Initial Back Pain Management

Click for info for patients

Click for pharma treatments

Patient aged 16+ presents to GP with back pain

Click for more info

History & Examination

Red flags?

Click for more info

Red flags present, clinician is uncertain of next steps

Discuss with on call orthopaedic registrar

Cauda equina syndrome, Possible Unstable Fracture or Acute Spinal Cord Compression

Click for more info

Emergency referral to Spinal or orthopaedic Surgeon (through on-call registrar)

Spinal Metastasis, or Infection or Pathological Fracture

Click for more info

Urgent MRI whole spine and 2WW referral to spinal surgeon

Suspected rheumatological condition, Spinal Deformity or Osteoporotic Fracture

Click for more info

Routine expedited secondary care referral (4-6 weeks)

No red flags

Lower back pain without radiculopathy

Lower back pain with radiculopathy

Click for more info

Keele STarT Back tool (exclude radiculopathy patients)

No

Any myotomal weakness?

Yes

Low/medium risk

High risk

Refer to MSK triage (if concerned, speak to orthopaedic registrar on call)

Patient follows GP/ first contact practitioner (FCP) directions or self-management plan

Self-management information

Click for more info

Refer to MSK triage – following assessment will refer on to pain clinic if required

MSK triage – following assessment will refer on to pain clinic if required

Emergency orthopaedic review if appropriate

Patient improved after 2-6 weeks

Discharge/ no follow-up

Patient not improved after 2-6 weeks

Refer to Physiotherapy (usually for 12 week period)

If no better physio to refer to MSK TRIAGE

Urgent

Referrals are assessed within 48hrs

Routine

If insufficient info triage will discuss with referrer/ request investigations

Spinal MDT meeting with secondary care if not resolved within MSK service

Refer to secondary care

Consideration for epidural or nerve root injection

Click for more info

Consideration for surgery

MSK triage referral

- Assessment by ESP
- Self-management / life style advice
- Investigations as required
- MDT discussions with specialists
- Signposting to other MSK provision e.g. pain /physio
- Onward referral to secondary care if required

Back to pathway

History

- Site of Pain
- Mechanism of Pain
- Duration and Progression
- Nature of Pain
- Referred or radicular leg pain
- Previous history of back pain and response to treatment
- History of significant trauma
- Limb weakness
- Urinary/faecal incontinence or retention
- Systemic symptoms: fever, unexplained weight loss

PMHx-

- Previously history of cancer
- Recent serious illness, IV drug use
- Long term steroid use of osteoporosis
- Immunocompromised

Examination

- Deformity
- Spinal processes tenderness versus paraspinal muscles
- Assess movement: lumbar flexion and extension, lateral flexion and thoracic rotation
- Heel walking, toe walking, single stance leg dip if able
- Assess MRC power grading http://www.gpnotebook.co.uk/simplepage.cfm?ID=-737804276
- Sciatic stretch test. Knee extension produces leg pain. Patient prefers to lean back (extend the hip) to reduce pain
- Assess knee and hip
- Tone/ sensation/ reflexes including plantars
- Assess for saddle anaesthesia (altered sensation when wiping) and reduced anal tone/ squeeze if indicated

Back to pathway

RED FLAGS

History

- Age <16 or >50 with NEW onset back pain
- Non-mechanical pain (worse at rest, interferes with sleep)
- Thoracic pain
- Previous history of malignancy
- Unexplained weight loss
- Recent serious illness
- Recent significant infection
- Fever/rigors
- Urinary retention/incontinence
- Faecal incontinence
- Altered perianal sensation (wiping bottom)
- Limb weakness

Examination

- New/progressive spinal deformity
- Limb weakness
- Hyper-reflexia, clonus, extensor plantar responses
- Generalised neurological deficit
- Saddle anaesthesia
- Reduced anal tone/squeeze
- Palpable full bladder or urinary retention

Back to pathway

Cauda equina syndrome, Possible Unstable Fracture or Acute Spinal Cord Compression

