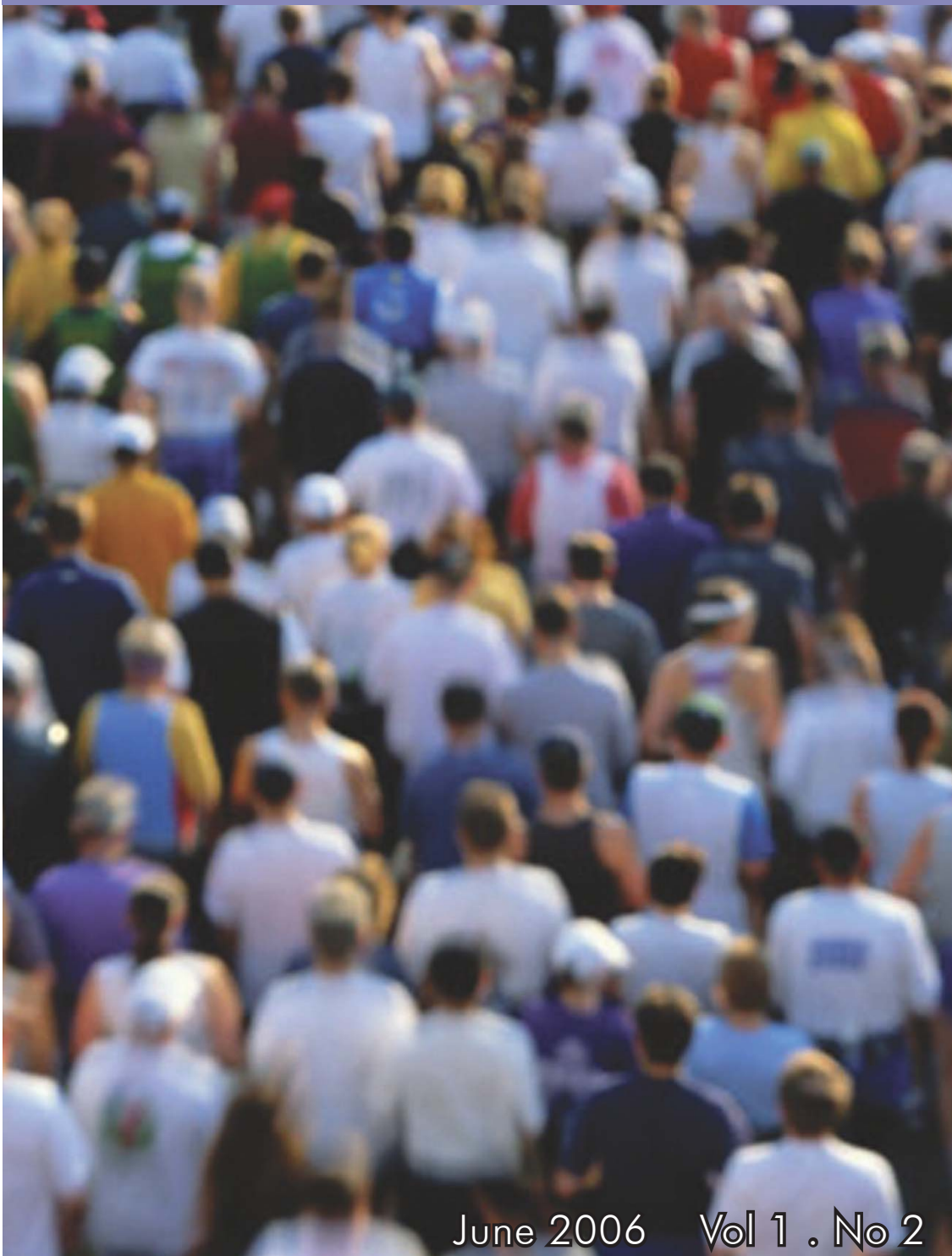




ProRehab

EVIDENCE BASED UPDATE

AN EVIDENCE-BASED NEWSLETTER RELATED TO THE
MANAGEMENT OF MUSCULOSKELETAL DISORDERS



June 2006 Vol 1 . No 2



ACUTE LOW BACK PAIN: AN EVIDENCE-BASED UPDATE

Acute low back pain (ALBP) is a major health care problem and commonly managed by primary care providers. Practice guidelines are developed, published, and disseminated to improve outcomes and reduce practice variation. This is considered an important part of the current trend toward evidence based medicine. The purpose of this issue is to highlight new research related to ALBP that may not be reflected in current practice guidelines.

