

Acute & Chronic Low Back Pain Guideline

(Adapted from the U.S. Department of Defense 1999 & ICSI 2006)

Guideline History

Date Approved	09/08
Date Revised	
Date Reviewed	08/08
Next Review Date	09/10

Back Pain at a Glance

Goals

Patients	Providers
Lessen pain	Comprehensive assessments & re-assessments
Improve functioning	Improve documentation
Enhance quality of life	Appropriate use of diagnostic imaging
Reduce further injury	Patient Education

1. Do a focused H & P and evaluate patient for serious medical problems and psychosocial indicators. Look for **RED FLAGS**. For serious conditions refer or obtain consult.

➤

Major Trauma	Age > 50
History of Cancer	Metabolic Disorder
Bladder or Bowel Dysfunction	Saddle Anesthesia
Persistent Fever	Major Muscle Weakness
Unrelenting night Pain	Decreased Sphincter Tone

- Use questionnaires to address psychosocial indicators/chronicity risk factors.
- Hx of previous episodes of back pain
 - Hx of psychiatric disorders (For more information, refer to Optima Health BH guidelines)
 - Substance Abuse (Tobacco, Alcohol, Drugs)
 - Legal, Compensation, or Work related issues
 - Family issues

2. Provide conservative treatment for acute low back pain if less than 6 weeks

- **T:** Therapy (PT/OT evaluation) (Depends on the expertise of the PT/OT)
- **E:** Education (Proper back ergonomics, Handout on Health “Back Pain”, Self-care)
- **A:** Activity (Modifications, Limited Bed Rest, Exercise, passive modalities)
- **A:** Alternative treatments (Acupuncture, massage, counseling to affect lifestyle changes — i.e. losing weight or quitting smoking).
- **M:** Medications (APAP, NSAIDs, Muscle Relaxants, etc.)

3. Providers should not routinely obtain diagnostic imaging tests in patients with non specific low back pain. Testing should be done if warranted when:

- Low back pain is severe
- Progression of neurologic deficits
- If serious underlying medical conditions are suspected
- Patient is a potential surgery candidate
- Patient is a potential candidate for epidural steroid injection w/ MRI (out of guideline)
- If there is a possibility of movement between bones-Flexion –Extension X-rays

4. If symptoms progress, re-evaluate patient

5. If symptoms do not improve after 4 to 6 weeks, re-evaluate and do a comprehensive H & P. Due to high percentage of reoccurrence, it is at the discretion of the MD to treat more aggressively.

