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Low back and radicular pain: a pathway for care developed by the British Pain Society

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Editor's key points

- Chronic spinal pain is common and can be associated with significant disability.
- Despite a lack of high-quality evidence in some areas practical clinical guidelines are needed.
- Best quality available evidence and expert multi-professional opinion have been used in this guideline.
- This guideline may be adapted for different healthcare systems to provide a structured management approach.

Summary. These consensus guidelines aim to provide an overview of best practice for managing chronic spinal pain reflecting the heterogeneity of low back pain. Most guidelines have covered only one aspect of spinal care and thus have been divisive and potentially worsened the quality of care. Additionally, some of the evidence base is subjective and of poor quality. The British Pain Society low back pain pathway has reached across all disciplines and involved input from patients. It is recognized, however, that there is an urgent need for further good-quality clinical research in this area to underpin future guidelines. Considerable work is still needed to clarify the evidence; however, foundations have been laid with this pathway. Key features include: risk stratification; clarification of intensity of psychological interventions; a logical progression for the management of sciatica; and decision points for considering structural interventions such as spinal injections and surgery.

Keywords: analgesics, opioid; injections, epidural; injections, spinal; low back pain; radiculopathy; sciatica; zygapophyseal joint

This article is complementary to the low back and radicular pain pathway available on Map of Medicine[1] and highlights particular areas of practice and discussion points. It is a part of a series of articles which accompany the five British Pain Society (BPS) pathways, the others of which are: the initial assessment and early management of pain;[2] chronic widespread pain, including fibromyalgia;[3] pelvic pain;[4] and neuropathic pain[5] (see http://bps.mapofmedicine.com/evidence/bps/index.html). Of all the pathways produced, that of low back pain is probably the one that will evoke the strongest debate: this article seeks to provide a greater understanding of the issues which give evidence to these discussions and the pathway itself.

The number of people suffering with chronic pain in England varies between 14% of the youngest men and 59% of the oldest women (mean 31% men, 37% women).[6] As with many conditions, those in the poorest households are more likely to suffer in both frequency and severity of the complaint. Spinal pain accounts for ~20% of the UK's spending on healthcare; this staggering figure arises when the direct and indirect costs are taken into account.[7] The spending exceeds most other major medical conditions.

Previous guidelines

In the UK, the National Institute for Health and Clinical Excellence (NICE) has produced guidance limited to the early management (<12 months) of persistent non-specific low back pain without radicular involvement[8] and, before this, there have been widely used guidelines such as those for low back pain by the Royal College of General Practitioners.[9] NICE Clinical Guideline 90 (management of long-term conditions and depression) covers pain[10] and NICE Public Health Guideline 19 (management of long-term sickness and incapacity for work) includes low back pain.[11] This guidance is fragmented and uncoordinated with respect to pain with a high potential for mixed and confusing messages for patients and clinicians. To date, available guidelines focus on many subsets of people, rather than what should be done for the group as a whole who are likely to need skills to manage a life long condition. There has been little use of a lifecycle approach to spinal pain.

Good-quality guidelines that address the needs of the majority and achieve a consensus are very much needed.

NICE adopts a comprehensive and transparent methodology, starting with an open selection process for its guideline development groups. Potential members apply for each defined standard and committees are structured to capture relevant stakeholders. The scope of work is defined by a process open to public comment. After this, NICE researchers, working to criteria set by the development group, select and assess the relevant evidence to produce the final guideline. NICE guidelines are specifically designed for use in NHS England and may therefore have some limitations when applied in different healthcare systems. NICE has considerable resources at its disposal (e.g. statisticians, health economists, project managers, policy experts, and access to the expert clinicians). Scholarly reviews published in journals are often written by a small number of experts in the field and may lack clinical and patient perspectives. In the UK, Royal Colleges, or other professional groups, often provide clarity in areas where there is considerable variation to improve the standards of care that their members and fellows provide. Usually, the skills mix is addressed but the details of how their standards should be measured are limited.

NICE produced a low back pain guideline in 2009 that was felt by some not to be consistent with best practice;[12] the issues have been debated elsewhere.[13] This led to subsequent confusion in commissioning healthcare for patients with back pain. This management methodology was to treat all spinal pain patients as a homogenous group rather than a broader, value-based approach which defines sub-populations who may benefit, and which may well lead to lower healthcare costs overall.[14] Other available NICE guidance covering low back pain from different scopes (CG90,[10] PH19)[11] is also not fully aligned.

Development of the BPS guidelines

In order to deliver effective care in this complex area, many healthcare professionals need to be involved, something that can be difficult to achieve in some healthcare systems. The problem is compounded by the fact that the teamwork issues exist not only between different professions but also within them. The clinicians involved in managing patients with spinal pain include: doctors (e.g. general practitioners, rheumatologists, pain specialists, orthopaedic surgeons, neurosurgeons, and general physicians); physiotherapists (specialists, generalists, independent practitioners working within a medical team, running groups within the specialty, or with psychologists); nurses (e.g. nurse specialists working within a care pathway, with a spinal surgeon, or within a multidisciplinary pain team); psychologists (working independently, within a multi-professional team, and leading a multi-professional pain management programme); and occupational therapists.

Tribalism in healthcare is well established[15] and is no more evident than in the management of spinal pain. There needs to be organizational and cultural change to bring about the level of cooperation necessary to affect good-quality spinal care. The BPS is a specialist society that aims to improve the management of pain with an emphasis on a multi-professional approach. It also has a strong patient and public involvement. It is, thus, well positioned to develop the necessary level of consensus to inform a clinical guideline.

The BPS spinal pain pathway guideline committee was a 19 member multidisciplinary group consisting of pain specialists, physiotherapists, psychologists, general practitioners with a special interest in pain medicine, a nurse pain specialist, patient representatives, a spinal surgeon, a neurosurgeon, and a rheumatologist (see Supplementary material, Appendix A). The pathway represents a consensus opinion based on the best available evidence and, where no evidence is available, common sense. It has been scrutinized by the UK Department of Health Spinal Taskforce and many aspects of the guideline were discussed more widely among professionals.

The pathway has been developed in collaboration with the Map of Medicine editorial team. The pathway is based on well reputed secondary evidence, as selected in accordance with the Map of Medicine's editorial methodology for developing care pathways. Practice based knowledge has been added by clinicians nominated by the BPS and by independent reviewers identified by the Map of Medicine editorial team. (For a detailed account of this methodology, see Supplementary material, Appendix B or www.mapofmedicine.com.) Map of Medicine care pathways can be customized to reflect particular healthcare structures and provide comprehensive, evidence-based local guidance, and clinical decision support at the point of care.

The pathway is pragmatic and follows the patient's journey as seen by clinicians. Other pain pathways connect wherever relevant. The assessment and management of radicular pain was included as this condition often goes unnoticed for some time and contributes to significant distress and disability.

Aims and objectives

The spinal pain pathway describes the variety of different presentations of low back pain providing a list of its possible causes. Given the high incidence of low back pain, the aim was to focus on primary care management where the greatest volume of work presents. However, there is also guidance on specialist assessment and management. The inclusion of radicular pain allows for early treatment, potentially avoiding surgery. The guidance is in line with a recent systematic review recommending a stepped care approach.[16] The initial management is shown in Figure 1 and specialist management in Figure 2.

Discussion points

Nine discussion points have been selected as they represent areas of potential controversy.

Self care

Most patients report that they have only very limited amounts of information on how to self-manage their back pain. The pathway devotes considerable effort in describing where to get self help beyond a simple leaflet. A variety of options are recommended including: links to online audio resources; telephone helplines; paper-based information; on-line