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CME/CE Information

CME/CE Released: 09/02/2010; Valid for credit through 09/02/2011

Target Audience

This activity is designed for physicians, psychologists, nurses, pharmacists, and other healthcare professionals and research scientists interested in the evaluation and management of chronic low back pain, including those specializing in pain management, anesthesiology, rheumatology, psychiatry, neurology, and internal medicine.

Goal

This activity will bring together clinical and research experts to review and discuss the evaluation, treatment, and prognosis of patients presenting with low back pain. The activity will consist of 3 lectures and a question and answer session to provide an in-depth and comprehensive discussion of the epidemiology, disparate etiologies, and clinical assessment of both acute and chronic low back pain. Evidence-based treatment strategies, including pharmacologic and nonpharmacologic therapies, and the evolving research into early interventions for patients at high risk for transitioning from acute low back pain to chronic low back pain will also be presented.

Learning Objectives

Upon completion of this activity, participants will be able to:

1. Discuss the differential diagnosis for low back pain and the importance of clinical red and yellow flags in evaluation of low back pain.
2. Integrate evidence-based pharmacologic and nonpharmacologic therapies into a comprehensive treatment plan for chronic low back pain.
3. Evaluate early interventions for acute back pain in patients considered at high risk for transition to chronic low back pain.

Credits Available

Physicians - maximum of 1.50 *AMA PRA Category 1 Credit(s)™*

Nurses - 1.50 *ANCC Contact Hour(s)* (1.5 contact hours are in the area of pharmacology)

Pharmacists - 1.50 *ACPE Contact Hour(s)* (0.150 CEUs)

Psychologists* - 1.5 *CE credit*

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All other healthcare professionals completing continuing education credit for this activity will be issued a certificate of participation.

Physicians should only claim credit commensurate with the extent of their participation in the activity.

Accreditation Statements

For Physicians

UCIrvine SCHOOL OF MEDICINE

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of University of California, Irvine School of Medicine and The Physicians Academy for Clinical and Management Excellence. University of California, Irvine School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

The University of California, Irvine School of Medicine, designates this educational activity for a maximum of 1.5 ***AMA PRA Category 1 Credits*** ™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Contact this provider

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Authors and Disclosures

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Disclosure: Consultant/Advisor: Eli Lilly and Company; Speakers' Bureau: Eli Lilly and Company Stock Shareholder: Johnson & Johnson; Employee: Aventine Company

Dr. Cole's presentation will not include discussion of off-label, experimental, and/or investigational uses of drugs or devices.

Evidence-Based Evaluation of Patients With Low Back Pain CME/CE

B. Eliot Cole, MD, MPA, Chair

Posted: 09/02/2010

Slide 1.

I'm going to go ahead and get started on the evidence-based evaluation of patients with lower back pain (LBP).

Slide 2.

And we've got our usual disclosures to show you. There they are for me: whom I speak for, whom I'm a consultant to, whom I've been employed by, and what stock I might actually own in my retirement account. I don't plan to talk about any medications, as far as I know. Nothing could be off-label or experimental because I'm basically going through the American College of Physicians (ACP)/APS guidelines for you.

Slide 3.

Learning objectives for this hour will be to help you better acquaint yourself with the differential diagnosis of LBP and the importance of both red and yellow flags in the evaluation of LBP. I don't think I'm the only person who's on a crusade, basically, to get us to think more specifically about the diagnosis of LBP. When I'm often faced with someone where I get the diagnosis, I wonder beyond knowing where they hurt. I don't really think I have much of an idea why they hurt, and we want to talk more about that.

Low Back Pain Guidelines

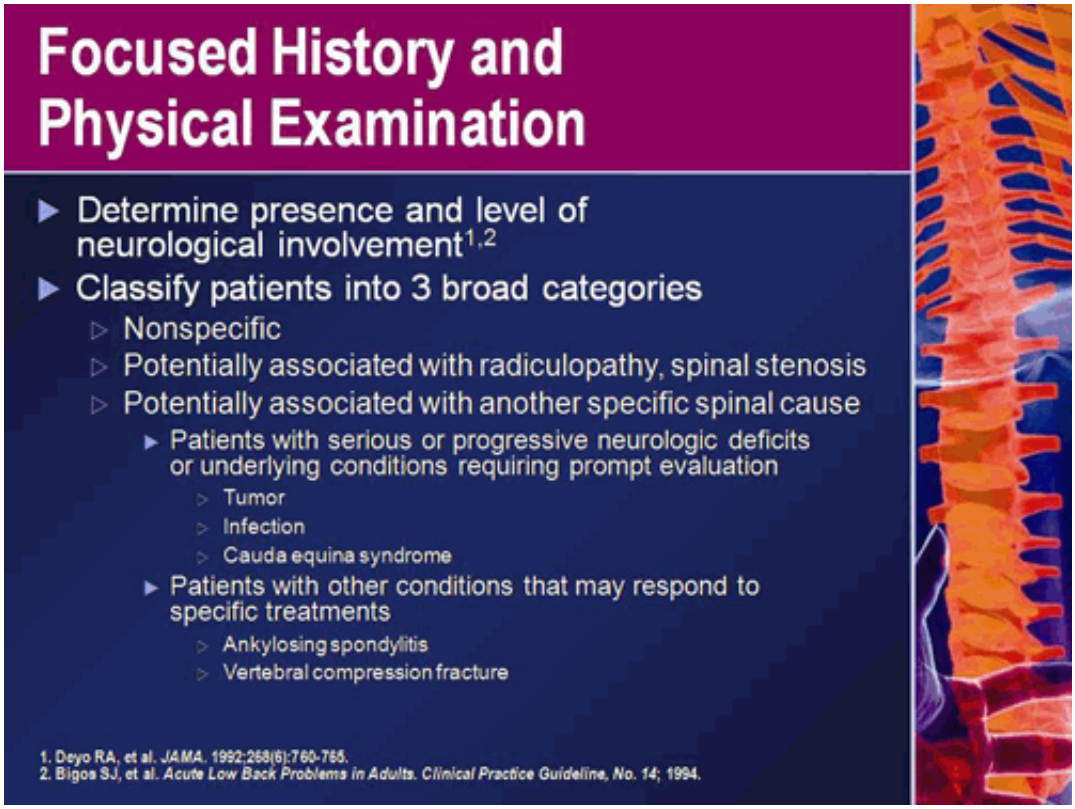
Slide 4.

The LBP guidelines from the ACP and the APS came out in 2007. Dr Chou was obviously a critical player in the development of those guidelines, and so I'm going to be paraphrasing most of the work that he's actually developed.