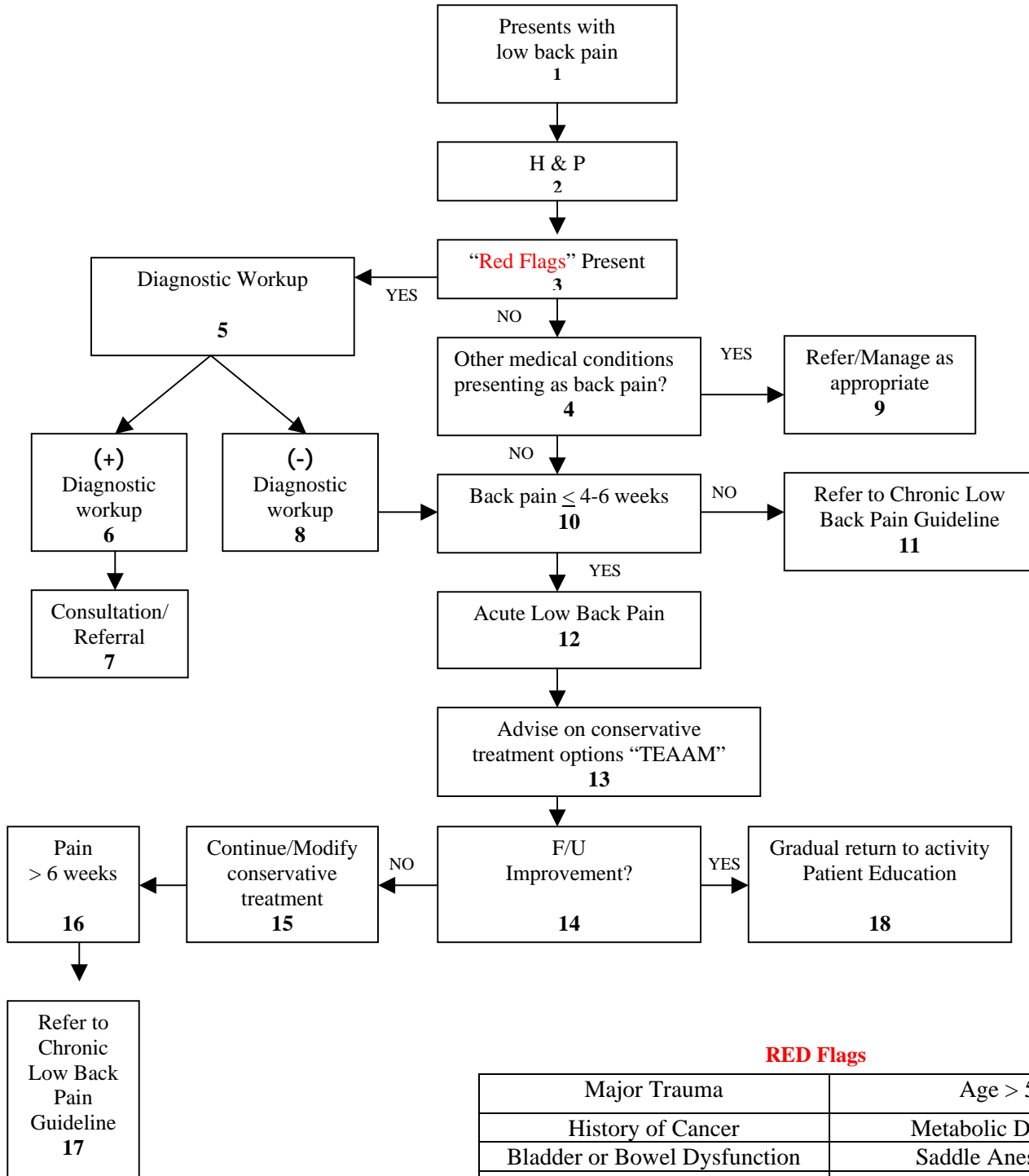
6. Managing Chronic pain

- Do appropriate diagnostic tests for consult or referral
- Combination treatment of medication with self care
- Use of non pharmacological therapy
- Potential surgery candidate

