Primary Care

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COMMON PRACTICE

Addressing Low Back Pain in Your Practice - Why?

Low back pain is the fifth most common complaint for patients presenting to the primary care office. It may be as a result of strain, overuse, injury, posture, musculoskeletal deformities or compression/pressure of a nerve root.

In 85 percent of patients who present to the primary care provider, a specific disease cannot be determined, and most patients have positive improvements within the first month of treatment. X-rays and imaging tests such as CT scans or MRIs are not recommended as a first diagnosis tool as they do not improve the outcome. The recommendation by the AAFP Choosing Wisely campaign is no imaging for six weeks in absence of red flags, as these options do not improve outcomes.

Evaluation Considerations

- Conduct a complete and focused medical history and exam, including location, frequency and duration of the pain. (May also inquire about previous back pain if any and the treatment course and response).
- Verify whether there is back pain with leg pain (May do straight leg raises to determine sciatic nerve involvement).
- Identify any risk factors that may indicate serious underlying conditions, such as infections, pancreatitis, aortic aneurysm, peripheral arterial disease, ulcer or nephrolithiasis.
- Be cognizant of red flags: Neurological deficits, fever, gait abnormality, thoracic spine symptoms, spinal tenderness point vertebrally at midline, malignancy which may be explained by sudden unexplained weight loss, new onset of bowel or bladder incontinence and steroidal use or falls or trauma in the elderly, which may lead to osteoporosis and spinal fracture. Red flags require immediate attention and consultation with appropriate specialists.
- Consider psychosocial and emotional distress because of the pain.
- Consider if this is a Worker's Compensation case or other litigation.

Imaging Consideration

Most patients with radicular symptoms will recover within several weeks of onset. The majority of disc herniations will regress or reabsorb within eight weeks of onset. In the absence of progressive neurologic deficits or other

red flags, there is a strong evidence to avoid CT/MRI imaging.
A metric many are using is no plain X-ray or other imaging for 28 days of diagnosis, unless there is point vertebral pain, trauma, or clinical suspicion of compression fracture or tumor. Seventy of 100 patients studied had disc herniation on MRI in the absence of back pain. When you take into account unnecessary radiation, the labeling phenomenon, and that studies show an increased rate of surgery in those imaged, this seems like a reasonable metric.

Treatment Options

Pharmacologic Options

- Acetaminophen-A low cost over-the-counter option
- NSAIDS/COX2 inhibitors-Provide more relief than acetaminophen, however presents a risk for stomach ulcers. Should be avoided in geriatric patients, and note that there is an FDA warning regarding potential heart attacks.
- Opioids/Tramadol-Risk/benefit evaluation should be considered.
- Muscle relaxants-Caution patient of potential sedation and fatigue with this short-term option.
- Corticosteroid pills and injections generally are not recommended as they have not been shown to be efficacious.

Therapy that has been demonstrated to assist and may be used in conjunction with pharmacologic treatment:

- Acupuncture or mechanical diagnostic therapy
- Supervised or scripted exercise therapy, including stretching, yoga and core strengthening
- Behavioral therapy if psychosocial/emotional issues are observed
- Appropriate reevaluation, necessary images and referral to Pain Management or Physical Medicine if no improvement

Diagnostic Coding

As there are numerous codes to use, just be sure that if there is another diagnosis with the back pain (for example, nephrolithiasis, both diagnosis codes are utilized).

Contact Us

Connected Care Partners
808 Varsity Drive
Tupelo, MS 38801
Phone: (662) 377-7811
www.ccpartnerscin.com

Contacts
Lee Greer, M.D., lgreer@nmhs.net

C.K. White, M.D., ckwhite@nmhs.net
Bo Calhoun, M.D. bcalhoun@nmhs.net
Stacie Penkova, Pharm.D., spenkova@nmhs.net

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