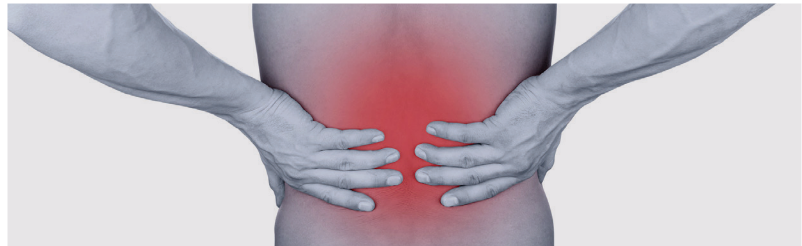
Chronic Low Back Pain

A Fact Sheet by Dr Laurence McEntee



70-90% of people will experience low back pain (LBP) at some point in their lives. In the majority of people it is short-lived and resolves completely. However, 5-10% of people will develop chronic low back pain (CLBP) which is defined as back pain of greater than 3 months duration or recurring episodes of acute low back pain.

As with acute LBP the patient should be screened for 'red flags".

- Known Cancer (past or present)
- Unexplained Weight Loss
- Night Pain / Non-mechanical pain
- Fevers/Recent infection/IV drug use/ Immune suppressed
- Saddle numbness/ Urinary retention/ Incontinence/ Progressive lower extremity neurological deficit.

It is also important to screen for 'yellow flags' in CLBP as these impact on the patients perception of CLBP, help guide treatment to a certain degree and also help determine prognosis.

- Inappropriate beliefs about back pain
- Inappropriate pain behavior
- Work dissatisfaction / Works compensation
- Emotional / psychological problems
- Passive recipient of health care.

Most patients with CLBP can function in daily life and can be managed nonoperatively. In the absence of red flags and sciatica initial imaging of the lumbar spine is not mandatory however in a patient with more chronic severe symptoms a lumbar CT or MRI scan is reasonable.

Treatment Options:

Self-management is the cornerstone of treatment for CLBP:

- Lifestyle changes such as weight loss, healthy diet, smoking cessation
- Self-directed light aerobic exercise, core muscle strengthening/pilates, stretching/yoga
- Environmental modifications such as sit/stand desk at work.

Patients with associated anxiety/depression should be referred to a psychologist for cognitive behavioural therapy.

A/Prof Laurence McEntee

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A/Prof Laurence McEntee's special interests include:

- Anterior approaches to the spine
- Total disc replacement
- Minimally invasive posterior fusion
- Adult spinal deformity

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Patients who don't improve with self-management can be referred to a physiotherapist for **active treatment.** There is little evidence for passive treatment modalities (massage, manipulation etc) in the management of CLBP.

Paracetamol and NSAIDs will help reduce symptoms in most patients. Muscle relaxants and opiate medications should only be used for short-term relief of exacerbations of CLBP.

Most patients will be able to manage their CLBP with the treatment strategies listed above. If not, then referral to a specialist is indicated.

- Low back pain is a symptom not a diagnosis
- It is our job to make a more precise diagnosis as to the cause of the patients CLBP and offer them further treatment options.

In general the source of low back pain will be:

- Discogenic 40-50%
- Facet joint 30-40% (increasing with age)
- Sacroiliac joint 20%.

Further treatment options include:

- Facet joint intra-articular steroid injections or radiofrequency ablations
- Sacroiliac joint intra-articular steroid injections or radiofrequency ablations
- Epidural steroid injections
- Surgery
    - Only after appropriate non-operative treatments have failed
    - Usually not required for isolated facet joint pain in the absence of sciatica
    - Sacroiliac joint fusion is effective for proven isolated sacroiliac joint pain
    - Very effective for discogenic low back pain at 1-2 levels (disc replacement or fusion)
    - Very effective for isthmic or degenerative spondylolisthesis with associated radiculopathy/sciatica (fusion).