7. Providers should provide information regarding treatment plan, goals, self-care, activity, & medications.

Acute Low Back Pain

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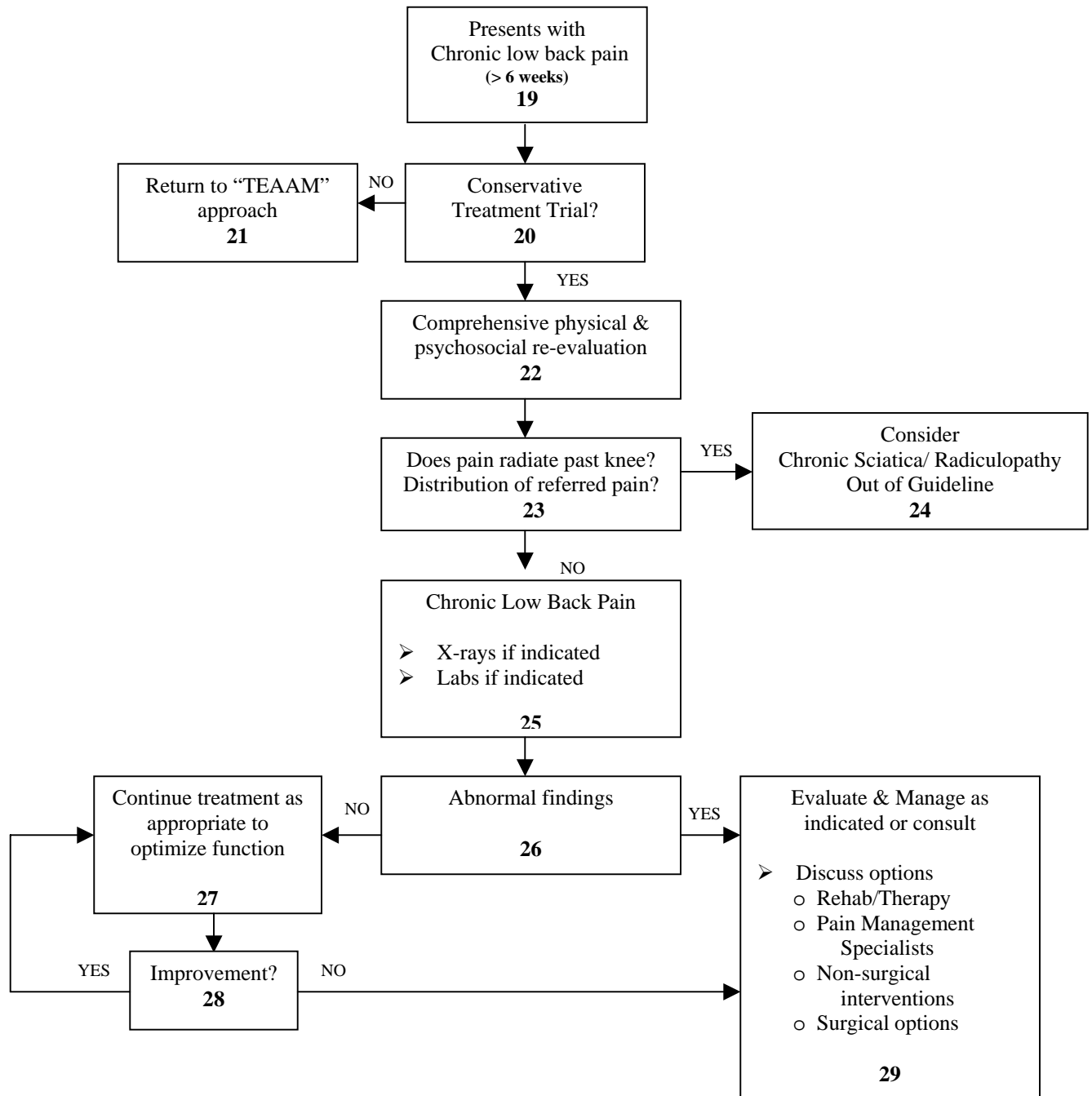


RED Flags

Major Trauma	Age > 50
History of Cancer	Metabolic Disorder
Bladder or Bowel Dysfunction	Saddle Anesthesia
Persistent Fever	Major Muscle Weakness
Unrelenting night Pain	Decreased Sphincter Tone

Chronic Low Back Pain

(Adapted from the U.S. Department of Defense 1999 & ICSI 2006)



(For more in-depth Chronic Pain Management w/opioids:
See **Chronic Pain (Non-Cancer) Management guideline**)

Back Pain Annotations

1. Presents with low Back Pain (\leq 4-6 weeks)
2. a. Perform a **focused history** to include:
 1. Location of pain. If more than one location they are assessed separately.
 2. Duration
 3. Type, quality, and patterns of radiation (if applicable)
 4. Alleviating and aggravating factors
 5. Description
 6. Intensity Rating (visual analog or FLACC scale)
 7. Patient's acceptable rating of pain and pain management history
 8. Current medications for pain and what works best
 9. Alternative methods of pain control used
 10. Vital signs
 11. Patient's emotional and behavioral expressions of pain
 12. Level of influence of pain on ADLs
- b. Perform focused physical examination to include:
 - Vitals signs
 - Neurological evaluation & Testing to include: motor & sensory function, stance, gait, reflexes & strength
 - Inspection of posture, body habitus
 - If indicated: Abdominal/Pelvic exams
3. **RED Flags** present? Red flags may present a serious underlying condition.
 - | | |
|------------------------------|--------------------------|
| Major Trauma | Age > 50 |
| History of Cancer | Metabolic Disorder |
| Bladder or Bowel Dysfunction | Saddle Anesthesia |
| Persistent Fever | Major Muscle Weakness |
| Unrelenting night Pain | Decreased Sphincter Tone |
 - Use questionnaires to address psychosocial indicators/chronicity risk factors.
 - Hx of previous episodes of back pain
 - Hx of psychiatric disorders (For more information, refer to Optima Health BH guidelines)
 - Substance Abuse (Tobacco, Alcohol, Drugs)
 - Legal, Compensation, or Work related issues
 - Family issues
4. Other Medical Conditions presenting as back pain. Many medical conditions can masquerade as low back pain, as well as complicate diagnosis and management of low back pain.
5. Consider doing a diagnostic work up if **RED Flags** are present, especially with severe or progressive symptoms.
6. Positive Diagnostic work up
7. For positive diagnostic results, Consider consultation/Referral
8. For negative diagnostic results, address how long they have had the back pain.
9. For other medical conditions refer/manage as appropriate.