Guideline #1

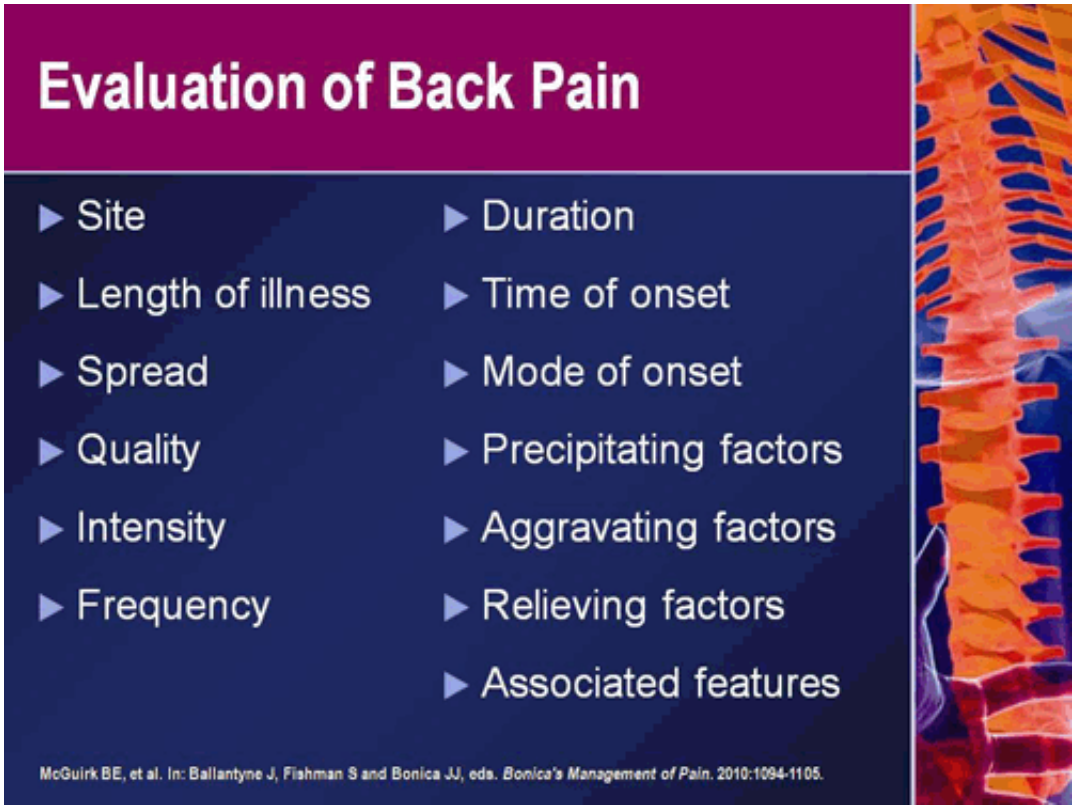
Slide 5.

The first principle of the guidelines was that clinicians should really conduct a focused history and physical examination to help place patients with LBP into 1 of 3 categories, so at least we are getting this some diagnostic specificity. It's either nonspecific LBP, probably something more muscular in origin. It could be LBP potentially associated with a radiculopathy or maybe spinal stenosis. Worse, it could be back pain that is coming from some other very specific but very serious spinal cause. And, it's important though to think biopsychosocially; it's not just doing a history and performing a physical, but thinking in the context of the whole patient that we've always been told since our early days in training biopsychosocial.



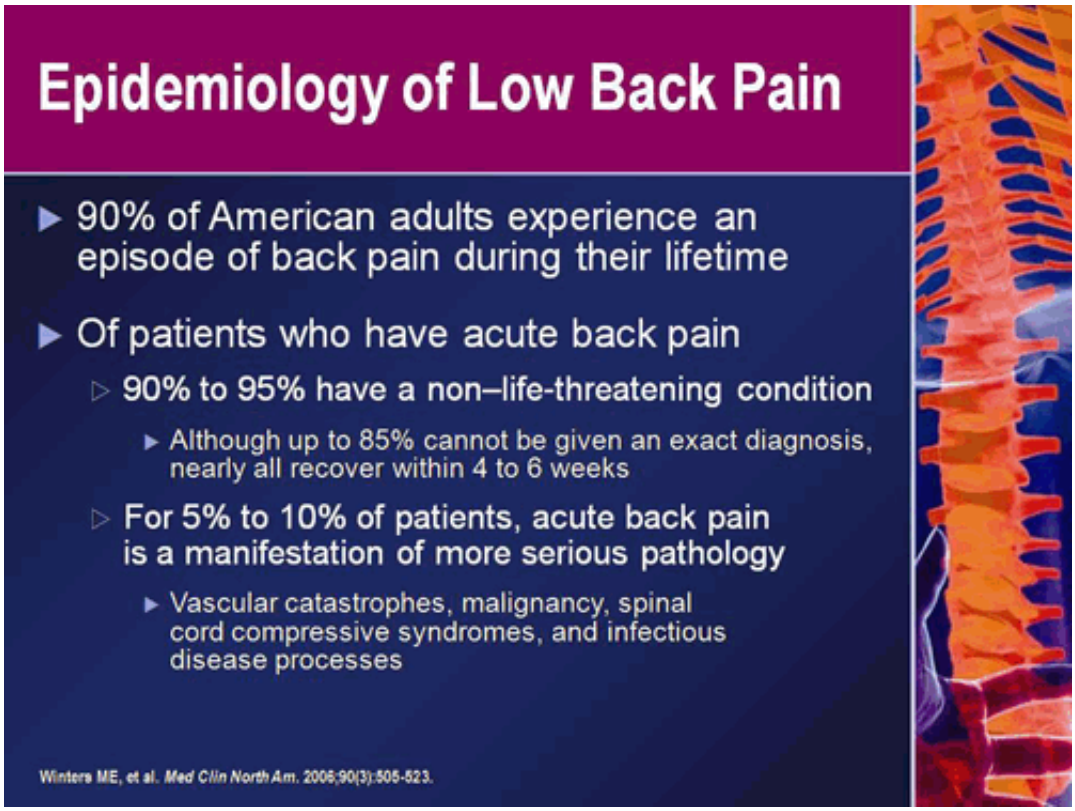
Slide 6.

In that focused evaluation, with our goal to be able to pigeonhole the patients into 1 of the 3 bigger buckets, we really want to look at probably the evidence for neurologic involvement. If there's a litmus test, to what extent can we determine the presence and level of something neurologic that is going to give us quite a specific marker? When we think about this third bucket—things that are associated with other causes for spinal-related pain—we've got to be able to differentiate people with very progressive, serious neurologic conditions like tumors, infections, or cauda equina syndrome, or people that would have actually a specific treatable pathology like ankylosing spondylitis or vertebral compression fractures.



Slide 7.

I won't begin to try and describe how you should do the physical examination for someone with LBP, but certainly the kinds of things we've been all talking about through all of the years who do pain management, is getting more than just the physical location—LBP—but understanding how long has it been going on, where does it spread to, what is the quality of the pain, what makes it worse, what makes it better, how did it begin, where did it go after there, what have been the treatments provided to date, and were those treatments actually effective at any point in time?



Slide 8.

In terms of epidemiology, if you want to depict the number 1 health problem in the United States, I guess you could probably throw LBP into that bucket, since 90% of us at some point have had LBP during our lives or will have it before we complete our lives. So, virtually everybody winds up with LBP. I guess you'd say that's the bad news. The good news is, for about 90% to 95% of us, it won't be a serious, life-damaging event. For maybe 5% to 10%, that LBP is really part of something far more serious, some kind of a vascular catastrophe, a malignancy spinal cord compressive syndrome, or an infectious disease process, so it's like a good news/bad news story to some extent.

