AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

QUICK GUIDE for general practitioners

Low Back Pain Clinical Care Standard

Quick guide for general practitioners

This quick guide outlines the care described in the *Low Back Pain Clinical Care Standard* for patients presenting to their general practitioner for a new acute episode of low back pain.

1. Conduct an initial clinical assessment

ASSESS patients early in each new presentation of low back pain. Include:

- Targeted history (pain, past history, functional capacity and alerting features for specific and/or serious pathology)
- Physical examination
- Focused neurological examination for patients with low back pain with leg pain
- Exclusion of differential diagnoses (such as nephritis colitis, hip osteoarthritis, aortic dissection).

ARRANGE

- Appropriate investigation if specific and/or serious underlying pathology is suspected
- Follow-up for monitoring or further assessment (such as psychosocial assessment using STaRT Back or Örebro).

IMMEDIATELY REFER patient to a spinal surgeon or emergency department for severe or progressively deteriorating neurological signs, suspected cauda equina compression, spinal infection or new acute neurological deficit – for example, foot drop.

DOCUMENT findings in the patient's medical record.

Communication tip

Explain to the patient that low back pain can be effectively managed even when the cause is not known – for example:

'We've done a good assessment here today and there is no indication that your back pain is associated with a serious underlying condition. While the pain can be severe, the good news is that most acute episodes of low back pain settle within a couple of weeks. In the meantime, there are a lot of things you can do to help reduce and manage your low back pain.'

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2. Assess for psychosocial factors

ASSESS patient concerns and factors which may delay recovery (psychological, social, occupational, legal) early in each new presentation of low back pain:

- Identify harmful misconceptions including fear-avoidance behaviour
- Consider using risk assessment tools (STaRT Back or Örebro) to prompt discussion.

DOCUMENT findings and repeat the assessment at subsequent visits to measure progress.

Communication tip

Inform the patient of the effect that pain can have on the body and the mind – for example:

'Back pain does not usually mean your back is badly damaged. It means it is sensitised. The brain acts as an amplifier: the more you worry and think about your pain, the worse it can get.'

3. Reserve imaging for suspected serious pathology

ADVISE that imaging:

- Is rarely helpful or indicated for low back pain
- Can create unnecessary concerns
- Often uncovers incidental findings (disc degeneration, facet joint arthritis, disc bulges, fissures and protrusions) that are common in people without pain and usually a normal feature of ageing.

REFER a patient with alerting features for specific and/or serious pathology for early imaging to confirm or rule out a suspected diagnosis.

NOTE If imaging is indicated, MRI offers better sensitivity and a superior safety profile.

DISCUSS radiological findings in the context of history, examination and other investigations.

Communication tip

Explain to the patient why imaging is not recommended – for example:

'Imaging is used mainly to rule out anything serious, but otherwise it is not very good for identifying the cause of your pain. From what I can see, I'm not concerned that you have any of the serious causes of low back pain, so there is no need for any scans at this stage. In fact, imaging shows up changes that occur normally with age, even in people without back pain, so the findings are often not very helpful.'

4. Provide patient education and advice

ADVISE patients about the:

- Benign nature of low back pain and the low risk for serious underlying disease and likelihood of recurrence
- Potential benefits, risks and costs of any treatment strategies being considered.

PROVIDE tailored educational materials to reinforce key messages and repeat at subsequent visits.

Communication tip

Reassure the patient about the nature of low back pain – for example:

'Most back pain is caused by a simple strain of the back and for the vast majority of people it does not indicate serious disease or long-term disability.'

'Most people with acute low back pain will feel much better or will have recovered within two weeks, if they follow some simple advice.'

5. Encourage self-management and physical activity

ADVISE that:

- It is important to maintain or return to normal activities including physical activity, a graded return to work and/or meaningful activity
- **Prolonged bed rest is harmful and should be discouraged**.

SUPPORT patients to self-manage their symptoms by:

- Prioritising active management strategies over passive strategies
- Gradually increasing activity levels by using pacing
- Setting SMART goals that are important to the patient.

Communication tip

Explain to the patient why it is important to stay active – for example:

'It is important to understand what you can do to help manage your symptoms and stop your pain getting worse.'

'Remember that your back is strong. Movements may be painful at first, like an ankle sprain, but they will get better as you gradually get active again. In fact, staying active and continuing daily activities as normally as possible (including work) will help you recover.'

6. Offer physical and/or psychological interventions

Based on the findings from the psychosocial/risk assessment:

PROVIDE reassurance, guidance on self-management and advice to stay active for patients likely to improve quickly.

ADVISE that physical activity and exercise therapy can help to relieve pain and improve function for patients with an acute exacerbation of persistent or chronic low back pain.

REFER for physical and/or psychological therapies for patients at higher risk of a poor outcome.

