

New clinical guideline for low-back pain

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A summary of evidence on the diagnosis and treatment of low-back pain has prompted the American Pain Society (ASP) and the American College of Physicians (ACP) to issue a new treatment guideline. The guideline is based on a thorough analysis of published research conducted by investigators at the Oregon Evidence-Based Practice Center at Oregon Health & Science University.

Among the recommendations issued by a panel of experts convened by the ACP and ASP are: Clinicians should rely less on X-rays and expensive diagnostic imaging and reports and more on therapies supported by the evidence, including some medications and some alternative therapies. The guideline and two background papers are published in the October issue of the *Annals of Internal Medicine*.

“There is good evidence that clinicians should not order X-rays or other imaging tests for patients with nonspecific low-back pain. They are not helpful and could result in excessive radiation exposure or unnecessary procedures,” said Roger Chou, M.D., co-author of the new guidelines, senior author of both background papers, and associate professor of medicine (general internal medicine and geriatrics) and medical informatics and clinical epidemiology in the OHSU School of Medicine, Oregon Evidence-Based Practice Center at OHSU.

That said, clinicians should order diagnostic imaging tests for patients known or believed to have underlying neurological or spinal disorders, Chou explained. Chou also is head of the American Pain Society’s Clinical Practice Guideline Program.

About one if four Americans experiences low-back pain at least once a day, resulting in more than \$26 billion in direct health care costs, studies have shown. And low-back pain is the fifth most common reason patients make a doctor's appointment.

The new guideline recommends clinicians weigh carefully potential benefits and risks of any drug and explain that they be used based on the severity of baseline pain and functional impairment.

“Some medications offer some benefits for low-back pain but they have risks,” said Chou. “For example, acetaminophen is safe but not that effective, NSAIDs [nonsteroidal anti-inflammatory drugs) like ibuprofen provide more relief but have gastrointestinal and cardiovascular side effects, and opioids can treat severe pain but pose risks for sedation and dependence over time. Physicians and patients should discuss proven options and select the ones that best suit their specific needs.”

There are a number of treatments for low-back pain that don't include medication, such as supervised exercise therapy, chiropractic care and massage therapy. The guideline suggests these options for patients who do not improve with self-care or pain medication.

The Annals article covers low-back-pain treatment in primary care settings only, and does not make recommendations regarding specialized, invasive procedures to treat the condition. Chou said APS will release the complete guideline in 2008 covering both the primary care recommendations as well as invasive treatments for low-back pain.

Members of the panel who issued the guideline represent more than 15 different areas of expertise Their seven recommendations are:

-- Clinicians should conduct a focused history and physical examination to help place patients with low-back pain into one of three broad

categories: nonspecific low-back pain, back pain potentially associated with radiculopathy (nerve disorders) or spinal stenosis (narrowing), or back pain associated with another specific cause. The history should include assessment of psychosocial risk factors, which predict risk for chronic disabling back pain.

-- Clinicians should not routinely obtain imaging or other diagnostic tests in patients with non-specific low-back pain.

-- Clinicians should perform diagnostic imaging and testing for patients with low-back pain when severe or progressive neurologic deficits are present or when serious underlying conditions are suspected.

-- Clinicians should evaluate patients with persistent low-back pain and signs or symptoms of radiculopathy or spinal stenosis with magnetic resonance imaging (preferred) or computed tomography only if they potential candidates for surgery or epidural steroid injection (for suspected radiculopathy).

-- Clinicians should provide patients with low-back pain evidence-based information about their expected course, advise patients to remain active, and provide information about effective self-care options.

-- For patients with low-back pain, clinicians should consider the use of medications with proven benefits in conjunction with back care information and self care. Clinicians should assess the severity of baseline pain and functional deficits, potential benefits, risks, and relative lack of long-term efficacy and safety data before initiating therapy.

-- For patients who do not improve with self-care options, clinicians should consider the addition of non-pharmacologic therapy with proven benefits for low-back pain. They are spinal manipulation for acute low-

back pain; and for chronic or sub-acute low-back pain options include: intensive interdisciplinary rehabilitation, exercise therapy, acupuncture, massage therapy, spinal manipulation, yoga, cognitive-behavioral therapy, or progressive relaxation.

Source: Oregon Health & Science University

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