Back Pain Annotations continued....

10. Back pain < 4-6 weeks is considered acute; Back pain > than 4-6 weeks is considered chronic. At the discretion of MD to treat more aggressively prior to “chronic back pain” diagnosis.
11. Follow Chronic Low Back Pain guideline (**page 4**)
12. Follow Low Back Pain guideline (**page 3**)
13. Advise on conservative treatment options. Use “**TEAAM**” approach.
 1. **T**: Therapy (PT/OT evaluation)
 2. **E**: Education (Proper back ergonomics, Handout on Health “Back Pain”)
 3. **A**: Activity (Modifications, Limited Bed Rest, Exercise, passive modalities)
 4. **A**: Alternative treatments (Acupuncture, massage, counseling to affect lifestyle changes — like losing weight or quitting smoking).
 5. **M**: Medications (NSAIDs, Muscle Relaxants,,etc.)
(For more in-depth Chronic Pain Management w/opioids: See **Chronic Pain (Non-Cancer) Management guideline**)
14. F/U, Any Improvement? Follow up as indicated. Goal is to identify patients with worsening or new neurological symptoms. For worsening symptoms, re-evaluation may be needed.
15. Continue/Modify conservative treatment. Goal is to determine whether the initial treatment course requires modification or assisted management to improve symptoms.
16. Has pain continued for > 6 weeks?
17. Refer to Chronic Low Back Pain guideline (**Page 3**)
18. Gradual return to activity. Patient Education. Medication modification and increasing activity should be individualized according to patient’s functional status. Goal is to return patient to a fully functional status and minimize future recurrence
19. Chronic Low Back Pain. Low back pain has persisted for greater than 6 weeks.
20. Has patient undergone a conservative treatment trial? “**TEAAM**” approach
21. Advise on conservative treatment options. Use “**TEAAM**” approach.
 1. **T**: Therapy (PT/OT evaluation)
 2. **E**: Education (Proper back ergonomics, Handout on Health “Back Pain”)
 3. **A**: Activity (Modifications, Limited Bed Rest, Exercise, passive modalities)
 4. **A**: Alternative treatments (Acupuncture, massage, counseling to affect lifestyle changes — like losing weight or quitting smoking).
 5. **M**: Medications (NSAIDs, Muscle Relaxants,,etc.)
(For more in-depth Chronic Pain Management w/opioids: See **Chronic Pain (Non-Cancer) Management guideline**)
22. Comprehensive Physical & Psychosocial re-evaluation. Goal is to identify patients whose back pain has not improved after 4-6 weeks for possible psychological & social dysfunction & potential for chronic low back pain.
 - Use questionnaires to address psychosocial indicators/chronicity risk factors.
 - Hx of previous episodes of back pain
 - Hx of psychiatric disorders (For more information, refer to Optima Health BH guidelines)
 - Substance Abuse (Tobacco, Alcohol, Drugs)
 - Legal, Compensation, or Work related issues
 - Family issues

Back Pain Annotations continued....

23. Does pain radiate past knee? Depends of the distribution of the referred pain. I.e. is it coming from the nerve, muscle, ligament, or joint?
24. Consider Chronic Sciatica/Radiculopathy: Out of Guideline.
25. Chronic Low Back Pain. Goal is to identify appropriate tests for patients with persistent Low Back Pain. Refer to HEDIS® for the Use of Imaging studies for Low Back Pain (LBP). Persistent low back pain, beyond 4 to 6 weeks of conservative treatment, may be diagnosed with X-rays, bone scans, or laboratory findings. Clinicians should evaluate patients with persistent low back pain.
26. Abnormal Findings. If there abnormal findings, may discuss options: Rehab/Therapy; non-surgical interventions; surgical options if necessary.
27. Continue treatment as appropriate to optimize functional status.
28. Improvement?
29. Evaluate & Manage as indicated or consult/refer. If there is no improvement, may discuss options: Rehab/Therapy; Pain Management Specialists; non-surgical interventions; surgical options if necessary.

