# Management of low back pain

**National Institute for Health and Care Excellence (NICE) recommendations for low back pain (acute or chronic) (NG59):**

- Think about alternative diagnoses, e.g. using Red flag clinical indicators.
- Consider using risk stratification, e.g. STarT Back which helps to inform shared decision making about stratified management.
- Yellow flags may indicate those patients who would benefit from early referral to specialist services.
- Imaging is not indicated in the first instance when managing patients with Low Back Pain (LBP) in the absence of red flags, as it is not usually due to any significant structural damage and imaging often does not change management. Patients should be reassured about this as a first principle.
- **Self-management should be encouraged at every stage of management, tailored to the person's needs and capabilities e.g. NHS back pain information.**
- **Exercise should be encouraged at all stages. Consider a group exercise programme or National Exercise Referral Scheme (NERS). Daily walking (of a distance suitable to the person) is considered good for maintaining function and fitness.**

**The desired outcome of management is to regain or improve function as well as reducing the pain experience**

**Low back pain is very common and usually resolves within a few weeks or months. People should be reassured as a priority.**

**Self-care, maintaining activity and improving function are key outcomes and should be highlighted at every opportunity and regardless of how long low back pain has continued.**

**Medicines should be offered judiciously and only continued if improvements in function are seen in addition to reduced pain report.**

**NICE states there is very poor evidence to support the use of diazepam or other muscle relaxants for low back pain of any duration but there is evidence of them causing harm.**

**Table 1. Medicines for low back pain without sciatica**

| | |
|---|---|
| **1. NSAID** (if no contraindications) | **Ibuprofen 400 mg tds** *(*dose reduce in < 50 kg or older people to 200 mg tds)<br>**Or…**<br>**Naproxen 500 mg bd** (Dose reduce in < 50 kg or older people to 250 mg bd) |
|  | If you have concerns about gastric side effects of NSAIDs, consider co-prescribing PPIs. |
| **2. Opioids for moderate pain** | **Codeine phosphate 30–60 mg up to qds** (for 48 hours then reassess)<br>**Or…**<br>**Dihydrocodeine 30–60 mg up to qds** (for 48 hours then reassess; doses up to 240 mg per day for severe pain)<br>Only if NSAIDs are contraindicated or ineffective after 1–2 week trial. |
|  | **Do not offer antidepressants or anticonvulsants for low back pain without sciatica, even if standard analgesics have not been helpful.**<br>Medicines should be initially prescribed acutely, reviewed after 2 weeks and only continued if functional improvement is shown. |
|  | **Do not offer paracetamol alone** for low back pain of any duration. |

**Table 2. Medicines for low back pain with sciatica** (in addition to those above)

| | |
|---|---|
| **1. Medicines used in the treatment of depression** | **Amitriptyline 10 mg increasing to 50 mg between 6–8 pm** initially but effectiveness for pain is dose related so may need **50–125 mg** in the evening.<br>**Or...**<br>**Duloxetine 30 mg increasing to a maximum 120 mg** daily (do not co-prescribe with another SSRI). |
|  | **Prescribers are reminded of MHRA advice relating to the use of antidepressants in patients at risk of harming themselves, including those aged less than 25 years.** |
|  | If a patient has no response after four weeks of being on a therapeutic dose of a medicine for neuropathic pain, they are unlikely to respond and the medicine should be tapered and stopped. Appropriate follow-up arrangements should be in place (e.g. telephone follow-up) to minimise the use of medicines that are ineffective. |