Communication tip

Inform the patient of the effect that pain can have on the body and the mind – for example:

'Because the experience of pain affects both body and mind, treatments targeted at both factors can reduce pain and disability more than medical care alone.'

7. Use pain medicines judiciously

ADVISE that the goal of pain medicines is to reduce pain to support continuation of usual activities including physical activity and work, rather than to eliminate pain completely.

PROVIDE information about:

- How pain medicines should be combined with physical activity and self-management strategies to help improve function and mobility
- Risks, benefits and potential side effects.

If a pain medicine is being considered:

DISCUSS the patient's individual expectations, preferences, comorbidities, needs and treatment goals.

PRESCRIBE the lowest effective dose for the shortest possible time, in-line with current *Therapeutic Guidelines*.

DOCUMENT clear stopping goals.

NOTE **Avoid anticonvulsants, benzodiazepines and antidepressants. Consider opioid analgesics only in carefully selected patients, at the lowest dose for the shortest duration possible**.

Communication tip

Inform the patient of the latest research on non-drug options for low back pain – for example:

'Nowadays non-drug options are preferred over pain medicines to manage back pain. For now I'd suggest you stay as active as you can.'

'You could try heat wraps to help with the pain. We can reassess whether you need medicines or other therapies to help manage your pain at our review within the next week or two. How do you feel about that approach?'

8. Review and refer

If the patient's pain is persisting or worsening:

REASSESS to reconsider diagnosis and review psychosocial factors, medications and compliance with self-management strategies.

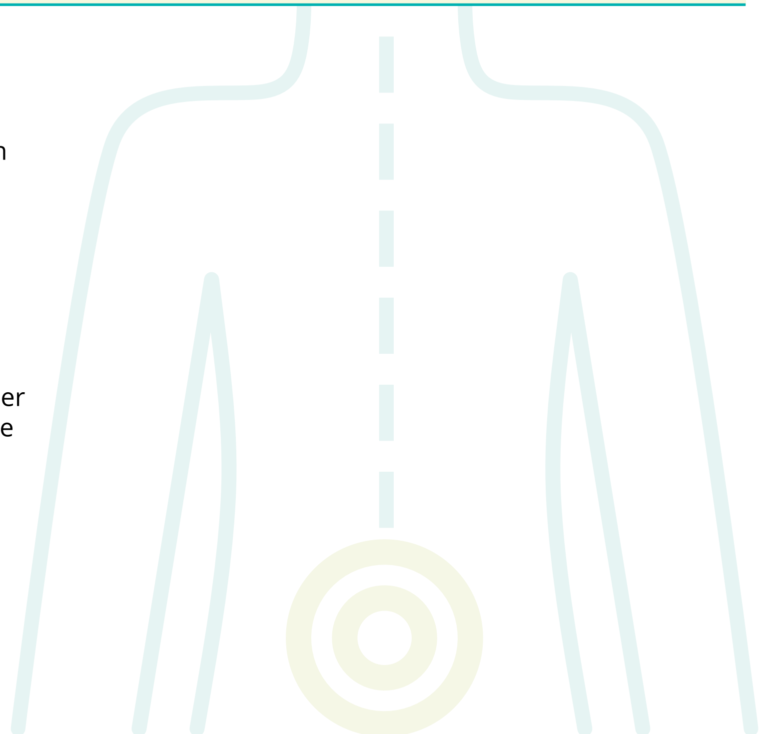
ARRANGE urgent investigation or specialist medical assessment if new concerning features are identified (serious pathologies or neurological deficits).

REFER a patient with:

- Disabling back or leg pain, or significantly limited function on review at 2–6 weeks to health practitioner/s or a multidisciplinary approach to address physical and psychosocial barriers
- **Severe or progressively deteriorating neurological signs and symptoms for imaging and surgical assessment**.

Communication tip

Advise the patient on the referral options suitable for their circumstances. In the absence of signs of specific and/or serious pathology, discuss the rational for further specialist review, such as for further diagnosis or multidisciplinary care to improve function.



Questions?

The *Low Back Pain Clinical Care Standard* describes an evidence-based approach to the early assessment, management, review and referral of patients with low back pain, with or without leg pain and other neurological symptoms, who present with a new acute episode.

Find out more about the *Low Back Pain Clinical Care Standard* and other resources. Scan the QR code or use the link safetyandquality.gov.au/lowbackpain-ccs.

The Australian Commission on Safety and Quality in Health Care has produced this clinical care standard to support the delivery of appropriate care for a defined condition. The clinical care standard is based on the best evidence available at the time of development. Healthcare professionals are advised to use clinical discretion and consideration of the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian, when applying information contained within the clinical care standard. Consumers should use the information in the clinical care standard as a guide to inform discussions with their healthcare professional about the applicability of the clinical care standard to their individual condition.

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