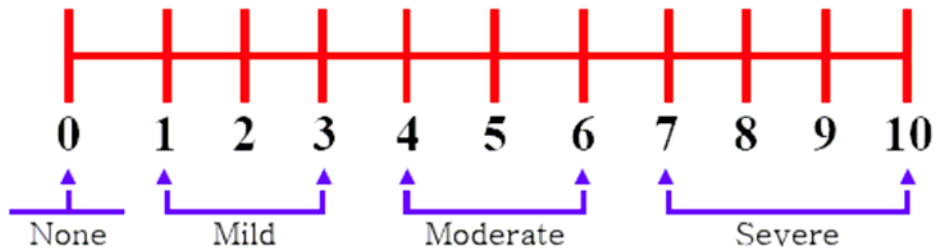
Other Appropriate Referrals: (Depends on the expertise of the professional)

Physiatrists/ Physical Medicine & Rehabilitation
<ul style="list-style-type: none"> ➤ Acute Back Pain < than 4-6 weeks ➤ Chronic back pain > than 6 weeks ➤ Chronic sciatica less than 6 weeks (Out of guideline) ➤ Chronic pain syndrome ➤ Recurrent back pain
Occupational Medicine (in certain cases)
<ul style="list-style-type: none"> ➤ Difficult worker' compensation ➤ Disability/Impairment ratings ➤ Return to work Issues
Rheumatology
<ul style="list-style-type: none"> ➤ Rule out inflammatory arthropathy ➤ Rule out fibrositis/fibromyalgia ➤ Rule out metabolic bone disease

Pain Scales

Pain will be assessed using one of the following pain scales:

- **0-10 scale B** this is a subjective scale where the patient communicates the current level of pain. Zero equals no pain and 10 equals the most severe pain the patient can imagine. In order to use this scale, the patient must be alert, oriented, and cognitively able to understand the rating scale.



- **Wong- Baker Faces Pain Rating Scale** this is a subjective scale where the patient communicated their level of pain by pointing to the picture that most accurately describes his current level of pain. Happy face means no pain and sad face with tears is the most severe pain the patient can imagine. To use this scale the patient must be alert and oriented.



Source: Sentara Healthcare Policy (2006). Pain Assessment & Management Policy. Retrieved February 1, 2008, from <https://webcontent.sentara.com/NR/rdonlvres/DB9875E9-EF21-47DB-B2B0-324E3609FF47/11290/DB9875E9EF2147DBB2B0324E3609FF47doc.pdf>

Pain Scales

Behavioral Health adults

Checklist of Non-Verbal Indicators (CNVI) (page 1 of 1)

	With Movement	At Rest
Vocal Complaints – nonverbal expression of pain demonstrated by moans, groans, grunts, cries, gasps, sighs)		
Facial Grimaces and Winces – furrowed brow, narrowed eyes, tightened lips, dropped jaw, clenched teeth, distorted expression		
Bracing – clutching or holding onto siderails, bed, tray table, or affected area during movement		
Restlessness – constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still		
Rubbing – massaging affected area		
Vocal complaints – verbal expression of pain using words, e.g., “ouch” or “that hurts;” cursing during movement, or exclamations of protest, e.g., “stop” or “that’s enough.”		
TOTAL SCORE		

Indications: Behavioral Health adults who are unable to validate the presence of or quantify the severity of pain using either the Numerical Rating Scale or the Wong-Baker Faces Pain Rating Scale.

Instructions:

1. Write a 0 if the behavior was not observed
2. Write a 1 if the behavior even briefly during activity or rest
3. Results in a total score between 0 and 5.
4. The interdisciplinary team in collaboration with the patient (if appropriate), can determine appropriate interventions in response to CNVI scores.

