Clinical practice guideline for low back pain

What's important, what works, what we know, and what we don't know

Low back pain (LBP) is a common symptom presenting in both primary care and across many specialties. LBP has bio-psychosocial components. The psychosocial aspects are significant determinants of disability and deserve our attention from the start. The 2007 clinical practice guideline for LBP summarizes the evidence as to what is important, what works, what we know, and what we don't know.

According to Dr Roger Chou, lead author of the guideline and a speaker at the WorkSafeBC 2011 Annual Physician Education Conference, coming to Vancouver on 22 October, the guideline is "firmly grounded in the evidence, developed from a true multidisciplinary perspective and resonates clinically…. The guideline has been widely disseminated—downloaded more than 250 000 times from the *Annals of Internal Medicine* website and is the second most downloaded article ever published in the *Annals*… Although the guideline was published in 2007, no new evidence would appear to require changes to the recommendations, and subsequent studies on LBP imaging and chronicity-predicting factors are consistent with the guideline recommendations."

This article is the opinion of WorkSafeBC and has not been peer reviewed by the BCMJ *Editorial Board.*

Recommendations

While the complete guideline can be viewed at www.annals.org/content/147/7/478.full, here's a summary of the recommendations:

- Conduct a focused history and physical exam to help place patients with LBP into one of three categories: nonspecific LPB, back pain potentially associated with radiculopathy or spinal stenosis, or back pain potentially associated with another specific spinal cause. The history should include assessment of psychosocial risk factors that predict risk for chronic disabling back pain (strong recommendation, moderate-quality evidence).
- Do not routinely obtain imaging or other diagnostic tests in patients with nonspecific LBP (strong recommendation, moderate-quality evidence).
- Perform diagnostic imaging and testing for patients with LBP when severe or progressive neurologic deficits are present or when serious underlying conditions are suspected on the basis of history and physical examination (strong recommendation, moderate-quality evidence).
- Evaluate patients using MRI (preferred) or CT only when they have persistent LBP and signs or symptoms of radiculopathy or spinal stenosis, and are potential candidates for surgery or epidural steroid injection (for suspected radiculopathy) (strong recommendation, moderate-quality evidence).
- Provide patients with evidence-based information on LBP about their expected course, advise patients to remain active, and provide information about effective self-care options (strong recommendation, moderate-quality evidence).
- Consider using medications with proven benefits in conjunction with back care information and self-care; assess severity of baseline pain and functional deficits, potential benefits, risks, and relative lack of long-term efficacy and safety data before initiating therapy (strong recommendation, moderate-quality evidence). For most patients, first-line medication options are acetaminophen or nonsteroidal anti-inflammatory drugs.
- For patients who do not improve with self-care, consider adding non-pharmacologic therapy with proven benefits: spinal manipulation for acute LBP; intensive interdisciplinary rehabilitation, exercise therapy, acupuncture, massage therapy, spinal manipulation, yoga, cognitive-behavioral therapy, or progressive relaxation for chronic or subacute LBP (weak recommendation, moderate-quality evidence).

Note: This is the first LBP guideline to recommend psychosocial assessment at first visit. Suggested examples of chronicity risk factors include depression, passive coping strategies, job dissatisfaction, higher disability levels, disputed compensation claims, or somatization. Other researchers have identified "catastrophization" and "fear-avoidance" responses, which can be found in both patient and healer.

WorkSafeBC specifics

For worker patients, please keep in mind that WorkSafeBC:

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- Recommends avoiding the use of opioids for chronic LBP.
- Requires pre-authorization for payment of acupuncture to ensure this is not the sole treatment.
- Has education materials available for injured workers.
- Can supply an excellent 3-minute back exam teaching video and a Physician's Toolkit, on request.
- Has access to multidisciplinary assessment and treatment programs —for information, visit WorkSafe BC.com and view the rehabilitation programs in the Health Care Providers section.

—Tim Dundas, MB, BS, CCFP
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18 000 allied health professionals in cancer, cardiac, mental health and addiction, musculoskeletal, neurodegenerative, palliative, renal, and respiratory care.

Many listings include a description of services, hours of operation, maps and parking details, patient eligibility criteria, referral forms, and patient information materials.

"CHARD gives new meaning to one-stop shopping. It's a win for both me and my patients," says Victoria-area family physician Dr Frank Egan.

Attachment

Recent research shows that British Columbians who are "attached" to a family physician have better health care outcomes and lower overall health care costs, especially patients with several chronic diseases.

With this in mind, the GPSC's Attachment initiative aims to provide every British Columbian who wants a family practitioner with a doctor by 2015.

Local divisions of family practice are leading this work to ensure that residents of their community have access to the benefits of primary care. The communities of Prince George, White Rock/South Surrey, and Cowichan are currently prototyping this initiative.

GPSC evolving

GPSC initiatives continue to evolve to meet the diverse needs of BC's family and general physicians, and there is evidence of a growing optimism and enthusiasm among them.

"GPSC programs are giving me the spark later in my career to continue to learn and to support my patients and practice in a way that keeps me loving the work that I do," says Powell River GP, Dr Bruce Hobson.

Indeed, as of April 2011, 1941 FPs—more than 55% of the province's FPs—and almost as many MOAs have participated in PSP learning modules. Uptake of incentives has steadily increased each year. Currently more than 90% of all BC GPs are billing one or more of the incentives and physicians who participate fully in the program have seen an average 11.8% increase in their earnings. The number of patients covered by these incentives and the number of patients receiving guideline-based, proactive planned care have also been increasing annually.

"We're seeing a coming together of resources, enthusiasm, and funding to support what I like to call a renaissance of family practice," says Dr Wong.

For more information, visit www.gpscbc.ca.

—Greg Dines
Assistant Director, Professional Relations

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