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Painful Dilemmas: An Evidence-based Look at Challenging Clinical Scenarios

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Emergency medicine practitioners experience a wide variety of patient-care experiences, and although some of these cases are quite straightforward, it is common to encounter challenging cases that present therapeutic dilemmas. Our practice is replete with examples of cases requiring difficult medical judgments such as: "Should I give analgesics to a patient who has abdominal pain?"; "What is the best pharmaceutical treatment for a patient who has migraine headaches?"; and "Which drug regimen will maximize relief for a patient who has acute low back pain while minimizing side-effects?". These difficult clinical questions are further complicated by gaps in our collective medical knowledge, pre-existing attitudes regarding pharmaceutical selection, practice habits, and entrenched medical dogma. In this article, the authors present clinical strategies and current evidence that will enable the emergency practitioner to make informed therapeutic choices during these more challenging patient encounters.

Acute low back pain

Acute and chronic musculoskeletal low back pain are frequent complaints of patients presenting to the emergency room. These patients represent a particular challenge, because most come with predefined expectations

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regarding their emergency department visit. Although many of these expectations are appropriate (eg, respectful treatment, pain relief, and reassurance), patients occasionally present emergency practitioners with unrealistic presumptions regarding the course of their care. It is for this reason that knowledge of the natural history of low back pain and an understanding of the available therapeutic options can be invaluable in the care of these patients. In this section, the authors focus on low back pain that is not attributable to recognizable pathology, such as infections, fractures and tumors; or due to acute medical and surgical conditions, such as pancreatitis, pyelonephritis, or abdominal aortic aneurysm. We briefly outline the available treatment options and undertake to provide an evidence basis regarding their use. Finally, we provide a review of our current recommendations based on the available medical literature.

Natural history of acute low back pain

Back pain is extremely common in developed counties, with a lifetime incidence of 60% to 80% [1]. Low back pain represents a high dollar loss to society in terms of work absenteeism [2], medical expenses, and disability payments [3]. Despite the implication of these social trends, it is essential for emergency practitioners to begin their evaluation of patients who have low back pain secure in the knowledge that it is typically a benign and self-limited disease process. Most patients will improve in 6 to 12 weeks, although many patients suffer relapses within 1 year [4,5], and approximately 5% of patients go on to develop chronic pain. This expectation of eventual wellness is crucial to impart to the patient.

Expectation management

It is often beneficial to begin the patient encounter with a brief acknowledgment to the patient that low back pain is a frustrating illness, both for patients and clinicians. Patients are often upset because they can suffer significant pain after a seemingly trivial injury, or in some cases, may not even recognize the inciting event. Their pain can linger for weeks and can severely limit or even prevent activities of daily living and the ability to function at work. Many patients have already tried over-the-counter therapies and home remedies without success, and look to the emergency practitioner for help in managing their disease.

Clinicians are typically frustrated with back pain patients because of our perceived limited armamentarium of therapeutic options; the seeming inability of some patients to improve despite therapy; the desire to avoid being manipulated (either real or imagined) by patients into prescribing "inappropriate" types, dosages, or durations of medications; and the concerns regarding potential abuse of disability and worker's compensation payment.

Some patients are inappropriately demanding, and insist that the emergency department clinician perform tests or radiographs that are not