The myth of short term acute low back pain

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For many years now in an attempt to lower costs by reducing the number of persons seeking treatment and care for back injuries, the ACC has embarked on a publicity campaign advising health care providers and the general public that acute back pain is short term, and most patients will recover within a few weeks. It is certainly true that a large number of acute episodes of back pain resolve quickly and spontaneously;[1,2,3,4,5] *'80–90% of attacks of low back pain recover in about six weeks'* regardless of the treatment, or lack of it.[6]

However, epidemiological evidence denies the suggestion that the majority of first time back pain subjects will have a brief self-limiting episode. Studies that have looked at the natural history of new episodes of back pain in primary care settings paint a more pessimistic picture. Carey and colleagues[2] found an average of sixteen days to functional recovery, and only 5% not functionally recovered by six months. However, at this point, 31% of the patients still had low-grade disability and did not consider themselves fully recovered. Cherkin and co-investigators[7] followed patients, mostly with recent onset back pain and found that around 30% were not satisfied by the outcome at seven weeks, a figure that had scarcely changed at one year. Only 31% were completely symptom free and had no functional loss at seven weeks, improving to only 39% of the study group at one year.

Philips and Grant found about 40% of their acute sample were still symptomatic at three months and even at six months.[8] Klenerman and colleagues followed a group of patients with back pain of less than one-week duration and found that 71% had intermittent pain during a one-year follow-up, and that 7% had developed constant pain.[9] Thomas and others interviewed patients who had presented to primary care with new episodes of back pain and found that 48% still reported disabling symptoms at three months, 42% at one year, and 34% were classified as having persistent disabling back pain at these two points.[10]

Some studies have included both recent onset and chronic cases presenting to primary care; one study found that at one month 70% were still symptomatic, 30% at six months and 10% at one year.[11] Recurrences amongst those whose pain had abated were extremely high and affected 75% of this group, although pain and disability were less than before. Those whose pain had been present for longer took longer to recover. In a large group of patients in primary care, studied one year after seeking medical treatment for back pain, a large majority of both recent and non-recent onset reported pain in the previous month (69% and 82% respectively).[12]

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The chance of having a recurrence of back pain after a first episode is greater than 50%. Many recurrences are common and more than a third of the back pain population have a long-term problem.[3,5,13,14,15,16,17,18,19]

'The message from the figures is that, in any one year, recurrences, exacerbations and persistence dominate the experience of low back pain in the community.'[13]

The inference from these figures is clear – an individual's experience of back pain may well encompass their life history. The high rate of recurrences, episodes and persistence of symptoms seriously questions the myth of an acute/chronic dichotomy.[20]

'Back pain should be seen from the perspective of the sufferer's lifetime – and given such a perspective the logic of self-management is over-whelming.'

To add to this substantial body of evidence the most recent study with a five year follow-up,[21] confirms that at that time, half of the respondents reported pain and disability, which was similar to the one year results. Many reported recurrence or continual pain and one-third reported health care consumption during the previous six months. The authors conclude: *'Changes are needed in health policies and treatment strategies in order to tackle the problem of recurrent or continual pain.'*[21]

The Accident Compensation Corporation has repeatedly advised the general public and health providers involved in management that acute back pain is short term. All that is

required if you have acute lower back pain is to remain active, remain at work and maintain a positive outlook for early recovery. This advice denies the opportunity for patients to learn, in the early stages of their problem, self-management protocols now known to assist in early resolution of such problems.[22]

Almost 1200 physiotherapists in New Zealand have been educated in the basics of assessment and management of patients with mechanical back pain. One hundred and twenty four have passed the credentialing examination and just over 20 hold a diploma in mechanical diagnosis and therapy.

The system allows for the identification of patients most likely to respond to repeated end range or prolonged loading. Perhaps of more importance, the system can identify within a few days those most likely to be unresponsive and at risk of developing long-term problems. Early onward referral of at-risk patients has been described as an essential target for the future management of low back and neck pain.

For those GPs interested in the debate on exercise efficacy, a randomised controlled trial demonstrated a significant benefit for those patients exercised with repeated movements that centralised or reduced their symptoms. Conversely most patients exercised in the direction opposite to that causing centralisation were worse or discontinued treatment.[23]

Centralisation of pain occurs in response to certain therapeutic loading strategies. Where symptoms are referred to the limb, pain is progressively reduced and then abolished in a distal to proximal direction as a result of the patient repeating specific end range exercise. If back pain only is present, this moves from a widespread to a more central midline location and then is abolished.

Repeated end range extension is the movement most frequently used to achieve centralisation but lateral flexion or translation may be required in some cases. Even fewer patients require end range flexion movements. A mechanical assessment will determine what is now described as the patient's 'directional preference'.

Centralisation can occur rapidly in the course of a few minutes when symptoms are of recent onset. Where symptoms have been experienced for weeks or month's centralisation may occur steadily and progressively over time.

The majority of patients in New Zealand with first time back pain choose firstly to consult their general practititoner. It is the GP who is the primary gatekeeper in New Zealand and it is for this reason that I draw attention to the misinformation disseminated by the ACC.

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