

Scope and Target Population:

Adult patients age 18 and over in primary care who have symptoms of low back pain or sciatica. The focus is on acute and chronic management, including indications for medical, non-surgical or surgical referral. For workers' compensation patients, check with state guidelines where the patient resides and where the injury took place, or in Minnesota, see the workers' compensation treatment parameters at <http://www.doli.state.mn.us/pdf/treatparam.pdf>.

Clinical Highlights and Recommendations:

- Cauda Equina Syndrome is a condition requiring emergent evaluation and surgery. A patient should be referred immediately to the ER if any of the following emergent symptoms are present:
 - Sudden onset or otherwise unexplained loss or changes in bowel or bladder control (retention or incontinence)
 - Sudden onset or otherwise unexplained bilateral leg weakness
 - Saddle numbness
- A patient should be offered an appointment within 24 hours if any of the following symptoms are present:
 - Fever 38°C or 100.4°F for greater than 48 hours
 - Unrelenting night pain or pain at rest
 - New onset (less than six weeks) of progressive pain with distal (below the knee) numbness or weakness of leg(s)
 - Leg weakness
 - Progressive neurological deficit
 - Patient requests for same-day appointment
- Lumbar spine x-rays should be considered when the following red flag indicators exist:
 - Unrelenting night pain or pain at rest (increased incidence of clinically significant pathology)
 - History of or suspicion of cancer (rule out metastatic disease)
 - Fever above 38°C (100.4°F) for greater than 48 hours
 - Osteoporosis
 - Other systemic diseases
 - Neuromotor or sensory deficit
 - Chronic oral steroids
 - Immunosuppression
 - Serious accident or injury (fall from heights, blunt trauma, motor vehicle accident) – this does not include twisting or lifting injury unless other risk factors are present (e.g., history of osteoporosis)
 - Clinical suspicion of ankylosing spondylitis
- Red flag and psychosocial indicators should be reviewed and evaluated at each contact/visit. While there is no outcome data related to this, an assessment that includes a subjective pain rating, functional assessment and a clinician's objective assessment should be done at each visit.
- Emphasize patient education and conservative home self-care, which includes limited bed rest, early ambulation, postural advice, resumption of light-duty activities, use of ice and heat, anti-inflammatory and analgesic over-the-counter medications, and early return to work or activities.
- Based on history and physical, classify symptoms by duration and location into appropriate categories:
 - Acute low back pain
 - Chronic low back pain
 - Acute sciatica
 - Chronic sciatica

- The natural history of low back pain is that most patients will experience improvement in four to six weeks and will have a recurrence of low back pain in 12 months.
Patients with acute low back pain should be advised to stay active and continue ordinary daily activity within the limits permitted by the pain. For chronic back pain, there is evidence that exercise therapy is effective.
- Consideration should be given to epidural steroid injections if patient is being considered for surgical interventions. Epidural steroid injections should not be done without fluoroscopic guidance.
- Referrals for advanced imaging studies should be limited to patients with:
 - Progressive neurological deficits
 - Minimal to no improvement of radicular symptoms despite six weeks of conservative treatment
 - Uncontrolled pain
 - Cauda Equina Syndrome

Priority Aims:

1. Increase the use of the recommended conservative approach as first-line treatment – such as activity, self-care and analgesics – for patients with low back pain.
2. Reduce unnecessary imaging studies in patients with acute low back pain.
3. Increase the appropriate assessment of patients with chronic low back pain.
4. Increase the use of appropriate outcome tools (such as Oswestry Outcome Tool or other).