B McGuirk et al. Spine. December (2001) Vol. 26 #23 p2615

Evidence based guidelines on the management of backpain are usually released before any measure of their effectiveness is established by research.

The authors of this report in *Spine* have written their own set of evidence based guidelines and tested them for safety, effectiveness and cost effectiveness when compared with 'treatment as usual'.

Emphasis in the new guidelines is placed on dealing with patient fears and misconceptions, providing confident explanations, encouraging empowerment to resume normal activities of daily living supplemented with analgesics and manual therapy for symptom relief. These aims mirror most of the evidence-based guidelines produced over the last decade.

This trial was based on the use of special clinics created especially for the study and staffed by experts, outcomes were audited by an independent research nurse.

Referral to the clinics was from general practice and A&E departments. Inclusion criteria were that the pain must be acute i.e. < 12 weeks, pain continuous for >7days or, two visits to GP.

Treatment was provided for up to 3 months or finished earlier in the event of full recovery.

If problems persisted after 3 months, patients were referred to pain clinic, after consultation with GP.

Excluded, were compensation cases.

Audit comprised interview, 0, 6 and 12 months, visual analogue scale for pain, SF-36 and the degree to which self-chosen, desired activity targets were actually met.

Clinic group had far more initial contact with specialist carers.

Out of 437 confirmed referrals 6 were found to have red flag conditions.

Of the GP treatment as usual group, 83 agreed to take part.

Both groups were demographically similar, mostly aged between 35 and 58.

By comparison, GPs tended to use physio, rest, hot/cold packs, opioids, NSAIDs and imaging far more than the special clinics which used, home rehabilitation, manual therapy in office, local injections far more than GPs. Both groups made some use of formal exercises and simple analgesics.

Costs average: clinic $276 vs. GP $472 .

At 3 months both groups showed significant improvements in pain score, physical function, social function.

At 3 months 67% of clinic and 49% of TAU had fully recovered, at 6 months; 70% and 64%, at 12 months; 71% and 56%.

It was the continuous pain group who became chronic care consumers. No other predictor was apparent.

Costs of continuing care were not included, but would favour clinic care because it gave rise to fewer chronic cases.

Continuing care was consumed as follows:
Clinics: 28%, 27% and 23% at 3, 6 and 12 months.
TAU: 44%, 47% and 37% at 3, 6 and 12 months.

Comment
Clinics based on these guidelines are more effective at preventing chronicity and cheaper than 'treatment as usual', as provided by GPs.

No red flags were missed, the safety of refusing unnecessary prescribe rest, imaging and NSAIDs is assured.

Efficient prevention of chronicity would seem to require another intervention, at around 3 months.