

Acute (<4 wks) or Subacute (>4 wks < 3 mos.) Low Back Pain



Purpose

To guide portal of entry providers (primary, urgent, emergency care) with decision making at the initial evaluation for acute or subacute low back pain. Target population: adults 18 year of age and older, in the outpatient setting. The guideline is not a comprehensive treatment guide, nor is it meant to facilitate or direct referrals for interventions or procedures. Recent research strongly suggests non-pharmacological care with treatment emphasis on patient active care and prevention.

Key Recommendations

- Set realistic expectations for time period (6-8 weeks) to feel better.
- Continue to reassure patients with positive reinforcement; movement and activity is helpful. Motion heals.
- Find a position of comfort.
- Fear avoidance behaviors are common and should be addressed before discussing exercise.
- Consider chiropractic/spinal manipulation therapy referral.
- Consider physical therapy referral.
- Do not recommend bed rest for more than 24- 48 hours when treating low back pain.
- Advise to continue daily activities as tolerated.
- Do not do imaging within first 28 days, in absence of red flags.
- See “Additional Risk Factors” on page 2.
- NSAIDs are an effective treatment for nonspecific acute low back pain.
- Muscle relaxants are considered second line therapy.
- Avoid opioids except in extenuating circumstances and with dosage restrictions.
- Consider limited use of Acetaminophen
- Consider limited or no use of oral/intravenous steroids due to limited evidence around its efficacy in acute/subacute low back pain
- Consider workplace ergonomic evaluation to optimize treatment plan
- Advise caution in co-prescribing additional centrally acting medications (muscle relaxants, opioids etc.) in patients maintained on chronic psychotropic therapy especially benzodiazepines.

**Choosing Wisely. An initiative of the ABIM Foundation. North American Spine Society - Five Things Physicians and Patients Should Question. 2013. Available from: <http://www.choosingwisely.org/doctor-patient-lists/north-american-spine-society/>*

Guidelines are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs.

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RED FLAGS AND ADDITIONAL RISK FACTORS FOR SERIOUS CONDITIONS	Refer To ER Immediately	<ul style="list-style-type: none"> • Sudden onset or otherwise unexplained loss or changes in bowel or bladder control • Sudden onset or otherwise unexplained bilateral leg weakness • Saddle numbness
	Appt < 24 hours	<ul style="list-style-type: none"> • Fever 38° C or 100.4°F for longer than 48 hours • Unrelenting night pain or pain at rest • Leg weakness (less than antigravity strength in major muscle groups) • Began < 6 wks ago w/ progressive pain & distal (below the knee) numbness or weakness of legs • Progressive neurological deficit
	Additional Risk Factors for Serious Conditions	<ul style="list-style-type: none"> • Recent significant trauma or age > 50 & milder trauma • Unexplained weight loss • Immunosuppression • History of cancer • IV drug use • Prolonged use of corticosteroids, history of osteoporosis • Age > 65
TREATMENT	For patients with red flags, suspected serious pathology	<ul style="list-style-type: none"> • Cauda equina syndrome or severe or progressive neurologic deficit – arrange for advanced imaging and definitive evaluation and care <i>immediately</i> • Expected spinal compression fractures – order plain LS spine X-ray. If x-ray does not confirm fracture, and after 10 days, patient is in severe pain OR has multiple sites of spinal pain, obtain MRI and consider referral • Cancer or infection – CBC, urinalysis, erythrocyte sedimentation rate, and plain X-ray. If still suspicious of cancer or infection, not sure about results of x-rays, get MRI scan or consider referral • Anticoagulation – concern for spinal bleed due to trauma or even suspected spontaneous bleeding – usually presents with severe back pain and progressive neurologic deficit. Obtain PT/INR and if neurologic exam is progressing MRI and emergent referral.
	For patients with no red flags	<p><i>Non-Invasive Treatment and Self-Care</i></p> <ul style="list-style-type: none"> • Reassure patients that 90% of episodes resolve spontaneously in 6 weeks • Do not do imaging within first 28 days, in absence of red flags. • Recommend remaining active and avoiding bed rest. Complete pain relief usually occurs after, rather than before, resumption of normal activities and return to work should be before complete pain relief. Light activity often hastens recovery and lessens pain. • Limited use of heating pads or heated blankets. • Aerobic exercise, exercise therapy, Intensive interdisciplinary rehabilitation (intervention that includes a physician consultation coordinated with psychological, physical therapy, social or vocational intervention), spinal manipulation by providers with appropriate training. • Recommend self-care education books such as <i>The Back Book</i>.
		<p><i>Medications</i></p> <ul style="list-style-type: none"> • Assess severity of baseline pain and functional deficits and consider use of medications with proven benefits. • For most patients, first line medication options are nonsteroidal anti-inflammatory drugs (NSAIDs). • Consider muscle relaxants with limited sedative side effects as 2nd line treatment in moderate to severe acute LBP not adequately controlled by NSAIDs. • Opioids are not suggested. <p><i>Follow Up Visit 1-3 Weeks After Initial Evaluation If</i></p> <ul style="list-style-type: none"> • No improvement with home management • Significant pain persists beyond a week • Symptoms persist, worsen or progress