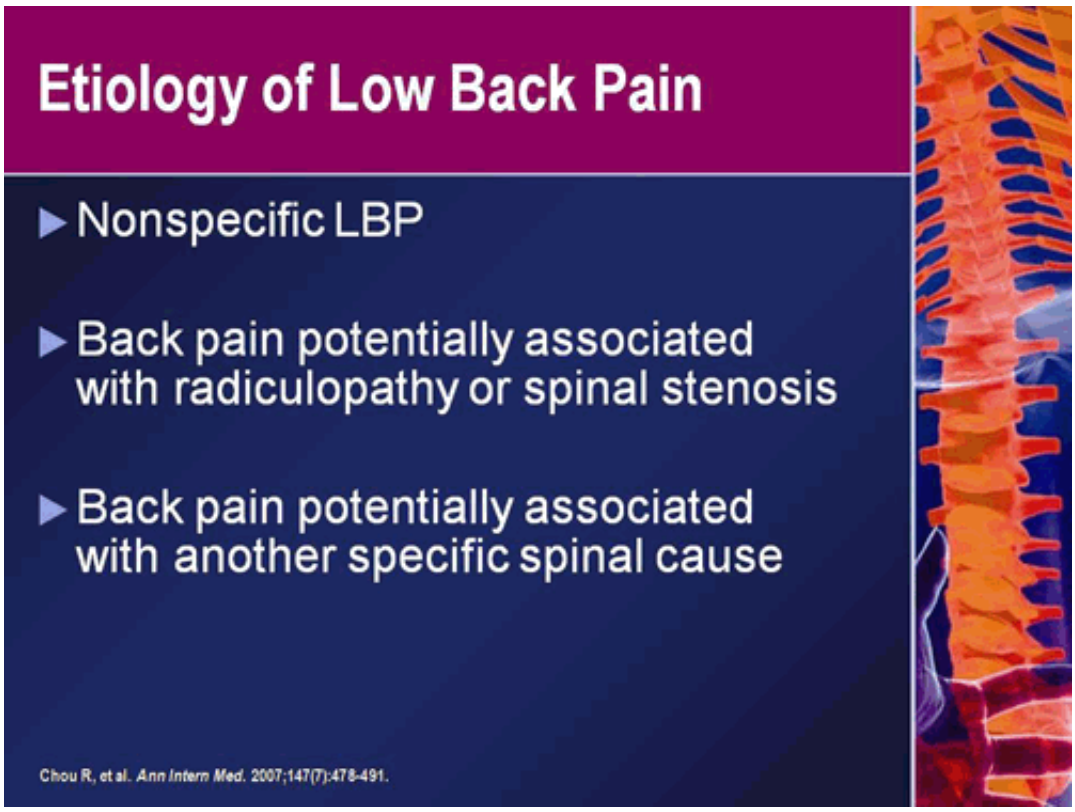
Slide 9.

In terms of those of you who are primary care practitioners, you are seeing all comers showing up in your emergency room in your private office just because you're working in an ambulatory treatment center. If you look at the probability of seeing cancer, compression, spinal cord infections, these are low probability events. It's even unlikely you'll be seeing cauda equina syndrome for that matter, but 3%, 4%, or 5% might be somebody with spinal stenosis or a symptomatic herniated disc, so these are the kinds of things that walk into our office.

Slide 10.

The economy and the economics of LBP are fascinating. I know someone working on a PhD right now trying to understand the cost of LBP, and apparently the problem is that there are really no good data sources. Back in 1991, $25 billion a year was thrown around. By 1998, it might have been $90 billion. Dr Chou was saying this morning when we were getting ready, it might be well over $100 billion by now. You know, it's sort of that old joke,

it is millions of people costing billions of dollars, to paraphrase Carl Sagan. But, people go to see primary care physicians and primary care providers in general because of LBP. It's in the top 10 list of why people go seeking medical care, and if 90% of us have LBP during our lifetimes, how interesting that 80% of adults will eventually seek medical care in some way to do something about this. So, virtually everybody who hurts will be going out and seeking some kind of medical attention.

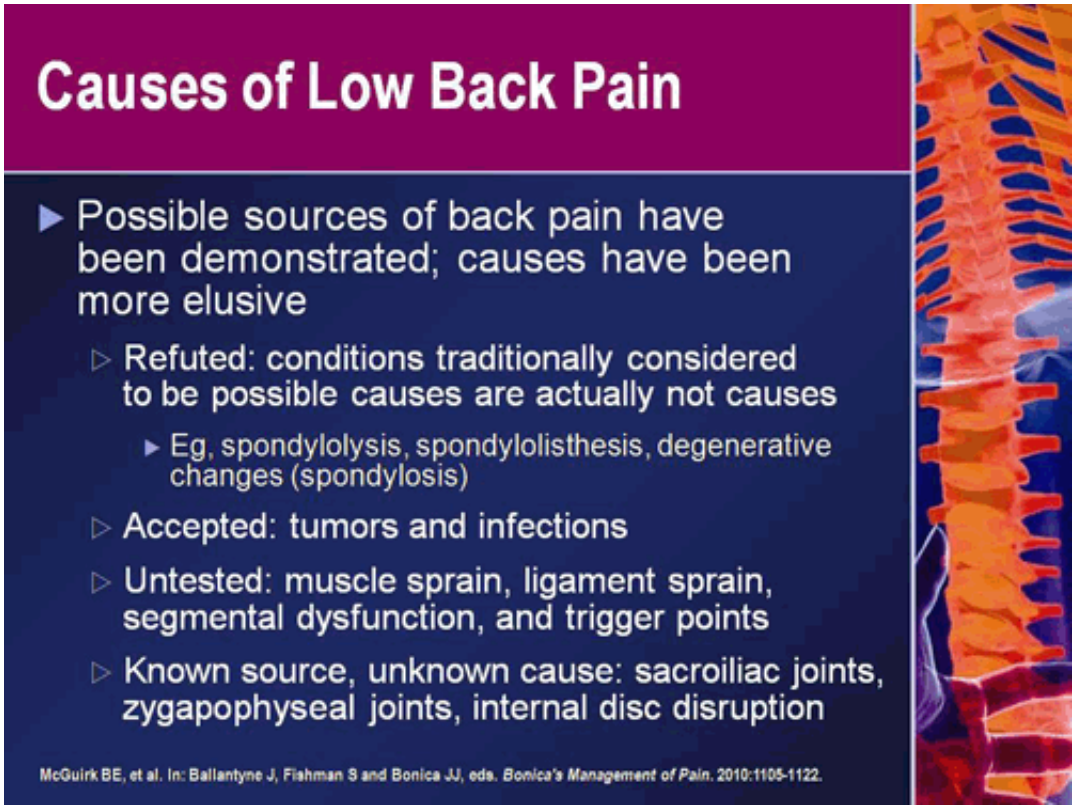


Slide 11.

Well, as I said before, the etiology boils down into these 3 larger buckets: nonspecific, specific to radiculopathy or spinal stenosis, or maybe it's associated with some other specific spinal cause.

