key points

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Chronic low back pain is a common problem. Lifetime adult prevalence rates vary from 50% to 80%, and around a quarter of adults say they have experienced back pain during the past month. One in 40 report disabling back or neck pain. Each year around 7% of patients consult their GP with back pain.

In 65-70% of primary care patients with low back pain there is no known pathoanatomical cause. Their pain is described as nonspecific and is postulated to arise from muscle strain or ligamentous injury. A further 15-20% of patients have mechanical low back pain with an identifiable cause such as degenerative disc or joint disease. The pain may be referred to the hips and legs but this should not be confused with neuropathic radicular pain (sciatica), which has a neuropathic quality, usually radiates distal to the knee and can be accompanied by sensory, motor and reflex deficits.

Clinicians should not routinely obtain imaging or other diagnostic tests in patients with nonspecific low back pain. However, if there are concerns that the patient may have a specific cause for their back pain then appropriate referral or investigation is indicated. Admission or urgent referral to orthopaedics or neurosurgery is required if neural deficit is suspected or severe systemic illness is apparent. Referral to rheumatology or oncology may be appropriate for patients with suspected malignancy, infection, fracture, or an inflammatory disorder such as ankylosing spondylitis.

Providing there is no suspicion of serious underlying pathology NICE recommends that GPs should provide patients with information on low back pain with regard to its expected course, the need to remain active, and effective self-management options. Patients should be encouraged to do exercises such as stretching, strengthening, aerobics, yoga, or tai chi in a group setting. Use of the STarT Back risk assessment tool is recommended to assess the risk of continuing pain and disability.

A combined physical and psychological programme incorporating cognitive behavioural therapy should be considered: in patients with a high risk of poor outcome (as assessed by STarT Back); if after initial treatment recommendations have been tried pain is still significant after three months, or sooner if pain is severe and accompanied by distress or physical impairment. NICE suggests this should preferably be in a group context that takes into account the individual's specific needs and capabilities.