Reference

Feldt, KS. (2000). The checklist of nonverbal pain indicators (CNPI). Pain Management Nursing, 1(1): 13-21.

Patient Education

- Provide all at risk patients & family education about pain.
- Teaching includes but is not limited to:
 - Patient's rights & responsibilities regarding pain control
 - Discuss possible physiological causes of pain that may be specific to the patient
 - Address barriers to good pain control
 - Address patient fears
 - Alternative methods of pain management
 - Report pain as soon as it starts before it gets severe because it is much easier to control.

Low Back Pain

Practice Good Back Health

Eight out of 10 people will experience back pain in their lifetime. Reduce your risk of back injury with these simple tips:

- Bend at your knees and hips (not at your waist)
- Use your legs and abdominal muscles when lifting
- Know your limits.
- Don't lift loads that are too heavy and take a break
- Don't twist your back -Maintain good posture

Source: http://www.sentara.com/NR/rdonlyres/70FD29F3-843B-4774-B05C-5FD3FAD51EF9/0/ExH_March_2005_peninsula.pdf

Prevent Lower Back Pain with Exercise

Prior to performing any exercise, Please consult your MD for the proper exercise related to the specific condition. Improper exercise can lead to a possible new injury or cause further injury to the original condition.

Exercises Back Pain Resources

Organizations

American Chronic Pain Association (ACPA)

P.O. Box 850
Rocklin, CA 95677-0850
ACPA@pacbell.net
<http://www.theacpa.org>
Tel: 916-632-0922 800-533-3231
Fax: 916-632-3208

National Institute of Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse

1 AMS Circle
Bethesda, MD 20892-3675
NIAMSinfo@mail.nih.gov
<http://www.niams.nih.gov>
Tel: 877-22-NIAMS (226-4267) 301-565-2966 (TTY)
Fax: 301-718-6366

American Academy of Orthopaedic Surgeons/ American Association of Orthopaedic Surgeons

6300 North River Road
Rosemont, IL 60018
hackett@aaos.org
<http://www.aaos.org>
Tel: 847-823-7186
Fax: 847-823-8125

American Academy of Physical Medicine & Rehabilitation

330 North Wabash Ave.
Suite 2500
Chicago, IL 60611-7617
info@aapmr.org
<http://www.aapmr.org>
Tel: 312-464-9700
Fax: 312-464-0227

NIH Neurological Institute

P.O. Box 5801
Bethesda, MD 20824
Voice: (800) 352-9424 or (301) 496-5751
TTY (for people using adaptive equipment): (301) 468-5981
http://www.ninds.nih.gov/about_ninds/addresses.htm

The National Pain Foundation

300 E Hampden Avenue, Suite 100
Englewood, CO 80113
<http://www.nationalpainfoundation.org/default.asp>

American Pain Foundation

201 North Charles Street
Suite 710
Baltimore, MD 21201-4111
info@painfoundation.org
<http://www.painfoundation.org>
Tel: 888-615-PAIN (7246)
Fax: 410-385-1832

American Association of Neurological Surgeons

5550 Meadowbrook Drive
Rolling Meadows, IL 60008-3852
info@aans.org
<http://www.aans.org>
Tel: 847-378-0500/888-566-AANS (2267)
Fax: 847-378-0600

American Academy of Family Physicians

11400 Tomahawk Creek Parkway
Suite 440
Leawood, KS 66211-2672
fp@aafp.org
<http://www.aafp.org>
Tel: 913-906-6000/800-274-2237
Fax: 913-906-6095

American Academy of Neurological and Orthopaedic Surgeons

10 Cascade Creek Lane
Las Vegas, NV 89113
aanos@aanos.org
<http://www.aanos.org>
Tel: 702-388-7390
Fax: 702-871-4728

American College of Rheumatology

1800 Century Place, Suite 250 Atlanta, GA 30345
404-633-3777
www.rheumatology.org

National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) Information Clearinghouse National Institutes of Health

1 AMS Circle
Bethesda, MD 20892-3675
Phone: 301-495-4484
Toll Free: 877-22-NIAMS (226-4267)
TTY: 301-565-2966
Fax: 301-718-6366
Email: NIAMSinfo@mail.nih.gov
Website: <http://www.niams.nih.gov>

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