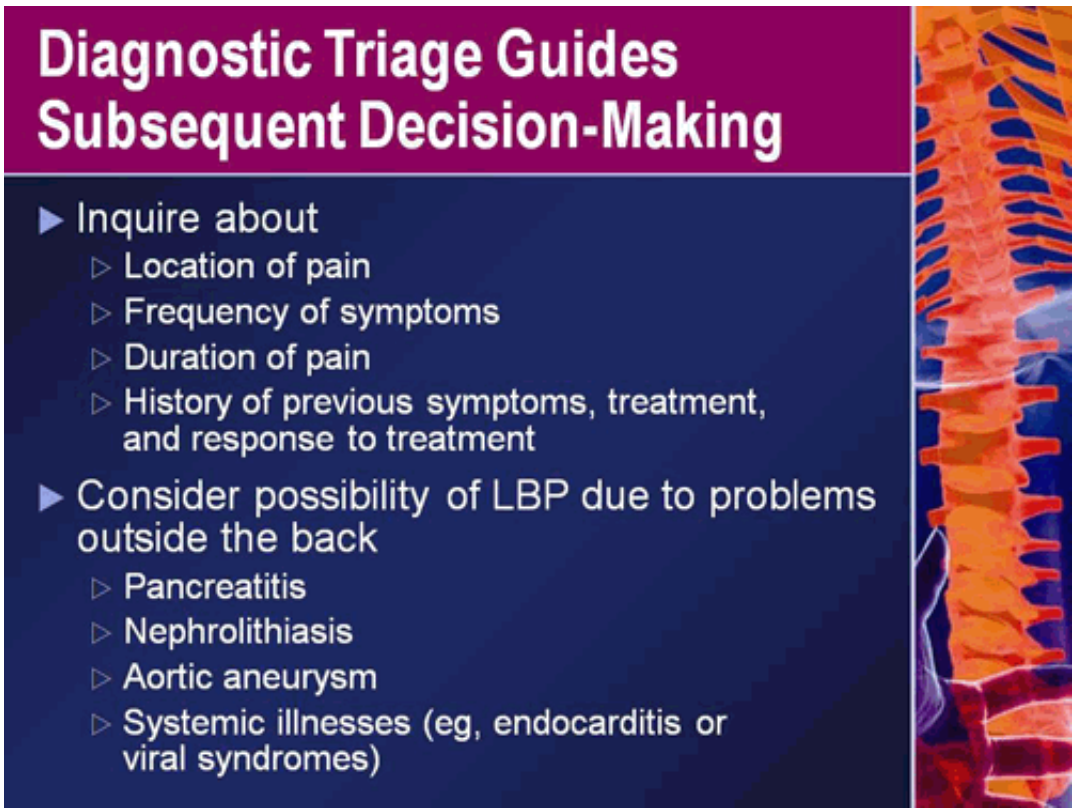
Slide 12.

We probably understand better the structural sources of LBP than we actually do the causes. We know that muscles can give rise to pain. We know ligaments give rise to pain. Joints of various types give rise to pain. The discs, apparently, have a pain-generating potential, and there could be mechanical or chemical irritations that lead to pain.



Slide 13.

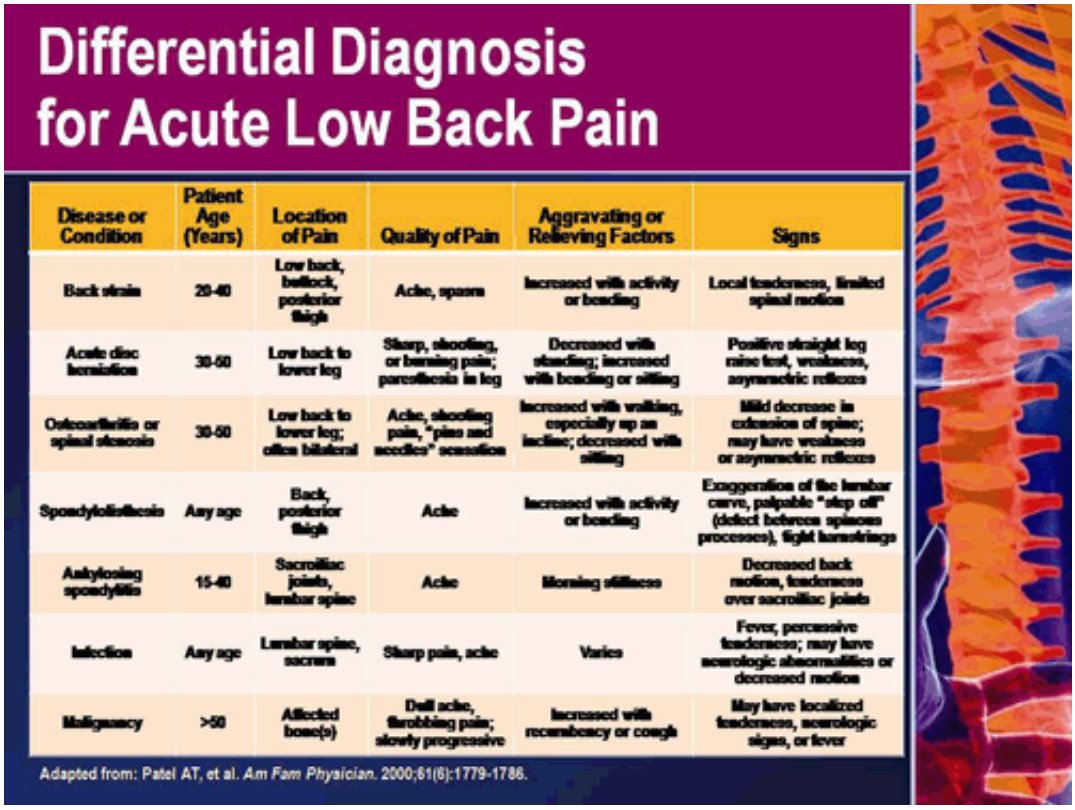
But, when we get into the more specifics of trying to understand how the structures cause the pain, it gets more enigmatic, and certainly there's been some dispute about the traditional sort of bony problems being the cause of LBP. It's probably much easier to make the compelling argument that tumors and infections around the spinal cord are causing problems, but then there's a lot of untested things like muscle sprain, ligamentous sprain, segmental dysfunction, and some might argue even trigger points, so lots of things still to sort out.



Slide 14.

We continue to look for the final answer, as if the final answer is out there, but you know maybe it is. Considering the possibility of LBP from something other than the back is very important. Think about a patient with

pancreatitis, or a patient with pancreatic cancer. It looks like LBP, but it's not. In reality, it's something much more serious. Passing a kidney stone, having a dissecting aortic aneurysm—it would be real important to sort that one out, so we need to move from the back to the front of the patient sometimes. And, there could be a variety of systemic illnesses that we need to be on guard about.



