What's new in the literature: Nonspecific low back pain

Nonspecific low back pain (LBP) is a common,[1,2] costly,[3-5] and debilitating condition, and to date, management of this disorder remains a challenge.[6,7] While the most recent medical evidence supports moderate physical activity as a valid and durable intervention for LBP, many conventional treatments appear to provide a lack of efficacy or durability. Indeed, for some treatments, including surgery, the risks might outweigh the benefits.

Recently, the American Pain Society published clinical guidelines based on high-quality, systematic reviews on the management of LBP.[8-10] Their key findings and recommendations are as follows:

- Provocative discography is not recommended for diagnosing discogenic LBP in patients with chronic, nonradicular LBP.
- Current evidence is insufficient to evaluate the validity or utility of diagnostic selective nerve root block, intra-articular facet joint block, medial branch block, or sacro-iliac joint block as diagnostic procedures for LBP, with or without radiculopathy.
- Intensive, interdisciplinary rehabilitation with a cognitive/behavioral emphasis should be considered for patients with nonradicular LBP who do not respond to the usual non-interdisciplinary interventions, including patients with persistent, disabling back pain.
- Facet joint injection, prolotherapy, and intradiscal steroid therapy should not be recommended for patients with persistent, nonradicular LBP. At present, insufficient evidence is available to evaluate the benefits of local injection, botulinum toxin injection, epidural steroid injection, intradiscal electrothermal therapy, therapeutic medial branch block, radiofrequency denervation, sacro-iliac joint steroid injection, or intrathecal therapy with opioids or other medications for nonradicular LBP.
- For patients with nonradicular LBP, common degenerative spinal changes, and persistent and disabling symptoms, the risks and benefits of surgery as a treatment option should be discussed. In addition, patients should be aware of the similarly effective benefits of intensive interdisciplinary rehabilitation, the small-to-moderate benefits gained from surgery over the use of non-interdisciplinary, nonsurgical therapy, and the less-than-optimal outcome for the majority of patients who undergo such surgery (an "optimal outcome" is defined as the presence of minimal or no pain, the ability to discontinue or occasionally use pain medication, and the return of high-level functioning).
- Patients with persistent and disabling radiculopathy caused by a herniated disc, or persistent and disabling leg pain associated with spinal stenosis, should know that the benefits of surgery for these conditions are moderate at best, and appear to decrease over time.
- At present, insufficient evidence exists to determine whether the long-term benefits outweigh the harm of vertebral disc replacement.
- Patients with persistent radiculopathy caused by a herniated lumbar disc should know about inconsistent evidence showing moderate, short-term benefits and lack of long-term benefits associated with epidural steroid injection. At present, insufficient evidence exists to evaluate the benefits and harms of epidural steroid injection for spinal stenosis.
- Patients with persistent and disabling radicular pain following surgery for herniated disc and no evidence of a persistently compressed nerve root should know that spinal cord stimulation is associated with a high rate of complications following the placement of a spinal cord stimulator.

A high-quality, systematic review on the role of imaging in LBP[11] found that lumbar imaging for LBP, without indications of serious underlying conditions, does not improve clinical outcomes. It is recommended that clinicians refrain from providing immediate or routine lumbar imaging for patients with acute or subacute LBP who don't appear to have serious underlying conditions, such as cauda equina, cancer, or infections.

Another high-quality, systematic review[12] concluded that physical exercise might be the only effective intervention to prevent episodes of LBP among working-age adults. To date, other interventions, including stress management, shoe inserts, back supports, ergonomic or back education, and reduced lifting programs have been found to be ineffective in preventing episodes of LBP.

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References

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calendar

CONFLICT MANAGEMENT
Toronto, 18–20 Oct (Sun–Tue)
Vancouver, 8–10 Nov (Sun–Tue)
CMA Physician Manager Institute (PMI) presents Negotiation and Conflict Management (foundation level). Negotiation and Conflict Management will provide you with the skills, tools, and insights to effectively manage conflict in your organization. Through a facilitated negotiation, you will develop strategies and processes for successful negotiations. With internationally respected PMI faculty members Dr Janice Stein and Ms Mary Yates, you will learn how to negotiate good agreements and maintain relationships, manage conflict creatively and constructively, employ strategies for enhancing collaboration and consensus, and identify the impact of cultures on organizations. Learn and share real-life, real-time solutions that are right for your health care workplace. This course can also be offered in your workplace. For information and registration, call 1 800 663-7336 ext. 2178, or visit www.cma.ca/pmi.

LEADING CHANGE & INNOVATION
Toronto, 21–23 Oct (Fri–Wed)
Vancouver, 11–13 Nov (Wed–Fri)
CMA Physician Manager Institute (PMI) presents Leading Change and Innovation (foundation level). Strategies, tools and skills learned in Leading Change and Innovation will help you to implement and manage change initiatives in your organization. With nationally respected PMI faculty member Ms Linda Tarrant, you will identify models and processes of planned change and their theoretical frameworks, learn strategies for gathering and accessing data to support and facilitate the change process, learn how to communicate the case for change and inspire and sustain momentum, understand the impacts of change on members of your organization, and explore ways to sustain change initiatives. Learn and share real-life, real-time solutions that are right for your health care workplace. This course can also be offered in your workplace. For information and registration, call 1 800 663-7336 ext. 2178, or visit www.cma.ca/pmi.

RHEUMATOLOGY UPDATE
Vancouver, 24 Oct (Sat)
This 1-day course at the Sheraton Wall Centre Hotel in Vancouver has been developed to assist general practitioners and allied health professionals gain the latest knowledge and practical points for practice management of common rheumatic conditions. At the end of the program, the participants will be able to differentiate the various types of arthritis on physical examination; use multiple modalities, including medications, to treat arthritis and osteoporosis; and judiciously use investigations to diagnose rheumatic diseases (7.0 Mainpro-M1 credits). To view the program and register, please visit our web site at medicine.ubc.ca/cme or contact Kathy Standeven at 604 875-4111 (ext. 63449), fax 604 875-4886, or e-mail Kathy.Standeven@vch.ca.

CLINICAL HYPNOSIS
Vancouver, 24–25 Oct (Sat–Sun)
Advanced Clinical Hypnosis for Anxiety and Symptom Management workshop with Gary Elkins, PhD, ABPP, ABPH is presented by the Canadian Society of Clinical Hypnosis (BC Div.). This workshop will provide professional training in both the theory and application of hypnosis in clinical practice of anxiety and pain management, behavioral health, and symptom management. Attendees will gain applied knowledge and practical skills regarding hypnotic interventions in the areas of pain manage-