Back Pain

Draft- Evidence-Based Clinical Guidelines
For The Management Of
Acute Low Back Pain

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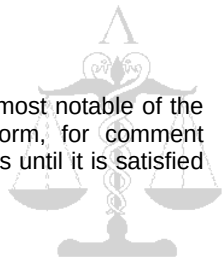
On behalf of:
The Australasian Faculty of Musculoskeletal Medicine



Backpain continues to attract the interest of guideline writers. This version, like the most notable of the 1990s, is evidence based. Unlike the others it is now opened up, in draft form, for comment internationally, and unlike the others, the sponsoring body will not ratify their contents until it is satisfied with its critical acclaim.

Several professional groupings will not be attracted to the findings.

Some of the findings are of interest in terms of diagnosis, causation and prognosis. Treatment guidance is based on a biopsychosocial model, as opposed to a tissue damage model.

Diagnosis

> "The only honest and legitimate diagnostic label that might be applied, in the first instance, to a patient presenting with acute low back pain is "lumbar spinal pain of unknown origin". Unfortunately, this term is no more than a substitute for "low back pain". However, it is more honest intellectually than a host of pseudo-labels that have been used in the past."

Our Comment
Some, but very few, cases of back pain are caused by identifiable pathologies. Many of these are given the label Red Flag conditions.

Many physicians will find it difficult to accept that they don't really know what the problem is and will have a strong need to reassure the victim that they know what's wrong and what to do about it. However, there is increasing evidence that baseless diagnoses and adoption of an unjustified medical model of back pain could be harmful.

Causation:

"*Precipitating Factors*

> A patient who has pain-free intervals might identify activities that can bring on their pain. However, there are no data to substantiate a relationship between particular precipitating factors and particular causes of back pain. At best, a record of precipitating factors provides only a description of the patient and their problem.
>
> *Aggravating Factors*
> Particular movements or activities will commonly aggravate back pain. These carry no diagnostic significance. Virtually any cause of low back pain is likely to be aggravated by movement and activities of daily living.
>
> At best, listing aggravating factors provides a description of the patient and their problem, and foreshadows the assessment of disability. What will be difficult to distil is the extent to which aggravation is due to an actual increase in painful sensations from the back or to fear of aggravation and resultant avoidance of activity."

Our Comment
It is clear that there is little evidence to associate actions or activity with the cause or worsening of pain. Again this will be difficult for some professions and victim representatives to accept. Much of the operation of medical and compensation world is predicated on physical, attributable causes of pain (actually injury). The evidence is that back pain will not easily fit into this paradigm. What is very often found in the evidence is that people with active manual jobs complain more often about back pain. The reason for this is speculative but may include the difficulties presented in carrying out work tasks while in pain.

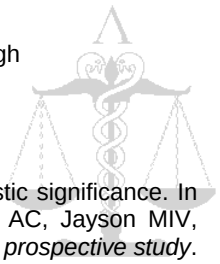
However, this does not mean that backpain is not an issue for liability insurers. EC guidance on manual handling at work was (hopefully) based on the need to protect against back pain, failure to meet these duties will be cited as evidence of breach of duty in support of compensation claims.

The effect of the EC guidance may be more accurately described as providing a mechanism for easing the work of those in pain, a laudable aim, but perhaps outside the remit of liability insurance.

Prognosis:

Epidemiological evidence finds that:

- "Patients are likely to recover from their presenting episode of back pain.
- The median time to recovery is about seven weeks; but
- Relapses are common; and
- Up to 80% of patients may remain disabled to some degree at 12 months; although
- Perhaps only 10% - 15% will be highly disabled.
- The status of the patient at 2 months is an indicator of their status at 12 months."



Risk factors for chronicity

> "It should also be recognised that a single risk factor alone carries little prognostic significance. In this regard, a recent study [Thomas E, Silman AJ, Croft PR, Papageorgious AC, Jayson MIV, Macfarlane GJ. *Predicting who develops chronic low back pain in primary care: a prospective study*. Brit. Med. J 1999; 318:1662-1667.] has highlighted the importance of multiple, simultaneous factors. In that study, the cardinal risk factors for chronicity identified were history of low back pain, dissatisfaction with current employment or work status, widespread pain, radiating leg pain, restriction in two or more spinal movements, and gender. Of patients with none, one or two risk factors, only 6% become chronic sufferers.
>
> The corresponding percentages for those with three or four factors were 27% and 35%; but of patients five or six factors, 70% become chronic.
>
> Without venturing to rank individual studies for rigour and reliability, the cardinal prognostic risk factors that have been identified for chronicity of back pain are listed in Table 6.1. Those factors identified in methodologically more rigorous studies are shown in upper case, while those factors found in less robust studies are shown only in lower case. Those factors listed in parentheses are ones detected in weaker studies but explicitly denied in stronger studies."

Our Comment

Prevention of unnecessary chronicity and severity of pain and disability should be the aim of those stakeholders with an obligation to the person in pain. However, as with causation, the existing systems and institutions that respond to back pain incidence are based on inappropriate paradigms. It is interesting that none of the factors prognostic for chronicity are based on traditional ergonomics, even though these were hypothesised in the research.

The stage is set for a more enlightened approach to back care.

IMMUTABLE	**Biological**	**Psychosocial**
	(age) (gender) (race) frequency of attacks playing adult sport DURATION. PAST HISTORY OF BACK PAIN.	marital status family status
RELATIVELY IMMUTABLE	severity job demands LEG PAIN	compensation employment wage occupation somatisation JOB DISSATISFACTION. EDUCATION. MMPI.
POTENTIALLY REMEDIABLE	smoking . BMI. inability to sit-up. WORK CAPACITY. DISABILITY.	inappropriate signs. lack of understanding. SICKNESS IMPACT. DEPRESSION. COPING. DISTRESS. RATINGOF LOADS. FEAR.