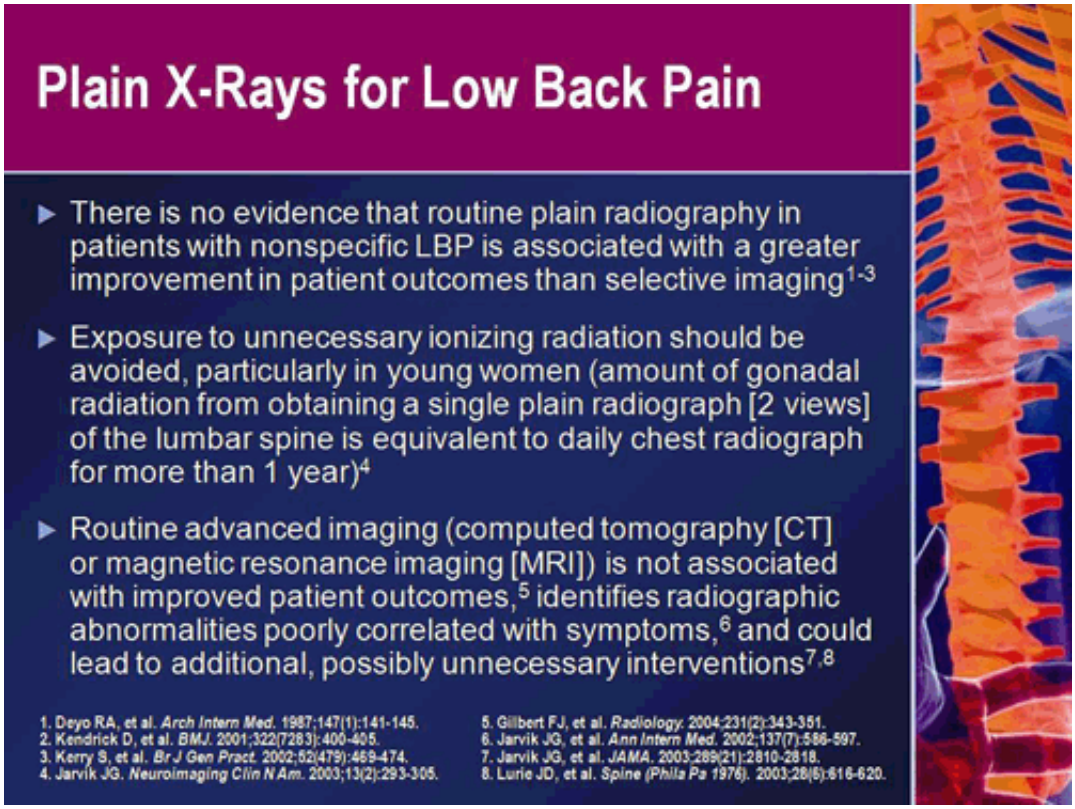
Slide 15.

The differential diagnosis gets a little bit puzzling. My takeaway from this is, even when you know what the differential diagnosis list is, it's often very difficult to puzzle between the various diagnoses. We can say some things stratify more toward youth, others toward an older population. We can try and look at location of pain, or quality of pain, or even what aggravates it. But, they start to overlap so much, that obviously we do not really know after getting a history and doing the best physical we can, exactly what might be the cause of an acute LBP problem.

Guideline #2

Slide 16.

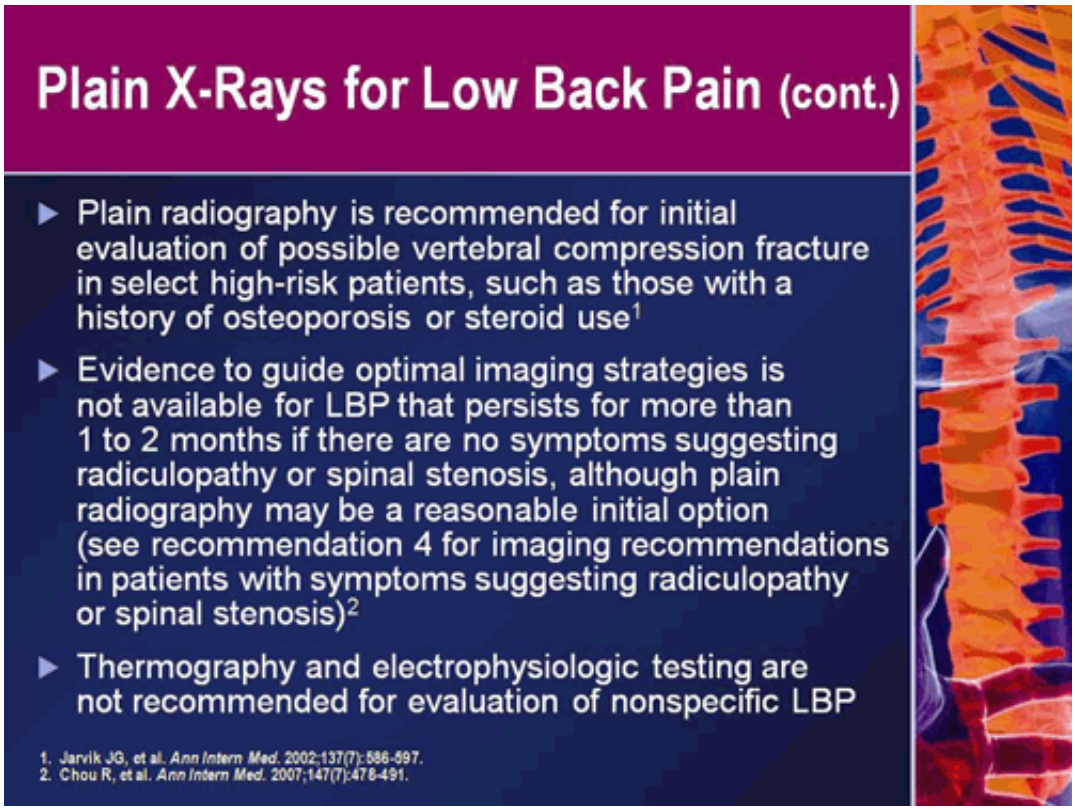
This usually says we're heading potentially toward something like imaging where we're hoping that a test will help us out. The problem is, according to guideline number 2, clinicians should not routinely obtain imaging or other diagnostic studies for people with LBP, and the reason for that, especially when it's nonspecific LBP, you have no neurologic findings; they just say their back hurts.



Slide 17.

The reason for that is there may not be any spectacular evidence that can make the case that plain films really change outcome or really make any difference in improvement for a patient, other than we got a nice set of plain films. And, the worst part is that a set of plain films of the lower back can virtually expose people to ionizing