- Bladder/bowel/sexual dysfunction
- Saddle anaesthesia

Or possible unstable fracture

- History of significant fracture
- Osteoporosis
- Obvious deformity

Or acute spinal cord compression

- Progressive leg weakness
- Altered sensation

Back to pathway

Spinal Metastasis, or Infection or Pathological Fracture

- History of cancer
- Thoracic back pain
- Unexplained weight loss
- Progressive non-mechanical back pain

Or fracture

- Sudden onset severe back pain with/without minor trauma
- Deformity not related to osteoporotic fracture

Or severe radicular pain that has not responded to treatment after 6-8 weeks

Back to pathway

Link to Keele STarT Back 9

This is a validated brief questionnaire based tool for risk stratification. Use the 9 item tool and then categorise as low, medium or high risk. The tool is available at this link –
https://www.keele.ac.uk/media/keeleuniversity/group/startback/Keele_STarT_Back9_item-7.pdf

Back to pathway

Suspected rheumatological condition, Spinal Deformity or Osteoporotic Fracture (refer to rheumatology)

- Early morning stiffness
- Symptoms improve with exercise
- Systemic symptoms e.g. uveitis, inflammatory bowel disease, psoriasis

Or spinal deformity (refer to spinal surgeon)

- Clinically or radiologically
- Scoliosis, anterior sagittal imbalance or high grade spondylolisthesis (grade 3,4,5)

This does not include suspected discogenic pain

Or osteoporotic fractures

- Analgesia and DEXA scan

If pain remains after 6-8 weeks can be referred to spinal surgeon

Back to pathway

Self-management information

Nonspecific Lower Back Pain in Adults from Patient UK: http://patient.info/health/nonspecific-lower-back-pain-in-adults

Back pain from Arthritis Research UK: http://www.arthritisresearchuk.org/arthritis-information/common-pain/back-pain.aspx#

Slipped (Prolapsed) Disc from Patient UK: http://patient.info/health/slipped-prolapsed-disc

British Pain Society leaflet, Managing your pain effectively using over-the-counter medicines: Managing your pain effectively - http://www.selfcareforum.org/fact-sheets/

Back to pathway

Consideration for epidural or nerve root injection

Medial Branch Blocks

The CCG will routinely fund a medial branch block where the aim is to **localise the origin of lower back pain and assess suitability of radiofrequency denervation.**

A medial branch block will be routinely funded when all of the following criteria have been met:

- The patient is 16 years or older.
- The pain is thought to be mainly from structures supplied by the median branch nerve.
- The pain is moderate-severe localised back pain (rated as 5/10 or more on a visual analogue scale, or equivalent) at the time of referral.
- The procedure is intended as a diagnostic test to localise the source of lower back pain to assess suitability for radiofrequency denervation.
- The pain has been present for ≥12 months.
- There has been a failure of non-invasive management (oral analgesia, guided self-management, physiotherapy) as per CCG pathway.
- The patient agrees to enter the combined physiotherapy and psychology (CPP) programme post ablation (if offered) to optimise self-management strategies and de-escalate their analgesic regime.

Radiofrequency (RF) Denervation

The CCG will routinely fund RF denervation when all of the following criteria have been met:

- All of the above medial branch block criteria have been met.
- There has been a positive response to a medial branch block at the proposed site with a ≥75% reduction in pain.

Repeat denervation will be considered on an individual basis where there has been clear evidence of benefit over a six month period and where the clinician feels that repeat is likely to be of benefit to the patient.

Therapeutic Facet Joint Injections

The CCG will routinely fund therapeutic facet joint injections only when the patient meets the guidance criteria for radiofrequency denervation but the procedure is contraindicated (e.g. presence of pacemaker/ICD).

Epidural Injections and Therapeutic Nerve Root Blocks

The CCG will routinely fund epidural injections and nerve root injections for patient suffering from predominantly **radicular pain due to herniated disc (sciatica).**

The CCG **will not routinely fund** epidural injections in patients with a diagnosis of central spinal stenosis (except in those with lateral canal stenosis).

