Guideline for the Evidence-Informed Primary Care Management of Non-Malignant

Low Back Pain

Toward Optimized Practice

new for 2009

Assessment

Conduct a full assessment including:

- history taking
- physical and neurological exam
- evaluation of red flags (refer for further evaluation and treatment as clinically indicated)
  - Features of Cauda Equina Syndrome including sudden onset or loss of bladder/ bowel control, saddle anaesthesia (emergency)
  - Severe worsening pain, especially at night or when lying down (urgent)
  - Significant trauma (urgent)
  - Weight loss, history of cancer, fever (urgent)
  - Use of steroids or intravenous drugs (urgent)
  - Patient with first episode over 50 years old (soon)
  - Widespread neurological signs (soon)

Emergency - referral within hours
Urgent- referral within 24 - 48 hours
Soon- referral within weeks

- psychosocial risk factors/yellow flags
  - psychosocial barriers to recovery that include:
    - belief that pain and activity are harmful
    - ‘sickness behaviours’ (like extended rest)
    - low or negative mood, social withdrawal
    - treatment expectations that do not fit best practice
    - problems with claim and compensation
    - history of back pain, time-off, other claims
    - problems at work, poor job satisfaction
    - heavy work, shift work
    - overprotective family or lack of support
- In the absence of red flags, reassure patient there is no serious cause
  - Pain typically resolves in a few weeks without intervention
  - Encourage patient to keep active

Management

Acute and Subacute (within 12 weeks of pain onset)

- **Educate patient** that low back pain typically resolves within a few weeks
- **Prescribe self-care strategies** including alternating cold and heat, continuation of usual activities as tolerated
- **Encourage early return to work**
- **Recommend physical activity and/or exercise**
- **Consider analgesics** in the order below:

  First line:
  Acetaminophen Up to 1000 mg QID (max of 4000 mg/day)

  Second line: NSAIDs:
  Ibuprofen: Up to 800 mg TID (max of 800 mg QID)
  Diclofenac: Up to 50 mg TID

Add: Cyclobenzaprine for prominent muscle spasm: 10 to 30 mg per day; greatest benefit seen within one week; therapy up to 2 weeks may be justified

If taking controlled release opioids: add a short-acting opioid or increase controlled release opioid by 20 to 25%

- Reassess patient, including red flags, after 1 to 6 weeks
  - if not returning to normal function or symptoms are worsening Consider Referral to:
    - Physical therapist
    - Chiropractor
    - Osteopathic physician
    - Physician specializing in musculoskeletal medicine
    - Spinal surgeon (for unresolving radicular symptoms)
    - Multidisciplinary pain program (if not returning to work)

Chronic (more than 12 weeks since pain onset)

- **Prescribe physical or therapeutic exercise**
- **Referral Options**
  - Community-based active rehabilitation program/Physical Therapy/Excerise Specialist to:
    - Establish functional goals
    - Establish functional home-based exercise program
    - Enhance self-management strategies
    - Focus on active rather than passive therapy
  - Community-based self management/ cognitive behavioural therapy program
- **Additional Options**
  - Progressive muscle relaxation
  - Acupuncture
  - Massage therapy, TENS as adjunct to active therapy

- **Analgesics Options:**

  First line:
  - Acetaminophen Up to 1000 mg QID (max of 4000 mg/day)

  Second line:
  - NSAIDs:
    Ibuprofen: Up to 800 mg TID (max of 800 mg QID)
    Diclofenac: Up to 50 mg TID

  Third line:
  - Weak Opioids
    Codeine: 30 to 60 mg every 3 to 4 hours
    Controlled release codeine: 50 to 200 mg Q8h, may also be given Q12h
  - Tricyclics (TCAs)
    Amitriptyline: 10 to 100 mg HS
    Nortriptyline (fewer adverse effects): 10 to 100 mg HS

  For moderate to severe pain

  Fourth line:
  - Tramadol (not currently covered by Alberta

Blue Cross): slow titration up to 400 mg daily; short acting form is only available in combination with acetaminophen. Monitor for total combined daily acetaminophen dose

Fifth line:

- Strong Opioids (controlled release)
  Morphine sulfate: 15 to 100 mg BID
  Hydromorphone HCl: 3 to 24 mg BID
  Oxycodone HCl: 10 to 40 mg BID-TID
  Fentanyl patch: 25 to 50 μg Q3days

Transdermal Fentanyl should NOT be pre-scribed in opioid naive patients

For appropriate patients: refer to the Canadian National Opioid Guideline endorsed by the College of Physicians and Surgeons of Alberta (coming soon)

- **Referral Options**
  - Multidisciplinary chronic pain program

- Epidural steroids (for short-term relief of radicular pain)
- Prolotherapy in conjunction with exercise

Contraindications

(evidence suggests that these maneuvers may be ineffective or possibly harmful)

- Lab tests and diagnostic imaging in the absence of red flags
- Prolonged bed rest
- Traction
- Oral steroids
- Epidural steroid injections in the absence of radicular pain
- TENS for acute pain
- Back schools for acute pain
- Massage therapy for acute pain