain
- An expectation of 'treatment' rather than engaging in self-help

Tackling these involves:

- Recognition of these beliefs/behaviours
- Reinforcing positive messages (consider the use of appropriate written material)
- Referral if the patient remains unable to manage their pain.

Referral options for patients who do not resume normal activity within six weeks

Guidance recommends that, where possible, referral should be to a multi-disciplinary back pain team. However, local back pain services will vary. These may be physiotherapy or physician led.

Referral for diagnostic imaging or orthopedic surgery is not indicated for mechanical low back pain.

Useful resources/links

Welsh Backs – www.welshbacks.com

Patient information:

- A public information leaflet can be ordered via the website - www.welshbacks.com or by phoning 0845 609 6006
- The Back Book – available from The Stationery Office (www.tso.co.uk/bookshop)

Advice about occupational health issues:

- Referral to a Jobcentre Plus Personal Advisor – www.jobcentreplus.gov.uk
- Referral to a Disability Employment Advisor – www.dwp.gov.uk/medical

References:

- The Occupational Health Guidelines for the Management of Low Back Pain at Work, Faculty of Occupational Medicine, 2000. www.facoccmed.ac.uk
- European Guidelines/COST B13 http://www.backpaineurope.org/web/files/WG1_Guidelines.pdf
- Referral Guidance: a guide to appropriate referral from general to specialist services, National Institute for Clinical Excellence, 2001. www.nice.org.uk