The following is a summary of international practice guidelines published in 2001¹³:

- Reassure patients (favorable prognosis)
- Advise to stay active
- Prescribe medication if necessary (preferably time contingent): paracetamol, nonsteroidal anti inflammatory agents, consider muscle relaxants or opioids
 - Discourage bed rest
 - Consider spinal manipulation for pain relief
 - Do not advise back-specific exercises

These guidelines were developed based on the available research up to 1999. There have been several studies published since then that raise doubt related to the homogeneity of the ALBP population and the widely held belief that an acute low back pain episode will resolve within 6 weeks.

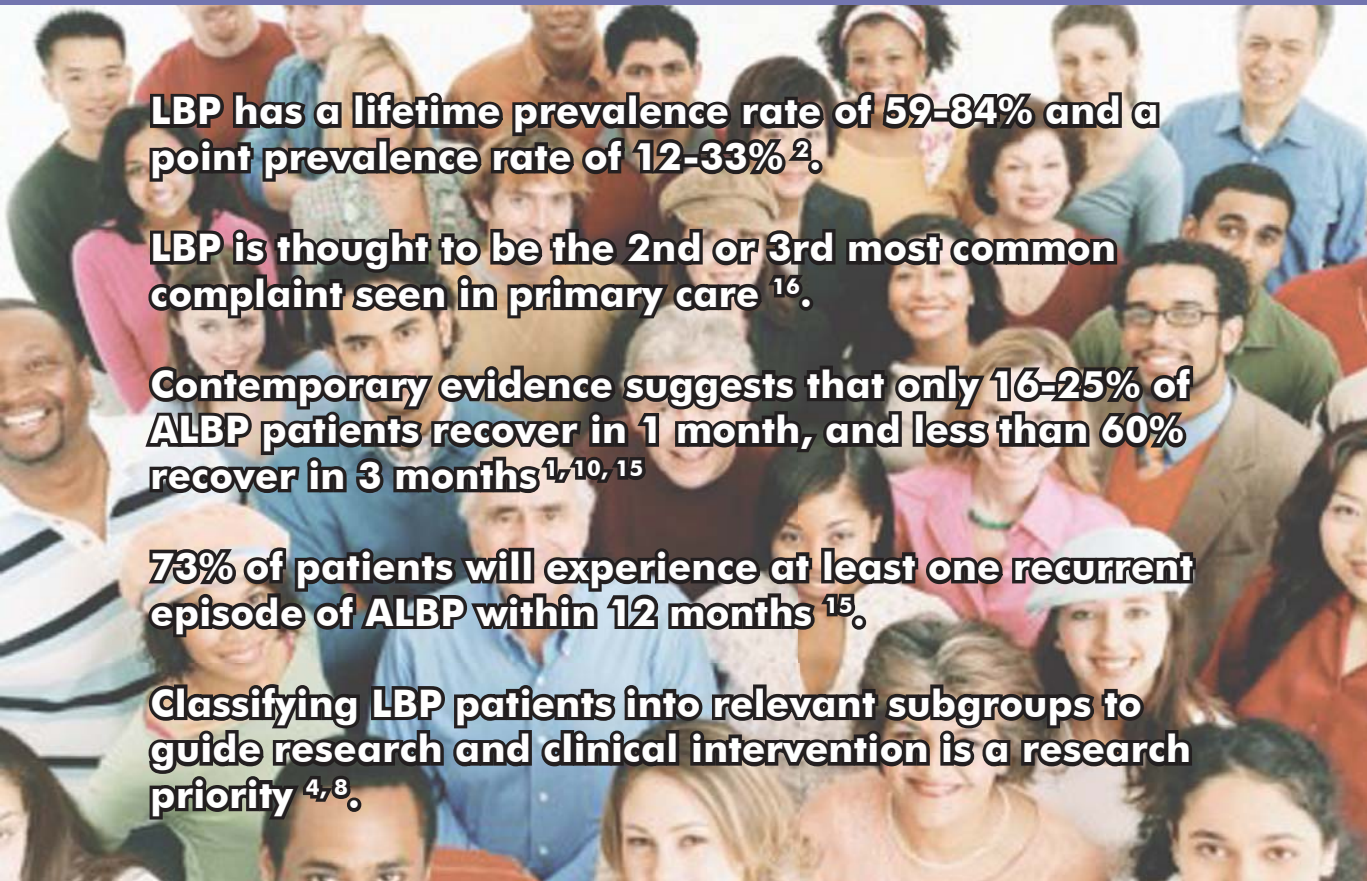
A systematic review¹ published in 2002, which included 22

