McGill Scoliosis and Spine Program

Acute/Subacute non-specific low back pain

Definition

Pain occurring primarily in the back between the 12 rib and the gluteal folds AND no signs of:

- o A serious underlying condition (such as cancer, infection, or cauda equina syndrome),
- o Spinal stenosis,
- o Radiculopathy
- o Another specific spinal cause (such as vertebral compression fracture or ankylosing spondylitis) or
- o Specific proven patho-anatomic cause.

Types of Pain:

- Acute back pain is any pain that has occurred for less than 6 weeks.
- Sub acute back pain is pain that is present between 6-12 weeks.
- Chronic back pain is any pain that has been present for more than 12 weeks.
- Recurrent back pain is recurring pain with pain-free intervals.

Initial assessment of any back pain patient

1. Establish standardized score

- Ask patient to complete the OSWESTRY 2.0 questionnaire correctly and document score 6
- Ask patient to complete the STarT Back Screening Tool (SBST) and document score

2. Assess your patient (diagnostic triage)

- Conduct a focused history and physical examination
 - Review the standardized questionnaire scores
- Classify your patient into one of five broad categories:

A. Presence of red flags

- New bowel/bladder incontinence or retention; recent severe trauma; progressive paraparesis/quadraparesis/neurologic signs → Send to Emergency in your RUIS (McGill RUIS = MGH, JGH)
- Unexplained weight loss (> 10 pounds over 6 months), fever, chills; saddle anesthesia without new bowel/bladder incontinence or retention; acute pain not eased by recumbent position; incremental non-relenting pain \rightarrow page Spine Resident in the Emergency department of your RUIS (McGill RUIS = MGH; (514) 934-1934 ext. 53333, ask forSpine Resident, JGH; (514) 340-8222)
- B. Unsteadiness of gait, weakness, numb/clumsy fingers → Go to Myelopathy Algorithm
- C. Unilateral leg pain below the knee (with/without numbness and weakness) → Go to Radiculopathy Algorithm
- D. Back pain associated with intermittent leg pain that is aggravated by standing or walking and relieved by sitting \rightarrow Go to Claudication/Spinal Stenosis Algorithm

E. Non-specific low back pain (NSLBP)



- Reassure patients on the favourable prognosis (if available, provide adequate printed information regarding the nature of NSLBP with emphasis that the majority of cases resolve within 6 weeks¹)
- Advise patients to stay active
- Discourage bed rest
- Promote self management (carry on with normal activities as much as possible).
- Discourage lumbar supports

4. Prescribe medication for pain relief (if needed)

- Non-narcotic analgesics
 - Acetaminophen
 - NSAIDs ^{7,14} (refer to the Conseil du Médicament du Québec for the algorithm)

and "An evidence-based approach to prescribing nonsteroidal antiinflammatory drugs" From the Third Canadian Consensus Conference)

- Muscle relaxants
- Narcotic analgesics (may provide short course)

5. Prescribe physiotherapy (re-assess after 10 sessions)

- For patients who have had pain for 2-4 weeks
- For patients whose pain is made worse by physical activity or exercise (these patients may benefit from therapeutic exercise recommendations)
- Active treatments have demonstrated greater efficacy than passive therapies
- Traction, therapeutic ultrasound, laser therapy, interferential therapy, TENS, massage therapy can be
 used to assist an exercise program but are not recommended alone
- ullet **Spinal manipulation:** consider spinal manipulation for acute NSLBP patients who are not improving with the present treatment program.
 - o Specialists include: physiotherapist, chiropractor, osteopath
 - o The patient has to agree to this treatment
 - o Inform the patient to maintain therapy if there is continued functional improvement after 2 sessions (\geq 50% improvement in the OSWESTRY score considers the intervention as successful)

6. Avoid the following investigations:

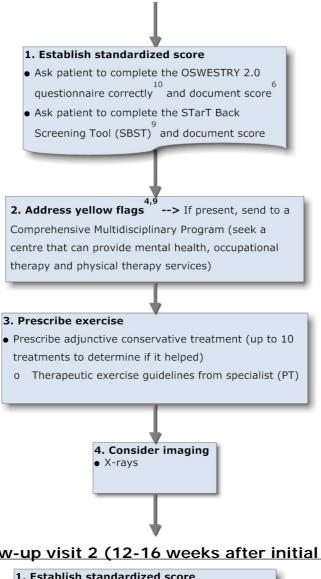
a) Diagnostic imaging

- Radiological imaging is not recommended for acute NSLBP for patients < 50 years of age
- Plain radiographs are optional for patients > 50 years of age
- EMG is not recommended for acute NSLBP
- b) Laboratory testing is not recommended unless specific illness is suspected

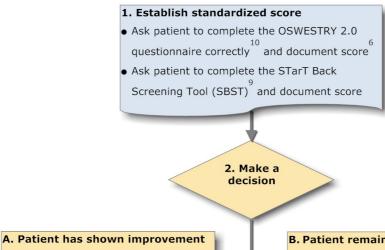
Follow-up Visit 1 (4-6 weeks after initial visit)

Purpose: Keep the Diagnosis under review

- Re-assess patient status 4-6 weeks after initial visit if symptoms fail to resolve:
 - Exclude serious pathology (Red Flags)
 - Review psychosocial risk factors (Yellow Flags)
 - Manage accordingly (medication, therapy)



Follow-up visit 2 (12-16 weeks after initial visit)



→ keep going; transition to home exercise program, (a few patients may still require sessions with the physiotherapist) with the judgement of the treating physiotherapist

B. Patient remains symptomatic and:

- **OSWESTRY score** < **40%** → Refer to a non-surgical multidisciplinary spine team in your community
- OSWESTRY score > 40% → Send the McGill Consult Referral Form to the McGill Spine Program
- Consider Imaging (MRI- degenerative disc disease; CTspondylolysis); patient may be a candidate for an intervention

3. Maintain intermittent communication with patient while awaiting imaging results and consultation replies:

- Advise patients to stay active
- Discourage bed rest
- Promote self management (carry on with normal activities as much as possible)

SPECIALIZED TREATMENT (WITHIN SPINE PROGRAM)

<u>Triage</u>

- 1. Pre-visit triage: Triager reviews patient consult and MRI/CT
- General Practitioner (musculoskeletal expertise)
- Physiatrist
- Physiotherapist
- Spine Surgeon

Spine Program initial visit

Keep the diagnosis under review, looking for pathoanatomical causes related to low back pain

1. Establish standardized score

Ask patient to complete the <u>Spine Program</u> <u>Survey</u> (includes OSWESTRY 2.1, Lifestyle questionnaires and SF36) and compare to latest score from referring physician's office

2. Assess patient and make a decision:

(Determine next course of care)

- **A. Patient re-assurance provided** (tertiary care not required)
- B. Patient needs further non-operative specialized, multidisciplinary care
- Psychologist
- Physiatrist
- Physiotherapist
- GP-Sports Medicine
- C. Patient is a surgical candidate (undergoes surgery)
- Lumbar fusion
- Disc replacement

3. Return patient to community with recommendations from the spine team:

- A. Guidance for non-operative care
- **B. Guidance from multidisciplinary group** (pain clinic, spine team)

C. Recommendations and guidance for post-operative care after acute care management has been completed

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