Management of low back pain in primary care

DR VINAY KETKAR
MBChB MRCGP DRCOG DPCR MSOM Dip SEM
MUSCULOSKELETAL PHYSICIAN
ROYAL ORTHOPAEDIC HOSPITAL

Low back pain prevalence

- Common reason for consultation
- 1 in 3 people will have back pain each year
- Lifetime incidence 60-80%
- Economic costs

In summary what can be done in general practice

- Differentiate spinal/non spinal origin
- Identify red flag patients and refer appropriately
- Manage non specific back pain with reassurance regular follow up
- Manage nerve root pain appropriately

Ensure pain is spinal in origin

Look at patient as a whole

GP in good position as have knowledge of and notes available regarding past history, social history occupation ,family history

History features gastrointestinal,genitourunary symptoms

Examination abdomen for AAA etc pelvic exam

Diagnostic triage

- Nonspecific low back pain (94%)
- Nerve root pain (5%)
- Serious spinal pathology (1%)

Red flags

- **Cauda equina syndrome**
- From medical history:
  - Saddle anaesthesia or paraesthesia.
  - Recent onset of bladder dysfunction (the bladder distends because sensation of fullness is lost; bladder control is lost because there is no sensation when passing urine).
  - Recent onset of faecal incontinence (due to loss of sensation of rectal fullness).
- From physical examination:
  - Perianal/perineal sensory loss.
  - Unexpected laxity of the anal sphincter.
  - Severe or progressive neurological deficit in the lower extremities, such as major motor weakness with knee extension, ankle eversion, or foot dorsiflexion.

Red flags

- Onset at age below 20 or above 50years
- Past medical history of cancer
- Past history of T.B. HIV, intravenous drug use
- Unexplained weight loss or systemic symptoms
- Severe trauma
- Constant unremmiting pain
- Past prolonged use of steroids
- Structural deformity
- Progressive worsening neurology

Red herrings

- Red flags as above may be absent early on
- 80 percent of patients will have one of the red flags
- Do not rely on recent normal investigations

Nerve root pain

- Sharp , burning, shooting pain in a dermatomal distribution
- May be associated with sensory loss, motor weakness
- Physical signs . Positive SLR or slump test, loss of reflexes, motor weakness and or loss of pinprick sensation

Nerve root pain

- Initial management
- Explain cause of problem, provide information and reassurance
- Good analgesia same as for non specific pain
- If muscle spasm can use diazepam or heat packs for a few days as well
- Regular review
- If not improving 2-3 weeks refer to back pain clinic

Nerve root pain

- Secondary care management
- Physiotherapy
- Epidural injection
- Selective nerve root blocks
- Investigation with mri/ct scan
- Surgery

Non specific back pain

- Acute
- Examine, reassure, educate e.g. back book
- Simple analgesia
- Encourage to keep active (bed rest only up to 48 hrs /as necessary)
- Self management c.f. migraine
- Offer to review

Persistent nonspecific back pain

- By definition more than 6 weeks
- Offer regular review , good communication and encourage self management
- Analgesia paracetamol regular use, NSAID with gastro-protection if over 45 yrs, weak opioid, tricyclic antidepressant, strong opioid short duration
- Exercise therapy (8-10 sessions over 12 weeks)
- Acupuncture (10 sessions over 12 weeks)
- Spinal manipulation (9 sessions over 12 weeks)

Sheffield Back Pain

The Keele STarT Back Musculoskeletal Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

		Disagree 0	Agree 1
1	My pain has **spread** at some time in the past 2 weeks	☐	☐
2	In addition to my main pain, I have had **pain elsewhere** in the last 2 weeks	☐	☐
3	In the last 2 weeks, I have only **walked short distances** because of my pain	☐	☐
4	In the last 2 weeks, I have **dressed more slowly** than usual because of my pain	☐	☐
5	It is really not safe for a person with a condition like mine to be physically active	☐	☐
6	**Worrying thoughts** have been going through my mind a lot of the time in the last 2 weeks	☐	☐
7	I feel that **my pain in terrible** and that and that **it's never going to get any better**	☐	☐
8	In general in the last 2 weeks, I have **not enjoyed** all the things I used to enjoy	☐	☐

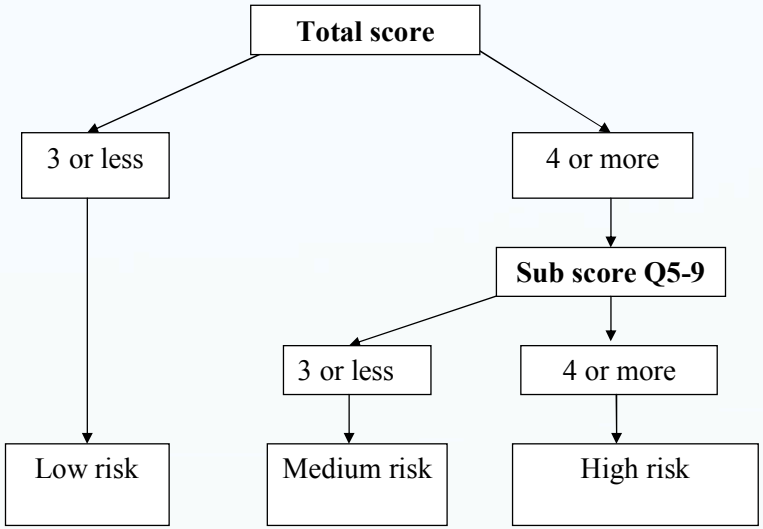
9. Overall, how **bothersome** has your pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ Sub Score (Q5-9):_____

