Back Pain – GP FAQs

What would be a primary care first line treatment recommendation for back pain?

The first line of treatment for back pain in the community in terms of primary care would be: -

- Firstly, reassurance.
- Simply analgesia
- Activity medication
- Physiotherapy

If the pain persists and is causing severe disability it may require onward referral to a specialist.

In order to understand the role of primary care in the management of back pain it is important to understand the nature of the problem. Back pain is incredibly common. The overall lifetime prevalence of that pain is around 80%. i.e. 80% of people would be expected to have severe symptomatic back or leg pain during their lifetime. In the vast majority of individuals this pain settles spontaneously in the order of weeks to months after its' onset. It is likely that both the doctor seeing the patient and the patient in the past would have suffered from significant episodes of back pain. The reassurance as stated is that this does spontaneously improve in the vast majority of people.

Therefore, the first line of management of this condition is reassurance. Although severe pathologies can occur in adults these are relatively uncommon in the overall quoted incidents is around 2%. This equates to 2 out of 100 people to have a serious pathology within their back.

Simple analgesia can help them in the form of Paracetamol or non-steroidal medications. Most medications can either be taken by the mouth or applied locally to the areas of the back that are painful. Physiotherapy can also help in this setting. The physiotherapy can take several forms. This can be in terms of conventional physiotherapy or chiropractor treatment or osteopathy. The overall effect of these therapies is quite similar in that they initiate muscle relaxation and help calm down any inflammatory process that occurs in the acute phase of back pain.

As adjuncts to these people often find activities such as Yoga and Pilates help. For the most part these activities try address one of the key features of the pathology of back pain which is disuse atrophy. This is due to the fact that once one suffers back pain, one ceases to undergo the normal set of activities one would normally engage in. Therefore, the muscles in the back often wither down and this can make the pain worse in the long-term. Many of the interventions that we carry out as spinal specialists aim to reverse these processes.

What are the yellow flags to look out for?

Yellow flags are psychosocial indicators suggestive increased risk of causing long term disability or long-term distress caused by severe pain. Yellow flags can relate to patients' attitudes, beliefs, emotions, family and workplace. The behaviour of a professional could also have a major influence.

Key factors in regard to back pain with regard to yellow flags include the following: -

1. Belief that the pain is harmful or severely disabling
2. Fear avoidance behaviour (avoiding activity because of the fear of pain)
3. Low mood and social withdrawal
4. Expectation that passive treatments rather than active participation will help
5. Problems at work or poor job satisfaction
6. Previous history of back pain with time off work.
7. Problems with work compensation systems.

It is important to understand that back pain is as with all other conditions can form part of a biopsychosocial model. Therefore, factors which are outside of the locus of the pain can heavily influence ones' symptoms. For example, it is well characterised that individuals who lose their jobs and have become unemployed during the period of their back-pain result firstly in worse pain scores but also poor responses to treatment. This has been described in multiple studies. The importance of the other factors is to understand that one must the whole individual rather than focusing on one anatomical locus. A holistic multi-disciplinary approach should be taken with these individuals to restore them to the optimal biological, physical and psychological state.

What are the red flags to look out for? -

Red flags are potential indicators of serious disease in an individual. Although there are universally agreed lists the following are widely accepted as red flag markers: -

1. History of cancer
2. Unexpected weight loss
3. Severe pain when supine or at night.
4. History of trauma
5. IV drug abuse
6. Recent bacterial infection or fever
7. Immunosuppression (HIV) infection on corticosteroids
8. Saddle anaesthesia
9. Bladder dysfunction which be urinary retention or incontinence
10. Bowel disruption or fecal incontinence
11. Neurological deficit in either or both the lower limbs, especially if progressive
12. Persistent symptoms of over 4 weeks with worsening pain

The things to understand with regard to red flags, is that they are relatively uncommon but can be potentially devastating. For example, the overall estimate is around 2% or 2 in 100

people will suffer from significant pathologies when presenting with back pain. This is interestingly the same in adults and children. However, when this occurs the effects can be quite devastating. For example, a condition such as cauda equina syndrome often presents quite indolently with a fairly low-grade bowel or bladder dysfunction on the background of back pain. This can precipitately deteriorate.

One of the issues that general practitioners often encounter is that in situations they are concerned about for example cauda equina syndrome, they often refer on to a clinician and are upset when the subsequent scans are normal. This is actually a relatively common finding in spinal surgery. Most studies have found that around 85% of scans done for cauda equina syndrome are negative. However, it is important to detect these rare but devastating conditions that occur in the remaining 15% at an early stage so that they can be managed to prevent devastating effects to the individual such as permanent bowel or bladder dysfunction. Therefore, if one refers for an MRI scan for an individual where one suspects serious pathology is occurring, one should not be upset when the scan turns out to be normal.