Epidural injections or nerve root injections will be routinely funded when **all** of the following criteria have been met:

- The patient is 16 years or older.
- The patient has radicular pain consistent with the level of spinal involvement.
- The pain is having a significant impact upon the patient's ADLs (this will need to be described in any applications for prior approval)
- The pain has persisted for 6 weeks despite non-invasive management (UNLESS an MDT agrees that there is acute severe radiculopathy in which case this criterion may be waived).

<u>Repeat Injections</u>

The CCG will routinely fund a total of two injections (epidural and nerve root injections are counted together). Repeat epidural injections or nerve root injections will be routinely funded when all the following criteria have been met:

- 6 months has passed since the previous injection.
- There is documented improvement in the patient's symptoms. This may be demonstrated by either of the following:
  - An improvement in NRS by 2 points or more.
  - An improvement in ODI tool by 10 points or greater.

In the event further injections are required, the clinician will need to demonstrate grounds for exceptionality (e.g. patients with symptoms impacting on their activities of daily living who are too high risk to be considered for surgery). In order for further injections to be considered there should be evidence of engagement with physiotherapy, an exercise programme and, if BMI ≥ 30, weight management programme.

Exceptionality to Guidance Criteria

Patients who do not meet guidance criteria will be eligible for funding if their clinician demonstrates grounds for exceptionality to the guidance. In this scenario, please submit an individual funding request (IFR) application (application form can be found be following the link: http://www.enhertsccg.nhs.uk/ifr

Back to pathway

Pharmacological treatments

For recommendations on pharmacological management of sciatica, see NICE's guideline on neuropathic pain in adults.

- Consider oral non-steroidal anti-inflammatory drugs (NSAIDs) for managing low back pain, taking into account potential differences in gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age.
- When prescribing oral NSAIDs for low back pain, think about appropriate clinical assessment, ongoing monitoring of risk factors, and the use of gastroprotective treatment.
- Prescribe oral NSAIDs for low back pain at the lowest effective dose for the shortest possible period of time.
- Consider weak opioids (with or without paracetamol) for managing acute low back pain only if an NSAID is contraindicated, not tolerated or has been ineffective.
- Do not offer paracetamol alone for managing low back pain.
- Do not routinely offer opioids for managing acute low back pain.
- Do not offer opioids for managing chronic low back pain.
- Do not offer selective serotonin reuptake inhibitors, serotonin–norepinephrine reuptake inhibitors or tricyclic antidepressants for managing low back pain.
- Do not offer anticonvulsants for managing low back pain.

Back to pathway

Information for patients and carers

Provide patients with advice and information, tailored to their needs and capabilities, to help them self-manage their low back pain with or without sciatica, at all steps of the treatment pathway. Include:

- information on the nature of low back pain and sciatica
- encouragement to continue with normal activities.

Exercise
Link to leaflet HCT
Exercise is generally beneficial (see physical activity pathway). Consider a group exercise programme (biomechanical, aerobic, mind–body or a combination of approaches) for people with a specific episode or flare-up of low back pain with or without sciatica. Take people's specific needs, preferences and capabilities into account when choosing the type of exercise.

Return-to-work programmes
Promote and facilitate return to work or normal activities of daily living for people with low back pain with or without sciatica.

HCT Lower Back Pain leaflet: https://www.hct.nhs.uk/media/2261/lower-back-pain-may-2017.pdf

British Pain Society leaflet, Managing your pain effectively using over-the-counter medicines:
Managing your pain effectively: http://www.selfcareforum.org/fact-sheets/

Arthritis Research UK, Back Pain leaflet: https://www.csp.org.uk/system/files/7_back_pain.pdf

BUPA – Osteopathy: http://www.bupa.co.uk/health-information/directory/o/osteopathy

BUPA – Chiropractic: http://www.bupa.co.uk/health-information/directory/c/chiropractic

Cauda equina syndrome reference cards: https://macpweb.org/home/index.php?p=548

Low Back Pain leaflet: http://dev.selfcareforum.org/wp-content/uploads/2013/03/170509-SCF-Fact-Sheet-No-1-Back-Pain-v101.pdf