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FACT SHEETS FOR CLINICIANS

Opioids – A review of the literature, identifying risk/benefits of opioid prescription and reviewing other options:

<http://mcms.org/resources/Documents/QC/Low%20Back%20Pain%20documents/Fact%20Sheet%20Opioid%201-4-19%20final.pdf>

Non-Opioid – Reviewing current evidence on non-opioid pharmaceuticals and non-pharmaceutical options:

<http://mcms.org/resources/Documents/QC/Low%20Back%20Pain%20documents/Fact%20Sheet%20Non-opioid%20Pharmacy%20for%20back%20pain%201-7-19%20final.pdf>

Patient Engagement, the key to non-pharmacological pain control. – Reviewing active care approaches and the role of patient passive care (Rx) only as a catalyst to active, patient engaged care.)

<http://mcms.org/resources/Documents/QC/Low%20Back%20Pain%20documents/Fact%20Sheet%20Pt%20engagement%20in%20active%20care%20final%201-7-19.pdf>

DECISION GUIDE FOR PATIENTS

Self-care basics – Simple guide to patient directed care for uncomplicated back pain:

<http://mcms.org/resources/Documents/QC/Low%20Back%20Pain%20documents/Self%20Care%20final.pdf>

Basic flexion and extension biased exercises – simple age appropriate exercises

Young to middle age:

<http://mcms.org/resources/Documents/QC/Low%20Back%20Pain%20documents/Exercise%20Extension%20young%20to%20middle%20age%20final%201-7-19.pdf>

Middle age to elderly:

<http://mcms.org/resources/Documents/QC/Low%20Back%20Pain%20documents/Exercise%20Flexion%20Middle%20Age%20to%20Elderly%201-7-19.pdf>

Do I need an MRI? - A primer for assisting patients in understanding the potential benefits and risks of getting an MRI:

<http://mcms.org/resources/Documents/QC/Low%20Back%20Pain%20documents/Do%20I%20need%20an%20MRI%20final%201-7-19.pdf>

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Do I need an opioid? – Reviewing the relative risk of opioid use while focusing on pain control options that are non-opioid or non-pharmaceutically based.

<http://mcms.org/resources/Documents/QC/Low%20Back%20Pain%20documents/Do%20I%20need%20an%20opioid%20prescription.pdf>

Do I need to see a surgeon? – Patients sometimes demand early surgical referral, even in the absence of a clear indication, which can trigger downstream inefficiencies and risk. Appropriate surgical need and timing is put into perspective.

<http://mcms.org/resources/Documents/QC/Low%20Back%20Pain%20documents/Do%20I%20need%20a%20surgical%20referral%201-7-19%20final.pdf>

Do I need an injection? – Like surgical referrals, patients sometimes request injections based on inaccurate (non-evidence-based) beliefs. These issues are explored.

<http://mcms.org/resources/Documents/QC/Low%20Back%20Pain%20documents/Do%20I%20need%20a%20steroid%20injection%20final%201-7-19.pdf>

Measures Commonly Used by National Organizations

Use of Imaging Studies for Low Back Pain: Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. (MIPS, HEDIS)

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<http://www.cdc.gov/drugoverdose/prescribing/guideline.html>

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Continued next page

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