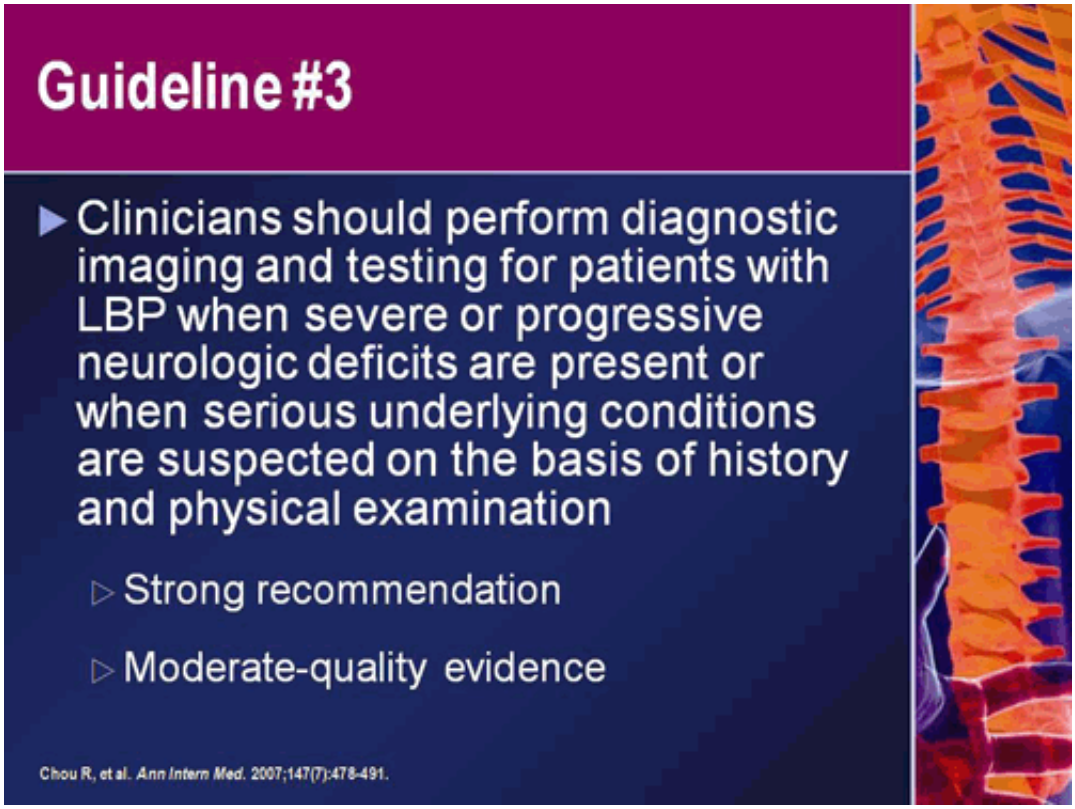
radiation levels on par with having a daily chest X-ray for a year, so that's not an insignificant amount of radiation that we probably ought to think about. Whether or not you need to jump to more sophisticated imaging techniques we'll get to in just a second.



Slide 18.

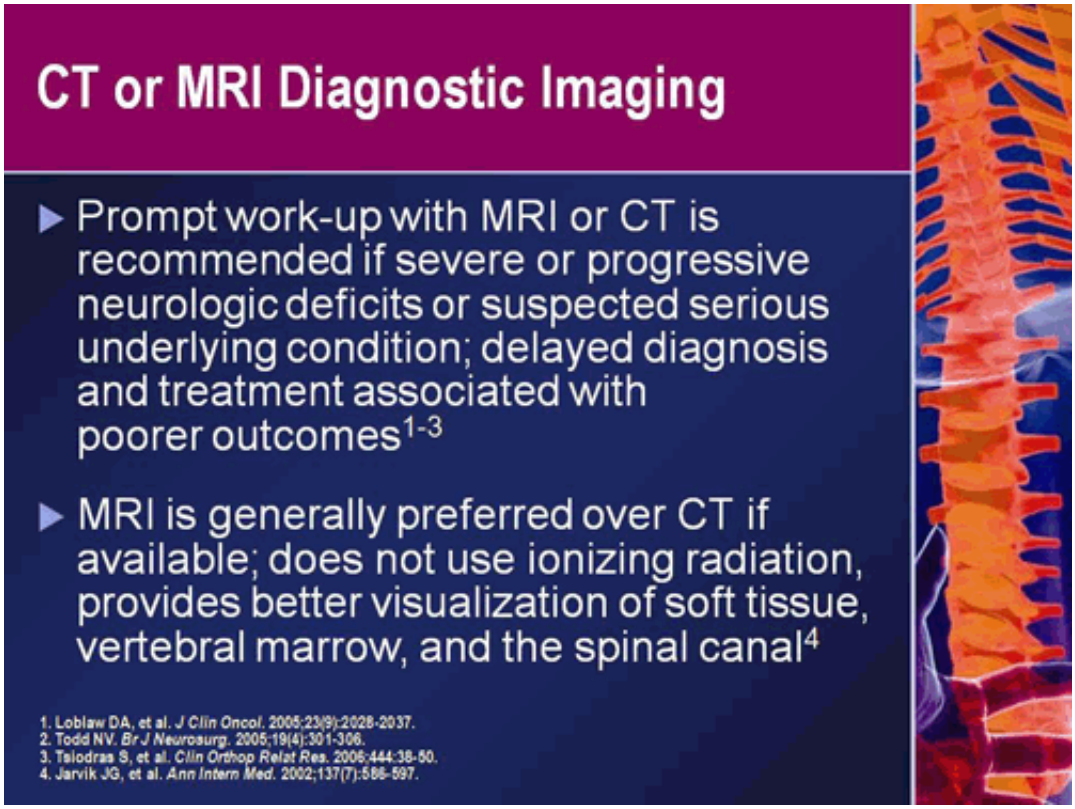
Now, in terms of plain radiography being recommended as a screening, it would make sense if you thought about vertebral compression fracture in a high-risk patient. So, for somebody who is older, somebody with known osteoporosis, somebody who is on steroids, you are thinking, well, compression fracture could be part of the real differential, and you want to be able to see that. Well, maybe plain films would make good sense. Whether they need to go immediately for thermography and electromyography (EMG)/nerve conduction velocity (NCV), it's probably not of any utility if it's a nonspecific LBP problem.

Guideline #3



Slide 19.

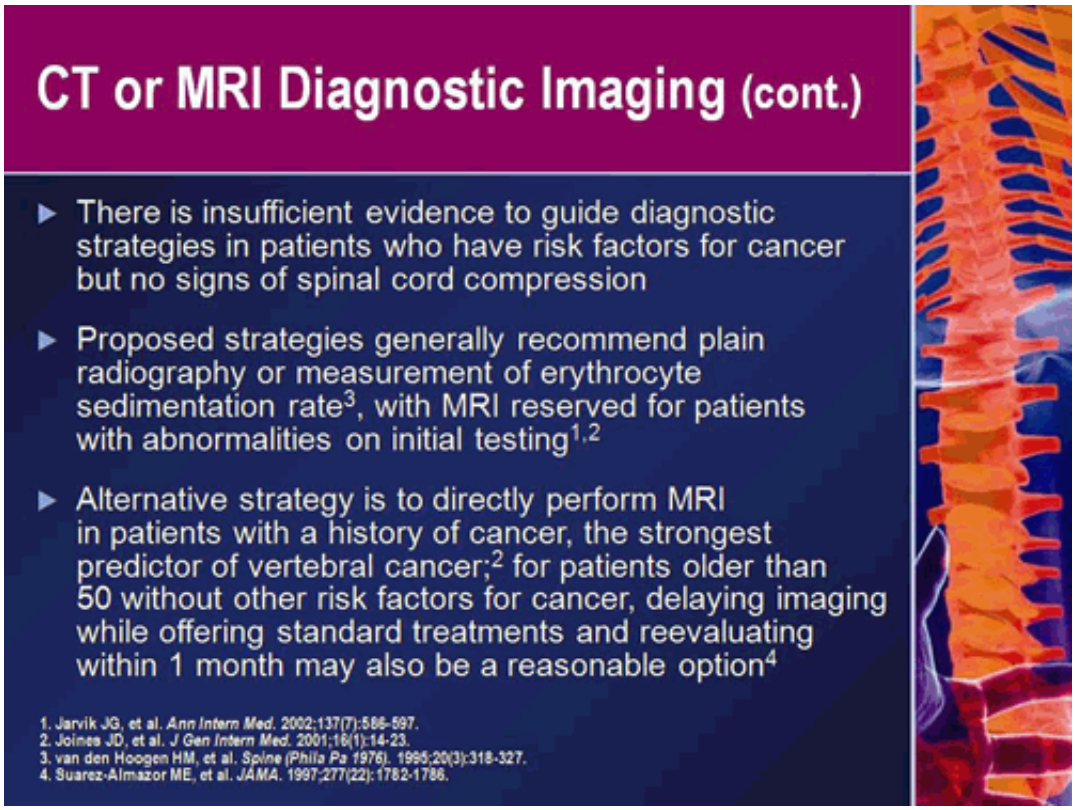
Then finally, clinicians should perform diagnostic imaging and testing for their patients with LBP, more precisely when there is severe or progressive neurologic deficit, or when there's some serious underlying medical condition that is going to lead you to some need for a corrective action. So, hopefully your imaging isn't just like surveying the field, but it's actually taking you to better medical decision-making.



