

Acute (<4 wks) or Subacute (>4 wks < 3 mos.) Low Back Pain



Purpose

To guide primary care physicians with decision making at the initial evaluation for acute or subacute low back pain, for adults 18 year of age and older, in the outpatient setting. (It is not a comprehensive treatment guide, nor is it meant to facilitate or direct referrals for interventions or procedures.)

Key Recommendations

Acute Low Back Pain

- Do not recommend bed rest for more than 48 hours when treating low back pain.*
- Avoid routine imaging which usually does not improve outcomes in patients with nonspecific pain. See “Additional Risk Factors” on page 2.
- In the absence of red flags, advise patient to limit bed rest and continue ordinary daily activity as tolerated.
- Opioids are rarely needed and should be prescribed cautiously.
- NSAIDs are an effective treatment for nonspecific acute low back pain.
- Possibly Acetaminophen.
- Consider muscle relaxants based on side effect profile as second line therapy.

- **Acute Low Back Pain not responding after 2 weeks or Subacute Low Back Pain**
- Continue to reassure patients that movement and activity is helpful.
- Address any fear avoidance behavior.
- Consider chiropractic/spinal manipulation therapy referral
- Consider physical therapy referral.

**Choosing Wisely. An initiative of the ABIM Foundation. North American Spine Society - Five Things Physicians and Patients Should Question. 2013. Available from: <http://www.choosingwisely.org/doctor-patient-lists/north-american-spine-society/>*

Guidelines for Acute (<4 wks) or Subacute (>4 wks < 3 mos.) Low Back Pain

RED FLAGS AND ADDITIONAL RISK FACTORS FOR SERIOUS CONDITIONS	Refer To ER Immediately	<ul style="list-style-type: none"> • Sudden onset or otherwise unexplained loss or changes in bowel or bladder control • Sudden onset or otherwise unexplained bilateral leg weakness • Saddle numbness 	
	Appt < 24 hours	<ul style="list-style-type: none"> • Fever 38° C or 100.4°F for longer than 48 hours • Unrelenting night pain or pain at rest • Leg weakness (less than antigravity strength in major muscle groups) • Began < 6 wks ago w/ progressive pain & distal (below the knee) numbness or weakness of legs • Progressive neurological deficit 	
	Additional Risk Factors for Serious Conditions	<ul style="list-style-type: none"> • Recent significant trauma or age > 50 & milder trauma • Unexplained weight loss • Immunosuppression • History of cancer 	<ul style="list-style-type: none"> • IV drug use • Prolonged use of corticosteroids, history of osteoporosis • Age > 70
TREATMENT	For patients with red flags, suspected serious pathology	<ul style="list-style-type: none"> • Cauda equina syndrome or severe or progressive neurologic deficit – arrange for advanced imaging and definitive evaluation and care <i>immediately</i> • Expected spinal compression fractures – order plain LS spine X-ray. If x-ray does not confirm fracture, and after 10 days, patient is in severe pain OR has multiple sites of spinal pain, obtain MRI and consider referral • Cancer or infection – CBC, urinalysis, erythrocyte sedimentation rate, and plain X-ray. If still suspicious of cancer or infection, not sure about results of x-rays, get MRI scan or consider referral • Anticoagulation – concern for spinal bleed due to trauma or even suspected spontaneous bleeding – usually presents with severe back pain and progressive neurologic deficit. Obtain PT/INR and if neurologic exam is progressing MRI and emergent referral. 	
	For patients with no red flags	<p><i>Non-Invasive Treatment and Self-Care</i></p> <ul style="list-style-type: none"> • Reassure patients that 90% of episodes resolve spontaneously in 6 weeks • Explain that early routine imaging & other tests usually cannot identify a precise cause & may trigger unnecessary procedures and worsen outcomes. • Recommend remaining active and avoiding bed rest. Complete pain relief usually occurs after, rather than before, resumption of normal activities and return to work should be before complete pain relief. Light activity often hastens recovery and lessens pain. • Superficial heat by heating pads or heated blankets. • Aerobic exercise, exercise therapy, Intensive interdisciplinary rehabilitation (intervention that includes a physician consultation coordinated with psychological, physical therapy, social or vocational intervention), spinal manipulation by providers with appropriate training. • Recommend self-care education books such as The Back Book. <p><i>Medications</i></p> <ul style="list-style-type: none"> • Assess severity of baseline pain and functional deficits and consider use of medications with proven benefits . • For most patients, first line medication options are nonsteroidal anti-inflammatory drugs (NSAIDs) or possibly acetaminophen • Consider muscle relaxants with limited sedative side effects as 2nd line treatment in moderate to severe acute LBP not adequately controlled by NSAIDs. • Opioids are rarely needed and should be prescribed cautiously. <p><i>Follow Up Visit 1-3 Weeks After Initial Evaluation If</i></p> <ul style="list-style-type: none"> • No improvement with home management • Significant pain persists beyond a week • Symptoms persist, worsen or progress 	

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Measures Commonly Used by National Organizations

- Use of Imaging Studies for Low Back Pain: Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. (*CMS Meaningful Use/HEDIS/PQRS*)

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