[1]

The STarT Tool Scoring System



[1] © Keele University 01/08/07
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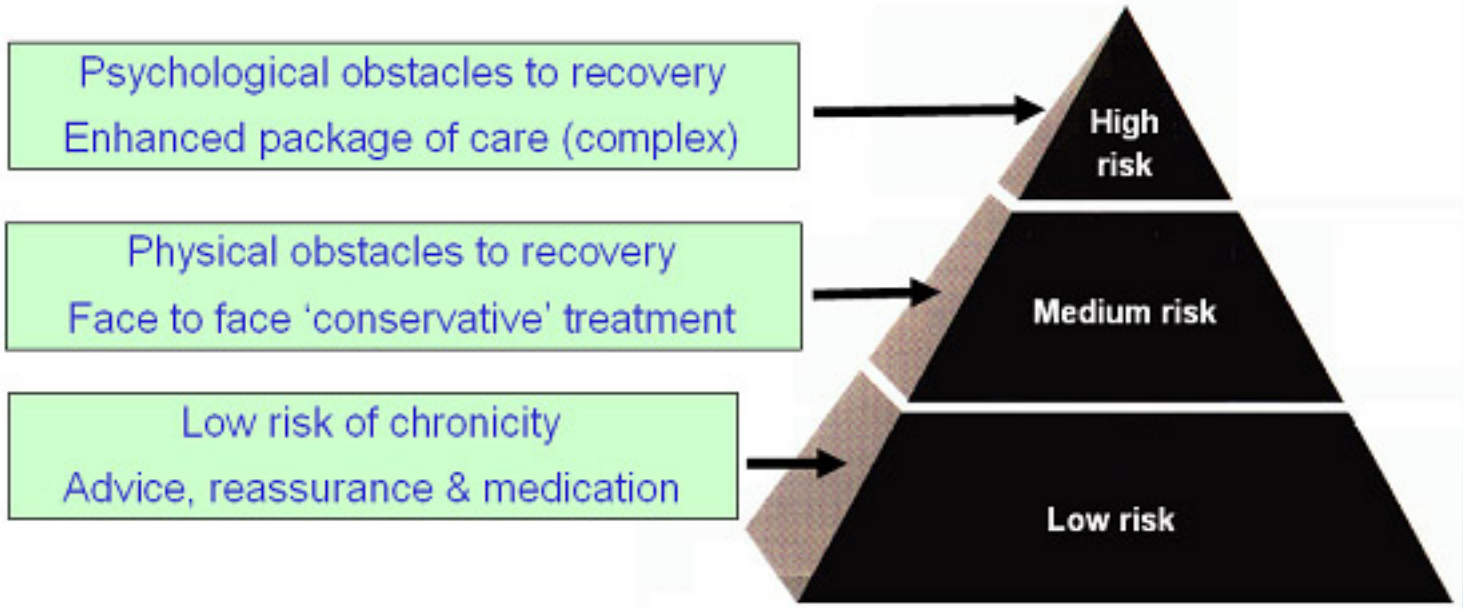
Concept of subgroup & targeting for primary care low back pain



Persistent low back pain

- Refer for combined physical and psychological therapy if above treatment has been tried and patient still has pain and have high disability and psychological distress
- Start-back questionnaire /Oswestry disability index
- Do not offer x ray for non specific back pain (radiation dose)
- Only offer MRI to exclude specific pathology or as part of surgical referral
- Refer for specialist assessment
- NICE guidelines suggest not offer laser, interferential, therapeutic ultrasound, injection, traction, lumbar support or tens

Persistent low back pain

Royal Orthopedic Musculoskeletal Medicine service

Assessment triage into appropriate service

Refer non specific low back pain at 4 -6 weeks or earlier depending on patients circumstances and risk level on StarT- back. Nerve root pain refer at 2-3 weeks

Bio-psychosocial assessment

Further treatments

Musculoskeletal medicine service

- Physiotherapy
- Functional restoration
- Injection therapy
- Surgical referral

Injection treatments

- Limited evidence but trials and research lacking and no evidence for many of the treatments recommended by nice
- NICE recommends use only if pain persisted 1 year (controversial)
- Facet joint injection ,
- Prolotherapy
- Radiofrequency denervation

In summary what can be done in general practice

- Differentiate spinal/non spinal origin
- Identify red flag patients and refer appropriately
- Mange nerve root pain
- Manage non specific back pain with reassurance regular follow up and refer if high risk for chronicity