Slide 20.

We would say that prompt workup with magnetic resonance imaging (MRI) or computed tomography (CT) is recommended if there are severe or progressive neurologic deficits or suspected serious underlying medical conditions where the delay of recognition in making the appropriate diagnosis will delay the treatment that is

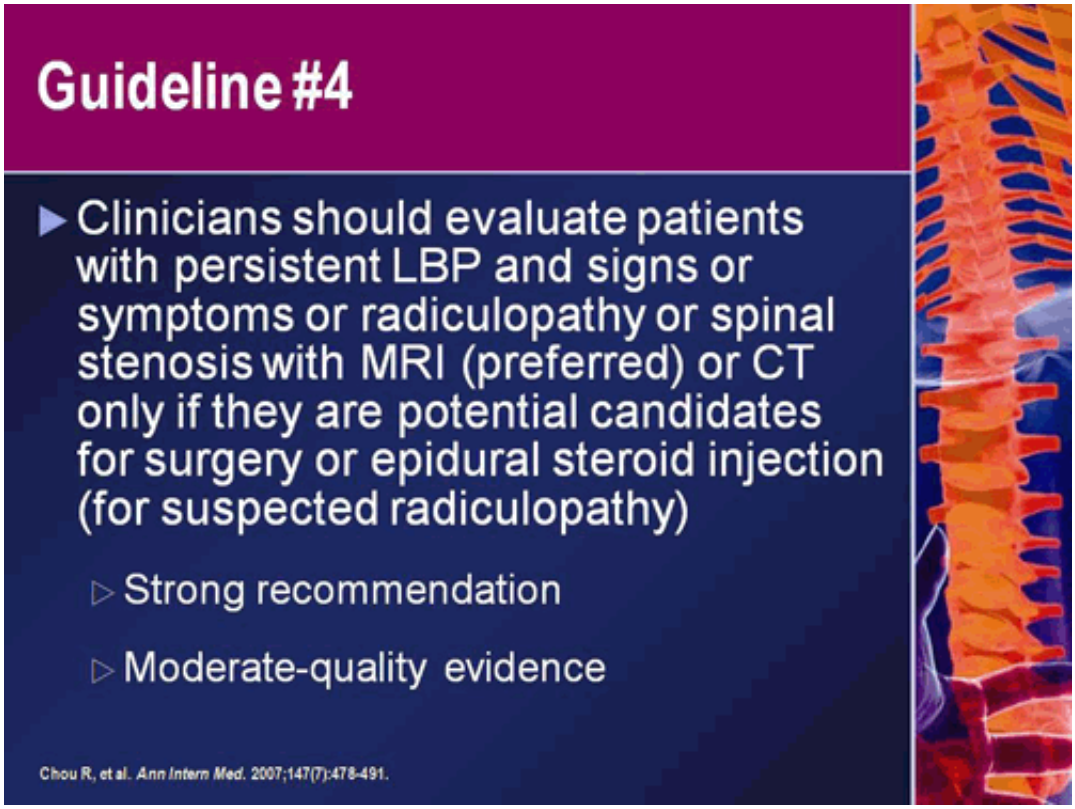
necessary for the condition, and therefore result in a poorer outcome. An MRI is probably preferred over CT, not just because it avoids the ionizing radiation, but it really lets us see the neural structures we want to know the most about. CT really is more for bony architecture, I would argue.



Slide 21.

And, there's insufficient evidence to guide diagnostic strategies in patients who have risk factors for cancer but no signs of spinal cord compression. So, just a history of cancer of and by itself does not necessarily warrant CT and MRI on a routine basis unless there is some reason to think that there is pathology in that area and that the proposed strategies generally are seeming to recommend plain radiography or measurement of something like erythrocyte sedimentation rate, with MRI being reserved for patients who have some kind of an abnormality on an initial screening. Alternatively, some people might just go directly to an MRI because they just want to see the nervous system structures right away. It's a bit equivocal.

Guideline #4



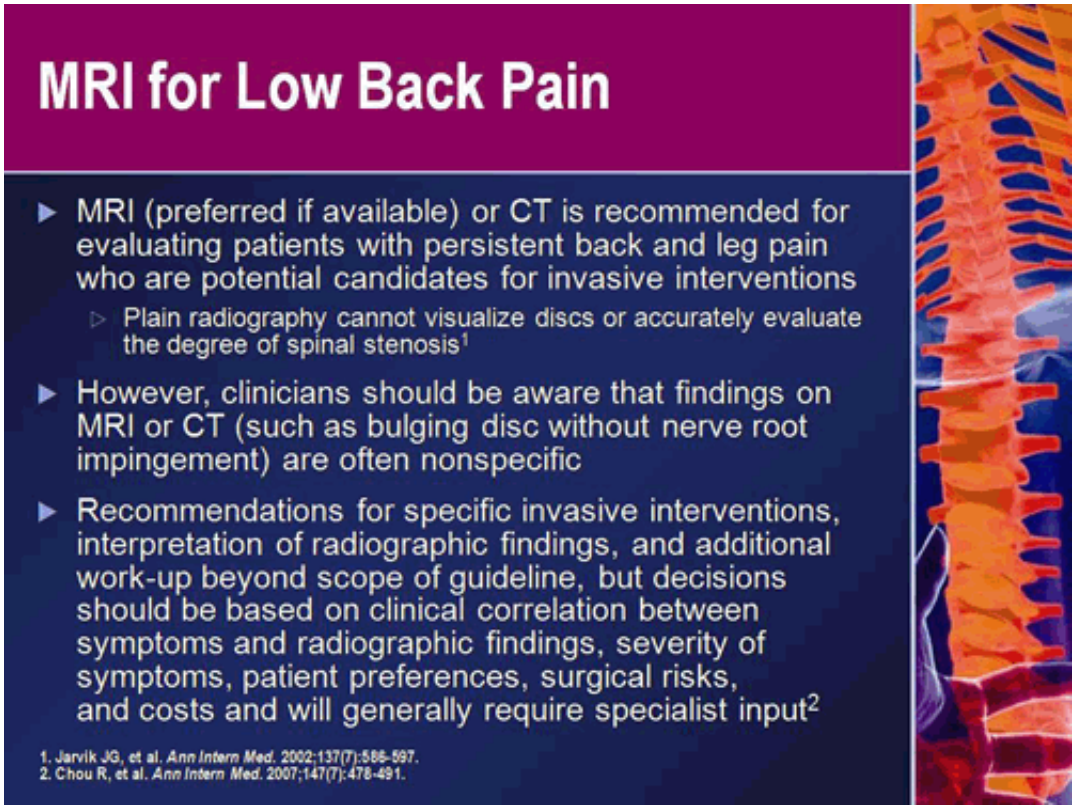
Slide 22.

