ORIGINAL ARTICLE

CLINICAL PRACTICE GUIDELINE: CHIROPRACTIC CARE FOR LOW BACK PAIN

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ABSTRACT

Objective: The purpose of this article is to provide an update of a previously published evidence-based practice guideline on chiropractic management of low back pain.

Methods: This project updated and combined 3 previous guidelines. A systematic review of articles published between October 2009 through February 2014 was conducted to update the literature published since the previous Council on Chiropractic Guidelines and Practice Parameters (CCGPP) guideline was developed. Articles with new relevant information were summarized and provided to the Delphi panel as background information along with the previous CCGPP guidelines. Delphi panelists who served on previous consensus projects and represented a broad sampling of jurisdictions and practice experience related to low back pain management were invited to participate. Thirty-seven panelists participated; 33 were doctors of chiropractic (DCs). In addition, public comment was sought by posting the consensus statements on the CCGPP Web site. The RAND-UCLA methodology was used to reach formal consensus.

Results: Consensus was reached after 1 round of revisions, with an additional round conducted to reach consensus on the changes that resulted from the public comment period. Most recommendations made in the original guidelines were unchanged after going through the consensus process.

Conclusions: The evidence supports that doctors of chiropractic are well suited to diagnose, treat, co-manage, and manage the treatment of patients with low back pain disorders. (J Manipulative Physiol Ther 2016;39:1-22)

Key Indexing Terms: *Chiropractic; Low Back Pain; Manipulation, Spinal; Guidelines*

Early development of the chiropractic profession in the 1900s represented the application of accumulated wisdom and traditional practices.[1,2] As was the practice of medicine, philosophy and practice of chiropractic were informed to a large extent by an apprenticeship and clinical experiential model in a time predominantly absent of clinical trials and observational research.

The traditional chiropractic approach, in which a trial of natural and less invasive methods precedes aggressive therapies, has gained credibility. However, the chiropractic profession can gain wider acceptance in the role as the first point of contact health care provider to patients with low back disorders, particularly within integrated health care delivery systems, by embracing the scientific approach integral to evidence-based health care.[3–7] It is in this context that these guidelines were developed and are updated and revised.[8–12]

By today's standards, it is the responsibility of a health profession to use scientific methods to conduct research and critically evaluate the evidence base for clinical methods used.[13,14] This scientific approach helps to ensure that best practices are emphasized.[15] With respect to low back disorders,

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clinical experience suggests that some patients respond to different treatments. The availability of other clinical methods for conditions that are unresponsive to more evidence-informed approaches (primary nonresponders) introduces the opportunity for patients to achieve improved outcomes by alternative and personalized approaches that may be more attuned to individual differences that cannot be informed by typical clinical trials.[16–18] To a large degree, variability in the selection of treatment methods among doctors of chiropractic (DCs) continues to exist, even though the large body of research on low back pain (LBP) has focused on the most commonly used manipulative methods.[17,19,20]

Although the weight of the evidence may favor the evidence referenced in a guideline for particular clinical methods, an individual patient may be best served in subsequent trials of care by treatment that is highly personalized to their own mechanical disorder, experience of pain and disability, as well as preference for a specific treatment approach. This is consistent with the 3 components of evidence-based practice: clinician experience and judgment, patient preferences and values, and the best available scientific evidence.[3,13]

Doctors of chiropractic use methods that assist patients in self-management such as exercise, diet, and lifestyle modification to improve outcomes and their stabilization to avoid dependency on health care system resources.[19,21] They also recognize that a variety of health care providers play a critical role in the treatment and recovery process of patients at various stages, and that DCs should consult, refer patients, and co-manage patients with them when in the patient's best interest.[19]

To facilitate best practices specific to the chiropractic management of patients with common, primarily musculoskeletal disorders, the profession established the Council on Chiropractic Guidelines and Practice Parameters (CCGPP) in 1995.[6] The organization sponsored and/or participated in the development of a number of "best practices" recommendations on various conditions.[21–32] With respect to chiropractic management of LBP, a CCGPP team produced a literature synthesis[8] which formed the basis of the first iteration of this guideline in 2008.[9] In 2010, a new guideline focused on chronic spine-related pain was published,[12] with a companion publication to both the 2008 and 2010 guidelines published in 2012, providing algorithms for chiropractic management of both acute and chronic pain.[10] Guidelines should be updated regularly.[33,34] Therefore, this article provides the clinical practice guideline (CPG) based on an updated systematic literature review and extensive and robust consensus process.[9–12]

Methods

This project was a guideline update based on current evidence and consensus of a multidisciplinary panel of experts in the conservative management of LBP. It has been recommended that, although periodic updates of guidelines are necessary, "partial updating often makes more sense than updating the whole CPG because topics and recommendations differ in terms of the need for updating."[33] Logan University Institutional Review Board determined that the project was exempt. We used Appraisal of Guidelines for Research & Evaluation (AGREE) in developing the guideline methodology.

Table 1. *Eligibility Criteria for the Literature Search*

Inclusion	Exclusion
Published between October 2009-February 2014	Case reports and case series
English language	Commentaries
Human participants	Conference proceedings
Age >17 y	In-patients
Manipulation	Letters
LBP	Narrative and qualitative reviews
Duration chronic (>3 mo)	Non–peer-reviewed publications
Patient outcomes reported	Pilot studies
Nonmanipulation comparison group	Pregnancy-related LBP
RCTs, cohort studies, systematic reviews, and meta-analyses	Secondary analyses and descriptive studies

LBP, low back pain; *RCT*, randomized controlled trial.

Systematic Review

Between March 2014 through July 2014, we conducted a systematic review to update the literature published since the previous CCGPP guideline was developed. The search included articles that were published between October 2009 through February 2014. Our question was, "What is the effectiveness of chiropractic care including spinal manipulation for nonspecific low back pain?" Table 1 summarizes the eligibility criteria for the search.

Search Strategy

The following databases were included in the search: PubMed, Index to Chiropractic Literature, CINAHL, and MANTIS. Details of the strategy for each database are provided in Figure 1. Articles and abstracts were screened independently by 2 reviewers. Data were not further extracted.

Evaluation of Articles

We evaluated articles using the Scottish Intercollegiate Guideline Network checklists (http://www.sign.ac.uk/methodology/checklists.html) for randomized controlled trials (RCTs) and systematic reviews/meta-analyses. For guidelines, the AGREE 2013 instrument[35] was used. At least 2 of the 3 investigators conducting the review (CH, SW, MK) reviewed each article. If both reviewers rated the study as either high quality or acceptable, it was included for consideration; if both reviewers rated it as unacceptable, it was removed. For AGREE, we considered "unacceptable" to be a sum of <4. If there was disagreement between reviewers, a third also reviewed the article, and the majority rating was used.