studies on ALBP in primary care, concluded that: *“although the belief that 80-90% of acute LBP will resolve in 6 weeks is widely perpetuated, there is considerable evidence that this is not the case”*. They state that persisting and recurring LBP is often *“hidden”* as many patients do not return to the health care system and the natural course of acute LBP and associated disability is persistent and episodic.

Another review published in 2003¹¹, also found no evidence to support the claim that 80%-90% of patients become pain-free within one month. They found, on average, that 62% of patients still experienced symptoms after 12 months and between 44% and 78% of subjects experienced relapses.

Results from a longitudinal study of ALBP patients showed that 90% of the subjects consulting general practice for LBP ceased to consult about their symptoms within 3 months, but most still had substantial LBP and disability. This study concludes with *“the true course of LBP is one of recurrence*

ACUTE LOW BACK PAIN FACTS



LBP has a lifetime prevalence rate of 59-84% and a point prevalence rate of 12-33%².

LBP is thought to be the 2nd or 3rd most common complaint seen in primary care¹⁶.

Contemporary evidence suggests that only 16-25% of ALBP patients recover in 1 month, and less than 60% recover in 3 months^{1,10,15}

73% of patients will experience at least one recurrent episode of ALBP within 12 months¹⁵.

Classifying LBP patients into relevant subgroups to guide research and clinical intervention is a research priority^{4,8}.



and continued disability”⁷.

Another longitudinal study¹⁰ published in 2006, which followed 342 ALBP subjects for 12 months, demonstrated that 4 distinct patterns or groups of ALBP exist. Overall, only 16% were resolved after one month. Thirty-six percent were classified as “mild persistent” with a mean pain level of 3/10, 21% were classified as “severe-chronic” with a mean pain level of 7/10 and 13% were classified as “fluctuating” with pain levels moving between 3/10 and 6/10 over the course of 12 months.

The evidence to date does not support the commonly accepted notion that an ALBP episode will spontaneously resolve in 4-6 weeks¹ and emphasizes that subclasses of ALBP patients exist. Classifying LBP patients into relevant subgroups to guide research and clinical intervention has been an immediate priority established at the first *International Forum for Primary Care Research on Low Back Pain* in 1995³ and again at this groups second meeting in 1998⁴.

Attempts to identify structural pain-generating lesions to discriminate between LBP patients and ultimately guide treatment have essentially failed. Several studies have shown that information gained from early MRI scanning and radiographs does not effect clinical management and no patterns were identified. Additionally, higher surgical rates and a diminished sense of well-being have been identified in those groups who received results of MRI scans^{12, 14}.

It is believed that pain cannot be attributed to a identifiable pathology or neurological encroachment in about 85% of LBP patients⁵.

Simply utilizing duration of symptoms as a means of classification has been a convenient, but not meaningful characteristic used to distinguish patients. Regardless of duration of symptoms patients clinical presentations vary⁶.

Physical therapy researchers have developed the Treatment-Based Classification (TBC) system⁹. This classification approach places patients into one of four categories based on the most appropriate physical therapy treatment. The categories include:

1. DIRECTION SPECIFIC EXERCISE (similar to McKenzie extension exercises and Williams flexion exercises),
2. MOBILIZATION/MANIPULATION (those who will respond favorable to spinal mobilization/manipulation)
3. STABILIZATION (those who will respond to a stabilization exercises program)
4. TRACTION (those who will respond well to mechanical traction).

Details of the TBC system and how it has been implemented across ProRehab clinics will be the topic of next month's newsletter.



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QUOTE OF THE WEEK

"The real purpose of the scientific method is to make sure Nature hasn't misled you into thinking you know something you actually don't."

-Robert Pirsig, "Zen and the Art of Motorcycle Maintenance"

Quote taken from Evidence In Motion's web site June 12, 2006 blog



UPCOMING EBP NEWSLETTERS:

July - "Treatment Based Classification"

August - Spinal Manipulation; Clinical Predictive Rule to identify patients which will respond favorably to manipulation

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