

key points

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Low back pain is nociceptive in nature i.e. described as a dull pain or ache. It may be associated with hip and upper leg pain. Low back pain that persists for ≥ 3 months, beyond the time required for normal tissue healing after acute injury, is classified as chronic. Estimates for the lifetime prevalence range from 50 to 80%. Although most episodes are of a benign origin and will resolve within the acute period, 3-4% of adults aged 18-44 and 5-7% of those aged ≥ 45 will develop chronic low back pain and disability.

Low back pain is a symptom with a range of possible causes. Most cases are either mechanical in origin (arising from the musculoskeletal components of the spine) or neurogenic (arising from nerve root irritation). However, rarer secondary causes must also be considered to ensure serious pathology is not missed. Around 65-70% of cases do not have an identifiable pathoanatomical cause.

If red flags are not present, it is helpful to determine the presence or absence of radicular features, as nerve root compression may warrant a different investigation and management pathway. Relevant features in the history may include: unilateral leg pain radiating below the knee, low back pain that is less severe than leg pain, and paraesthesia or numbness in a dermatomal distribution. A focused musculoskeletal and neurological examination should be carried out. If both red flag symptoms and radicular features are absent, the back pain is likely to be of mechanical origin and in many cases will resolve with simple management. Risk stratification tools such as the validated STarT Back tool provide an approach to categorise patients into low, medium and high risk of continuing pain and disability.

It is important to provide advice and information to help patients self-manage their condition. Exercise is recommended. However, manual therapies, e.g. spinal manipulation or massage, or psychological therapies should only be considered as part of a treatment package including exercise. Combined physical and psychological programmes are appropriate in patients at high risk of chronicity (e.g. those with a high STarT Back score) or patients who have not improved with other treatments. The evidence for analgesic drugs in acute and chronic back pain is similar. For both categories, paracetamol (as a sole agent) is not recommended, but NSAIDs and weak opioids (e.g. codeine) can be used as second-line or adjunctive therapy.

Patients with suspicion of ankylosing spondylitis should be referred to rheumatology, suspicion of cauda equina syndrome to the emergency department/neurosurgery immediately. Those with persistent radicular symptoms for more than six weeks despite treatment should be considered for referral to orthopaedics or neurosurgery. Complex cases can be referred to the pain service, where patients will undergo a comprehensive holistic assessment, and specialist physiotherapy, psychology and group-based pain management programmes are also available.