

# Managing acute low back pain

## An insurer's guide

This guide will assist CTP insurers to manage claims involving people with acute low back pain following a motor vehicle accident.

It is largely based on the National Health and Medical Research Council Guidelines, *Evidence-Based Management of Acute Musculoskeletal Pain*. It is not intended to be mandatory or prescribed practice and application will vary according to individual needs.



**MOTOR ACCIDENTS  
AUTHORITY**





## Acute low back pain

Acute low back pain is the presence of pain for less than three months in the lumbar, sacral or lumbosacral spinal areas. It does not refer to the severity or quality of the pain, and is distinct from chronic low back pain, which is pain persisting beyond three months.

Recommended treatments in this guide do not deal with low back pain associated with serious conditions such as a fracture, tumour or infection, injury to a nerve (neuropathic pain), degenerative conditions or chronic low back pain.

## Assessment

Acute low back pain is usually non-specific and does not always correlate with a particular condition. Conditions associated with acute low back pain include a fracture, sprain, strain and tears of muscle fascia, ligament, joint or disc. It is not necessary to know the specific cause of acute low back pain in order to manage the pain effectively. However, the clinician should conduct an assessment to exclude the presence of serious conditions.

X-rays reveal bone and may provide a crude image of some soft tissues. X-rays should not routinely be performed unless a fracture is suspected. Computed Tomography (CT) is restricted to confirming pathology already indicated by history.

Magnetic Resonance Imaging (MRI) is useful for identifying conditions such as herniated discs, disc bulges, spinal stenosis, disc degeneration and spondylosis. When a serious condition is suspected (eg fracture, tumour or infection) ancillary investigations are appropriate.

## Recommendations for managing acute low back pain

While it is preferable that treatment for acute low back pain is evidence based, the Australian Acute Musculoskeletal Pain Guidelines Group has identified that in some instances there is insufficient or conflicting evidence for particular therapies. Treatment decisions should be based on the knowledge of existing evidence, consideration of individual patient needs and clinical judgement.

The clinician should provide the injured person with information, reassurance and advice to resume normal activity, and discuss other options for pain management as needed.

## Information for the injured person

Several booklets have been produced containing advice consistent with this guide. They are listed below with details of how to get electronic copies.

- ▶ Australian Acute Musculoskeletal Pain Guideline Group, *Information Sheet 1 Acute Low Back Pain: A Partnership approach to pain management*, February 2004. <http://www.nhmrc.gov.au/publications/pdf/cp94a.pdf>
- ▶ Alliance of NSW Divisions and WorkCover NSW, *Back at work: Recovery from back pain information for workers* <http://www.answd.com.au/wc/pdf/recovery.pdf>
- ▶ NSW Therapeutic Assessment Group Inc, *Low back pain: what you can do* [http://www.ciap.health.nsw.gov.au/nswtag/publications/guidelines/back\\_pain\\_patient.pdf](http://www.ciap.health.nsw.gov.au/nswtag/publications/guidelines/back_pain_patient.pdf)

## Notes to table (page three):

- ▶ The NSW Motor Accidents Authority has developed the above advice using *Evidence-Based Management of Acute Musculoskeletal Pain* and the consensus of CTP insurers and Trudy Rebbeck, Musculoskeletal Physiotherapist and member of the Australian Acute Musculoskeletal Pain Guidelines Group.
- ▶ \*Back exercise – exercise is often recommended for people with low back pain, however general exercise programs differ in content, delivery and objectives making it difficult to generalise about their effectiveness as a whole. There is evidence that specific therapeutic programs are effective eg: McKenzie Therapy reduces pain and sick leave compared to other treatments, and multifidus exercises reduce recurrences of low back pain compared to usual care. Therefore it is reasonable to approve specific therapeutic exercises if they are recommended by the clinician.
- ▶ These recommendations are in relation to acute low back pain only and do not apply to chronic back pain.
- ▶ There is evidence continuous low level heat wrap therapy is effective in management of acute low back pain but has only been tested in one study and contradicts advice to stay active.



