Evidence Based Management of Low Back Pain and Sciatica, the new NICE Guideline

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Low back pain causes more disability, worldwide, than any other condition. Episodes of acute back pain are usually transient with rapid improvements in pain and disability seen within a few weeks to a few months. However, whilst the majority of episodes resolve spontaneously, up to one third of patients report persistent back pain of at least moderate intensity one year after an acute episode requiring care and episodes of back pain often recur and can become chronic.

The NICE guideline covers the evidence based assessment and management of non-specific low back pain and sciatica in adults over 16. This diagnosis means that the back pain is very unlikely to be caused by serious pathology such as cancer, infection, fracture or as part of a more widespread inflammatory process. Serious causes of low back pain are rare (for example, less than 1% of patients presenting with low back pain in primary care will have cancer) and clinicians are usually alerted to serious pathology by using clinical screening tools such as Red Flags.

A number of spinal structures are supplied by sensory nerves and therefore capable of pain generation. However there are no reliable clinical features or imaging findings that allow us to identify these specific causes with any confidence. We capture this diagnostic uncertainty by using the now widely accepted term 'non-specific low back pain' but acknowledge that the terminology is imperfect. Whilst the name may be helpful to clinicians in terms of describing a condition that is very unlikely to be caused by a serious disease process, it does not imply the absence of an underlying cause. There is a risk that in using the term 'non-specific', this is misinterpreted as 'non-organic' or as manifestation of abnormal psychology or behaviour. It is accepted that as the condition continues, some cases might be diagnosed as having a specific cause whish is amenable to targeted treatments.

The new Guideline recommends risk stratification on initial assessment, a strong recommendation to give advice to support self management, and then evidence based treatments. These include using a NSAID, or weak opioid plus or minus paracetamol. Exercise either alone or with manual therapy and/or psychological treatment and/or education can be considered. If there is no response, then a division into low back or sciatic predominant pain is made with different pathways.

Selected patients in the low back pain group should be considered for RF denervations, and those with sciatica can be considered for treatment for neuropathic pain, including SCS, also Epidural Steroids and finally Decompression Surgery. The guideline and its implications, will be discussed.