Are there any symptoms that would lead to a certain back condition? -

Two common conditions that one sees regularly in clinic would be:

1. Radiculopathy
2. Spinal stenosis

Radiculopathy

This is commonly referred to as sciatica. This involves pain being referred down to the leg by compression of the nerve or in the back. This is typically referred at around 80% across a lifetime. Thankfully, the vast majority settle within the first 6 to 8 weeks of onset. The pain is quite characteristic. It radiates down the back down the bottom of the leg to the dermatomal distribution that supplied that particular nerve. Thus, the most commonly affected nerves would be L5 and S1 and so the pain would be referred to the dorsum of the foot or the plantar aspect of the foot. This can also be associated with a sensory disturbance in the form of numbness or paraesthesia as well as motor weakness which is an extreme form and can take manifestations as foot drop. Usually the signs are unilateral. If there are any signs of bilateral sciatica or any bowel or bladder dysfunction, individuals should be referred for urgent scanning.

Spinal Stenosis

This commonly affects elderly people. It often manifests with little in the way of physical signs but has a characteristic history. It presents with a similar claudication picture to that which occurs in smokers. People get cramping feeling within their legs when they walk a certain distance and have to stop for the pain to be relieved. Progressively over time the walking distance can decrease. This can occur in relatively active people who enjoy long active walks, to essentially be housebound. The treatment for this is very straightforward. It simply involves releasing the pressure on the nerves within the back and can affect almost

instantaneous pain relief. Again, if there are any concerns about bowel or bladder dysfunction or perineal paraesthesia these individuals should be referred urgently for scanning.

When would you refer to secondary care?

The following is a sample of conditions that should be referred to secondary care but is not an exhaustive one: -

1. Radiculopathy. Typically, radiculopathy should be referred to secondary care once the individual has persistent after about 6 – 8 weeks. During this time, they should have undergone analgesia and physiotherapy. In my routine practice I would then assess this individual's suitability for further interventions. My approach is very much patient centred and to provide individuals with information so that they can come to their own decision about which procedure if any they would like to undergo.

2. Spinal stenosis. This again should be referred to secondary care if the individual has persistent symptoms which are restricting their daily activity. Typically, analgesia and physiotherapy are ineffective in this condition and therefore if the symptoms persist, they should be referred for secondary care.

3. Vertebral compression fractures. This is a condition which is quite common in the elderly. This presents with back pain which the individual can often pinpoint with a certain activity which is often low energy in nature. Individuals can get these when bending over to do gardening, doing minor lifting activities or following some more major trauma. Typically they affect post-menopausal women who suffers much more precipitous symptoms than men do. The effective treatments for these particularly with regard to chondroplasty, and again if these individuals have persistent significant pain and they are anxious as to the etiology or would be interested in intervention they should be referred on.

Are there any good tips for GPs that you could share?

1. If as the presiding physician, you are concerned that the individual has a serious pathology do not hesitate to refer him or her to a spinal surgeon. Certain conditions especially cauda equina syndrome are very time dependent. Delays in treatment of this condition, even over 48 hours can result in permanent dysfunction. This can leave relatively young fit individuals in an undignified condition of permanent bowel and bladder dysfunction. Therefore, my suggestion is again as a presiding physician, if you are concerned please refer on the individual.

2. I understand that serious pathologies within the spine are relatively rare. Overall this is quoted around 2% and therefore the vast majority of your patients will not have a significant abnormality.

3. Do not be upset if scans that they you request for urgent conditions turn out to be normal. As described above for conditions such as cauda equina syndrome, this is a very

common occurrence. Most of us as a community of spinal surgeons don't mind scanning people but do get upset when treating people whose pathologies have been missed or treatment delayed to the point where they cannot recover.

4. I understand back pain, radiculopathy and spinal stenosis can be severely debilitating. During my career of treating many numbers of staff in hospitals, I always find it fascinating to the extent that people often have little sympathy for individuals with severe back problems until they suffer their conditions themselves.

5. The vast majority of individuals can be treated non-operatively. The list of conditions you can treat surgically with regard to back pain is relatively small. Therefore, the vast majority of individuals can be treated non-operatively. The important thing is to have completely patient-centred care. In my routine practice this involves involving the patient at all stages of the decision-making process and providing support and information for them to make the decision which is correct for them.

Mr Dimpu Bhagawati

MA (Oxon) MBBS (Lond) MRCS (Eng) MSc (Lond) FRCS (Trauma and Orthopaedics)
Consultant Orthopaedic & Spinal Surgeon

NHS
Luton and Dunstable
University Hospital
NHS Foundation Trust