## Treatments for acute low back pain

Evidence level	Treatment and Precautions
<b>1. Treatments identified as effective</b>	<ul style="list-style-type: none"> <li>▶ Staying active (rather than resting in bed)</li> <li>▶ Activity-focussed printed information provided by a clinician with supporting verbal advice</li> </ul>
<b>2. Treatments with mixed results</b> These treatments may or may not relieve acute low back pain compared to others	<ul style="list-style-type: none"> <li>▶ Muscle relaxants – common adverse effects of muscle relaxants include drowsiness, dizziness and dependency</li> <li>▶ Anti-inflammatory drugs (NSAIDs) – serious adverse effects include gastrointestinal complications (eg: bleeding, perforation)</li> <li>▶ Spinal manipulation/manual therapy such as mobilisation and manual adjustment – adverse effects of some forms of spinal manipulation (ie: high velocity thrust techniques) are rare but potentially serious</li> </ul>
<b>3. Treatments identified as inconclusive</b> These treatments have not been tested against a placebo. They have only been compared to other treatments and not to no-treatment	<ul style="list-style-type: none"> <li>▶ Acupuncture – adverse effects are rare but potentially serious</li> <li>▶ General back exercises (ie: not specific therapeutic exercises, see below*)</li> <li>▶ Back schools</li> <li>▶ Bed rest – there is evidence prolonged bed rest is harmful</li> <li>▶ Cognitive behavioural therapy</li> <li>▶ Injection therapy to epidural, soft tissue or facet joint – adverse effects are rare but serious</li> <li>▶ Topical treatments</li> </ul>
<b>4. Treatments not studied</b> These treatments have not been tested	<ul style="list-style-type: none"> <li>▶ Pain relieving medication (simple, compound and opioid analgesics) – in general, opioids and compound analgesics have a substantially increased risk of side effects compared with simple analgesia such as paracetamol alone</li> <li>▶ Lumbar supports</li> <li>▶ Massage</li> <li>▶ Multi-disciplinary rehabilitation in the work place (note: not generally indicated for people with acute pain)</li> </ul>
<b>5. Passive treatments not studied</b> These treatments have not been tested and contradict advice to stay active. They should not generally be used	<ul style="list-style-type: none"> <li>▶ Electromyographic biofeedback</li> <li>▶ Traction – adverse effects have been reported</li> <li>▶ Transcutaneous Electrical Nerve Stimulation (TENS)</li> </ul>

## What you can do

**If first line treatment, recommended by the provider, does not include advice to stay active and reassurance:**

- ▶ Clarify with the provider
- ▶ Suggest they provide one of the consumer booklets listed above or send one to the claimant yourself
- ▶ Note other treatment or pain management being recommended and monitor progress.

**If the provider recommends treatments listed next to Boxes 2-4:**

- ▶ Clarify goals of treatment
- ▶ Consider approving appropriate treatments
- ▶ Ask for a report/review form that includes outcome measures in pain and function levels
- ▶ Monitor progress closely
- ▶ Consider approving further treatment if the condition is resolving.

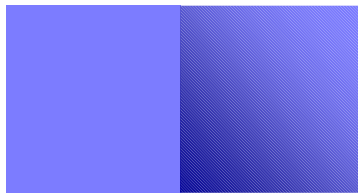
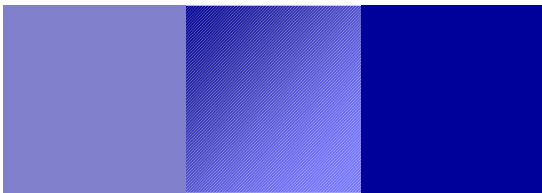
**If the provider recommends treatments listed next to Box 5:**

- ▶ Ask the provider to demonstrate why they are indicated
- ▶ Consult the rehabilitation advisor
- ▶ Consider approving appropriate treatments
- ▶ Ask for a report/review form that includes outcome measures in pain and function levels
- ▶ Monitor progress closely
- ▶ Consider approving further treatment if the condition is resolving.

**If the claimant's condition is not resolving:**

- ▶ Contact the provider to discuss progress
- ▶ Consult the rehabilitation advisor
- ▶ Consider referral to specialist rehabilitation provider.





## References

Australian Acute Musculoskeletal Pain Guideline Group, *Evidence-Based Management of Acute Musculoskeletal Pain*, Australian Academic Press, 2003

The development of *Evidence-Based Management of Acute Musculoskeletal Pain* was a joint initiative of the University of Queensland and the Australian Government Department of Health and Ageing. A multi-disciplinary group undertook the evidence review and approved content. The group included representatives from these organisations:

- ▶ Australian and New Zealand College of Anaesthetists, Faculty of Pain Medicine
- ▶ Australian Physiotherapy Association
- ▶ Australian Osteopathic Association
- ▶ Australian Rheumatology Association
- ▶ Chiropractic and Osteopathic College of Australasia
- ▶ Chiropractors' Association of Australia
- ▶ Consumer Health Forum of Australia
- ▶ Royal Australian College of General Practitioners

Australian Physiotherapy Association, *Low Back Pain Position Statement*, September 1999

NSW Therapeutic Assessment Group, *Prescribing Guidelines for Primary Care Clinicians, Low Back Pain: Rational Use of Opioids in Chronic or Recurrent Non-malignant Pain*, First published 1998. Revised 2002

Alliance of NSW Divisions, WorkCover NSW, *Work-related acute low back pain clinical guidelines information for general practitioners*, Version 1.0, 2002

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