MBIPA Monterey Bay INDEPENDENT PHYSICIAN ASSOCIATION

MBIPA CONSENSUS STATEMENT

EVALUATION AND TREATMENT OF ACUTE LOW BACK PAIN

CRITICAL GOALS

- **AVOID IMAGING AND LABS**
- **INVOLVE PATIENT IN ACTIVE SELF-THERAPY, COMBINED WITH NSAID'S**
- **MANAGE EXPECTATIONS FOR RECOVERY**
- **AVOID OPIOID NARCOTICS – *NOTE* RECENT EPIDEMIC OF ADDICTION AND ACCIDENTAL DEATHS**

ETIOLOGIES

- Nonspecific low back pain (*>85% of those presenting to primary care*)
- Serious etiologies to consider and rule out:
  - Spinal cord/cauda equina syndrome
  - Spinal epidural abscess
  - Metastatic cancer
  - Vertebral osteomyelitis
- Less serious specific etiologies:
  - Vertebral compression
  - Disc herniation
  - Radiculopathy
  - Spinal stenosis

INITIAL EVALUATION

1. IF ACUTE (<4 weeks) – ***NO LABS OR IMAGING***
   - However, r/o severe etiologies that would indicate the immediate need
2. HISTORY
   - Location, duration, severity, compare with previous episodes
   - Constitutional sx's, Hx of diabetes or malignancy, Rx's attempted, Neuro sx's, Recent bacterial infection/injected drugs/corticosteroids /invasive back procedures
3. PHYSICAL EXAM
   - Inspection, palpation, percussion
   - Neurologic – reflexes, strength, sensation, gait
   - Straight leg raise – r/o psychologic component w/ distraction
4. IMAGING
   - *No imaging studies indicated prior to referral* - (see below)

TREATMENT OF ACUTE NONSPECIFIC BACK PAIN

FIRST TWO-WEEK PROTOCOL

1. ACTIVITY
   - Do NOT advise bed rest. If pain limits activity, gradually *increase* as tolerated.
2. MANDATED HOME EXERCISE/ACTIVITY PROGRAM –
   - Give patient instructions and printed materials.
   - Empower patient to self-therapy.
3. WORK

- Return to work if able to control activity and does not require back strain.

4. MEDICATIONS
   - INITIAL MONOTHERAPY
     - NSAID's / COX-2 inhibitors
       - Ibuprofen 800 TID
       - Naproxen 250-500 BID
       - COX-2 inhibitors - more expensive, use if above not tolerated
     - Acetaminophen (esp. if cannot tolerate NSAID's)
       - Less evidence of benefit
       - Watch dose, hepatotoxicity
   - SECOND-LINE COMBINATION THERAPY
     - Combination with muscle relaxants
       - Cyclobenzaprine (Flexeril) – alone, some benefit; mixed evidence in combination
       - AVOID BENZODIAZEPINES – less evidence of benefit; abuse potential
     - Combining NSAID's with Acetaminophen – no evidence combination is more effective acutely, limited evidence in first-line failure who cannot tolerate muscle relaxants
   - REFRACTORY OR VERY SEVERE PAIN
     - Opioids
       - *Limited evidence of benefit over others in acute setting*
       - Short term (limit to 3 days only), scheduled doses better than prn
       - Accidental addiction and abuse potential is a *serious concern*
     - Tramadol
       - *Little data for acute,* may be effective for chronic back pain
   - OTHER MEDICATIONS – no evidence of benefit in acute back pain
     - Antidepressants, systemic glucocorticoids, antiepileptics, topical agents (*low-quality evidence for capsicum*), herbal therapies

IF PAIN PERSISTS AFTER FIRST TWO-WEEK PROTOCOL (*add* to above)

1. EXERCISE AND PHYSICAL THERAPY REFERRAL (AQUATIC AND LAND-BASED)
   - Initiate if insufficient relief with 2 weeks of conservative therapy
2. SPINAL MANIPULATION (CONSIDER) - OSTEOPATHIC PREFERRED *(more active for patient)*
   - Integration with other therapy improves pain scores / decreases disability
3. ACUPUNCTURE (CONSIDER)
   - Safe - reasonable option to try, inexpensive
4. FOR SYMPTOMATIC IMPROVEMENT
   - Massage, Heat, Cold
5. PLAN FOR REFERRAL (SEE BELOW) IF NOT IMPROVING
   - Inform patient to make call in 2-3 weeks for appointment if not improving

IF PAIN NOT IMPROVED AFTER 6-8 WEEKS:

REFER TO *NON-OPERATIVE* SPINE SPECIALIST.

- They request *no imaging* prior to their seeing the patient.

PREVENTION

Exercise interventions beneficial.
Ergonomic interventions as appropriate.
Smoking cessation, weight loss – other obvious health benefits.