DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Management of Low back pain and Sciatica in primary care

Introduction

This guideline is based on NICE NG59 Low back pain and sciatica in over 16s. The aim is to provide guidance for clinicians in primary care for pain management, with specific recommendations for prescribed medication. Nevertheless, medications should usually be a small part of the pain management plan and should be used in conjunction with non-pharmacological interventions.

Low back pain is pain in the lumbosacral area of the back, between the bottom of the ribs and the top of the legs. Up to 60% of the adult population can expect to have low back pain at some time in their life. Examples of specific causes of low back pain include sciatica, intra-abdominal pathology, or ankylosing spondylitis. Non-specific low back pain refers to when the pain cannot be attributed to a specific cause, although in many cases, may be related to trauma or musculoligamentous strain.

Sciatica describes symptoms of pain, tingling, and numbness which arise from impingement/ compression of lumbosacral nerve roots as they emerge from the spinal canal, and are felt in the distribution of the nerve root (dermatome). Episodes of sciatica are usually transient, with rapid improvements in pain and disability seen within a few weeks to a few months.

Assessment and Risk stratification

Think about alternative diagnoses when examining or reviewing people with low back pain/ sciatica, particularly if they develop new or changed symptoms. Exclude specific causes e.g. infection, trauma or inflammatory disease such as spondyloarthritis. Assess for the presence of red flag symptoms that may suggest a serious underlying causes e.g. Caude equina syndrome or cancer. Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica.

Consider using risk stratification (e.g. STarT Back risk assessment tool) to inform decision making regarding treatment:-

- simpler and less intensive support for people likely to improve quickly and have a good outcome (e.g. reassurance, advice to keep active and guidance on self-management)
- more complex and intensive support for people at higher risk of a poor outcome (e.g. exercise programmes with or without manual therapy or using a psychological approach).

Self-management advice

Provide people with advice and information, tailored to their needs and capabilities and encouragement to continue with normal activities.

- Acute non-specific low back pain is not caused by serious structural damage. Most people can reasonably be expected to recover from an episode of acute non-specific back pain within a period of weeks.
- Sciatica symptoms usually settle within 4–6 weeks but may persist for longer in some people.
- Prolonged bed rest is not recommended. Normal movements may produce some pain which should not be harmful if activities are resumed gradually and as tolerated. The person does not need to be pain-free before returning to normal activities or work.
- For some patients weight loss may improve outcomes. Support for assistance with weight loss efforts is available from Live life better Derbyshire website.
- Keeping as active as possible and exercising regularly is important to reduce the risk of recurrence.

Examples of Patient Resources :-

- Live life better Derbyshire https://www.livelifebetterderbyshire.org.uk
- Versus Arthritis Patient Decision Aid
- Keele University Start back patient information- including leaflet, app, and animations.
- Backcare.org.uk Exercises for back pain patient information leaflet

Non-pharmacological interventions
Options recommended by NICE include group exercise programme, manual therapy and/or psychological therapies (cognitive behavioural approach) as part of a treatment package including exercise. See below referral section for more information.

Being active when in pain can be a challenge and it is therefore important for patients to know that it is safe to be active in spite of pain; provide reassurance that pain does not always indicate harm especially when pain persists for a long time.

Pharmacological Management
For treatments of minor, short-term back pain, patients are encouraged to self-care with lifestyle changes and over-the-counter painkillers e.g. paracetamol, ibuprofen. British Pain Society (BPS) has produced a useful patient information leaflet on managing pain using OTC medicines.

Oral NSAIDs

- Consider oral NSAIDs for managing low **back pain**. Be aware of the risk of harms and limited evidence of benefit from the use of NSAIDs in **sciatica**.
- **Ibuprofen up to1200mg daily** first line; alternatively naproxen up to 1000mg daily (NB use plain tablets).
- Use lowest effective dose for the shortest possible time.
- Add lansoprazole 15mg or omeprazole 20mg daily if high risk for serious GI adverse events as per JAPC guideline
- NSAIDs may be used with or without paracetamol 1g 3-4 times daily (Consider dose reduction in patients at risk of hepatotoxicity and those <50kg)
- British pain society (BPS) patient information leaflet- NSAID for treatment of pain

Opioids

- Do NOT routinely offer opioids for managing acute low back pain.
  Consider weak opioid (first line- codeine) with or without paracetamol for managing acute low back pain, only if an NSAID is contraindicated, not tolerated or has been ineffective.
- Provide verbal and written information on weak opioids (if used) and pain management. Ensure patients are counselled on side effects e.g. constipation, driving, and risk of addiction. See opioid resource page for templates and patient information leaflets.
- Do NOT offer opioids for managing chronic (≥3 months) low back pain or chronic sciatica.

Gabapentinoids (gabapentin, pregabalin) and antiepileptics

- NICE does NOT recommend gabapentinoids or antiepileptics for managing low back pain or sciatica, as there is no overall evidence of benefit and there is evidence of harm. See meta-analysis on chronic low back pain.
- Local pain specialists recognise the potential issues in the long-term use of these medications for back pain and sciatica, however, reserves the option to use of gabapentinoids and some antiepiliptics e.g. carbamazepine, oxcarbazepine for small number of selected individuals after considering all other options. These should be started on specialist recommendation on a trial basis with clear plan to review/ stop.

Other medications

- Paracetamol alone for managing low back pain is not recommend by NICE.
- Do NOT offer SSRI, SNRI, TCA for managing low back pain.
- Do NOT offer oral corticosteroids or benzodiazepines for managing sciatica as there is no overall evidence of benefit and there is evidence of harm.

Existing treatment
NICE recommends that if a person is already taking opioids, gabapentinoids or benzodiazepines for sciatica, clinicians should explain the risks of continuing these medicines, and as part of shared decision making about whether to stop these medications for sciatica, discuss the problems associated with withdrawal.

The faculty of pain medicine (FPM) and the British pain society (BPS) have expressed concerns over NICE's recommendations on the pharmacological management for chronic back pain/ sciatica due to the potential for harm to patients by omitting treatments that are valuable in the context in which they are used, namely to enable rehabilitation and an improved quality of life.

JAPC recognises that withdrawing these medications may not be feasible/ appropriate, especially for stable patients, following FPM/BPS concerns, and also partly due to current limitations in capacity and service provision for alternative non-pharmacological treatment options. Pragmatically, patient should be provided with relevant information where appropriate. See opioid resources page to support review of opioids use in chronic pain.

Referrals
If the GP requires more detailed assessment and treatment for low back pain and sciatica, then a referral to specialist services, such as the pain clinic, the physiotherapy service, a pain management programme (for group-based management of mood and activity) or the Health Psychology Service (for management of mood, adjustment and coping issues) is recommended. See non-malignant chronic pain guideline for further details on criteria for referral and DCHS referral form.

Reference

1. NICE NG59 https://www.nice.org.uk/guidance/ng59
2. CKS back pain https://cks.nice.org.uk/topics/back-pain-low-without-radiculopathy/
3. CKS sciatica https://cks.nice.org.uk/topics/sciatica-lumbar-radiculopathy/
4. The British Pain Society https://www.britishpainsociety.org/
5. Faculty of Pain Medicine of the Royal College of Anaesthetists https://fpm.ac.uk/

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