Guideline 4: clinicians should evaluate patients with persistent LBP and signs or symptoms of radiculopathy or spinal stenosis with MRI or CT only if they are potential candidates for procedures like epidural injections or surgery. So, if we're not ever going to do anything, what's the point of the imaging modality? Does the imaging modality change anything we're doing? Theoretically, there's a linkage between what we're thinking, what we're ordering, and then what we're going to do—the plan of action. So, there ought to be some connection there.

Slide 23.

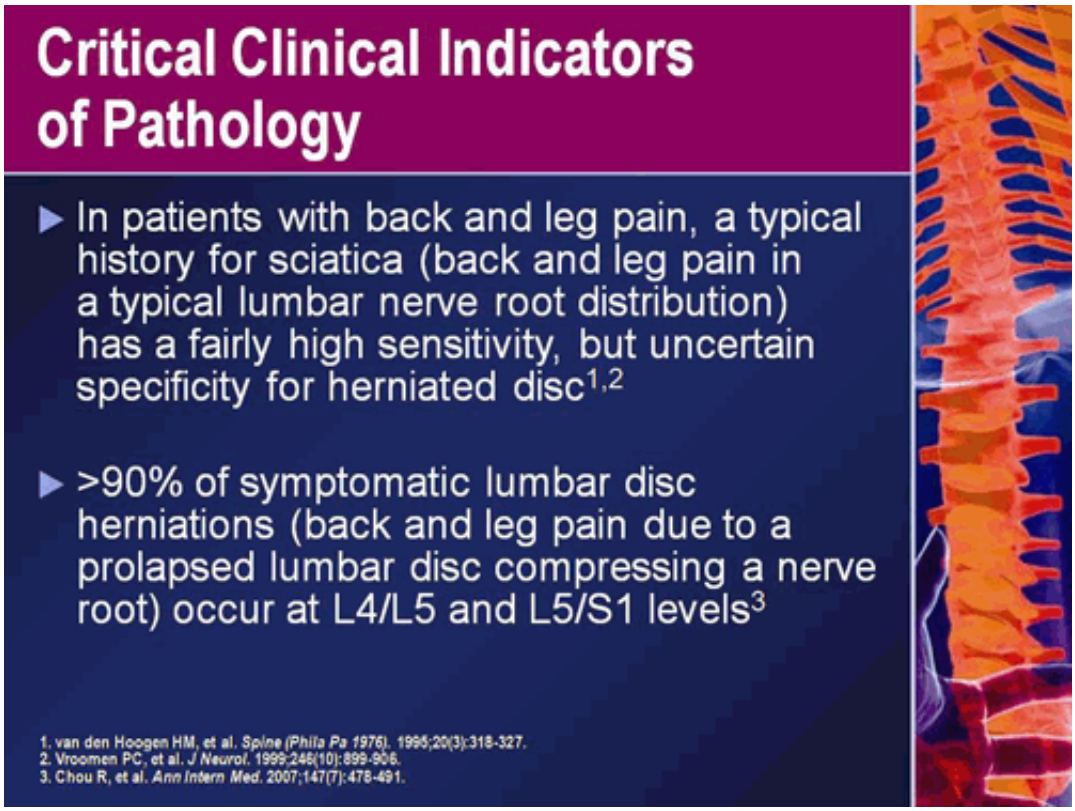
In terms of imaging for LBP, you know what are the take away messages? Well, the good news is, if you wait 4 weeks, most people even with herniated discs are doing better, so after a couple million years of evolution, we

actually can fix ourselves on the fly when that's necessary. Not everybody needs, you know, the "feel of steel" to be recovered. There's no compelling evidence that routine imaging necessarily affects treatment decisions or absolutely improves the outcomes. And, surgery is probably an option more when there's persistence of symptoms, and especially when it's associated with things like spinal stenosis.



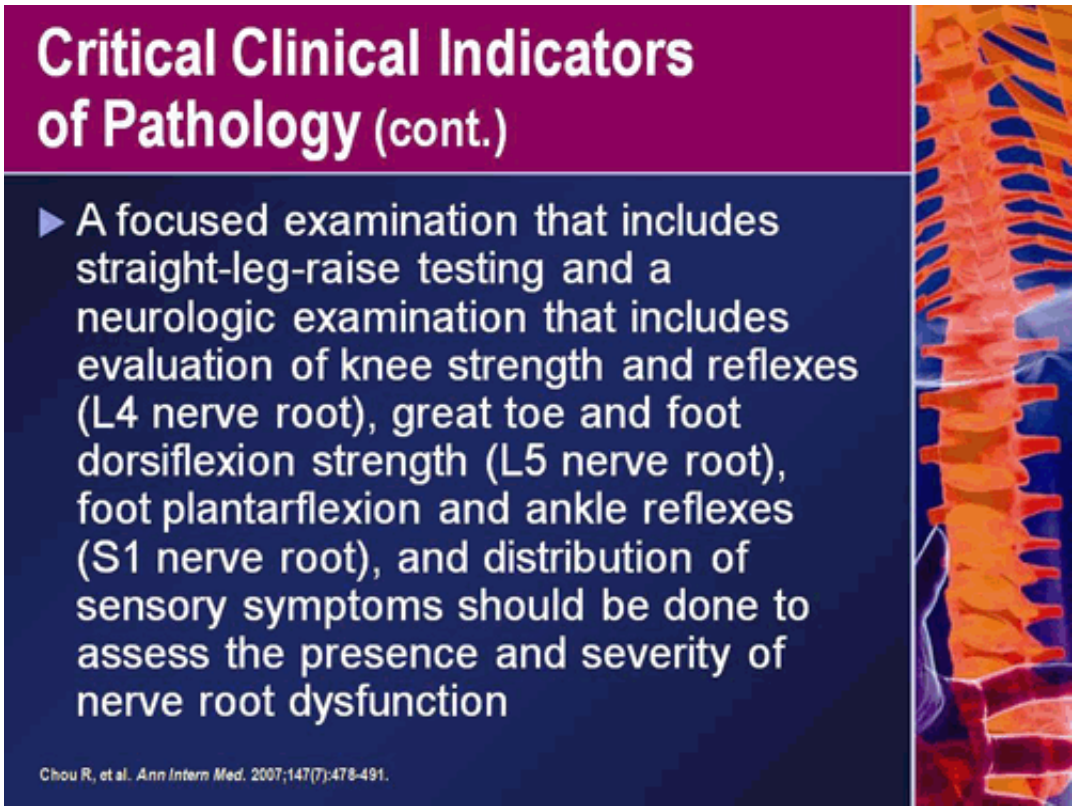
Slide 24.

MRI for LBP: just a couple of last points before we move on to something else. MRI is preferred over CT and recommended for evaluating patients with persistent back pain and leg pain who, again, are potential candidates for an interventional procedure. Plain X-rays just won't be able to show what we need to see accurately: the discs, and the neural structures as well, as one of the more sophisticated measures.



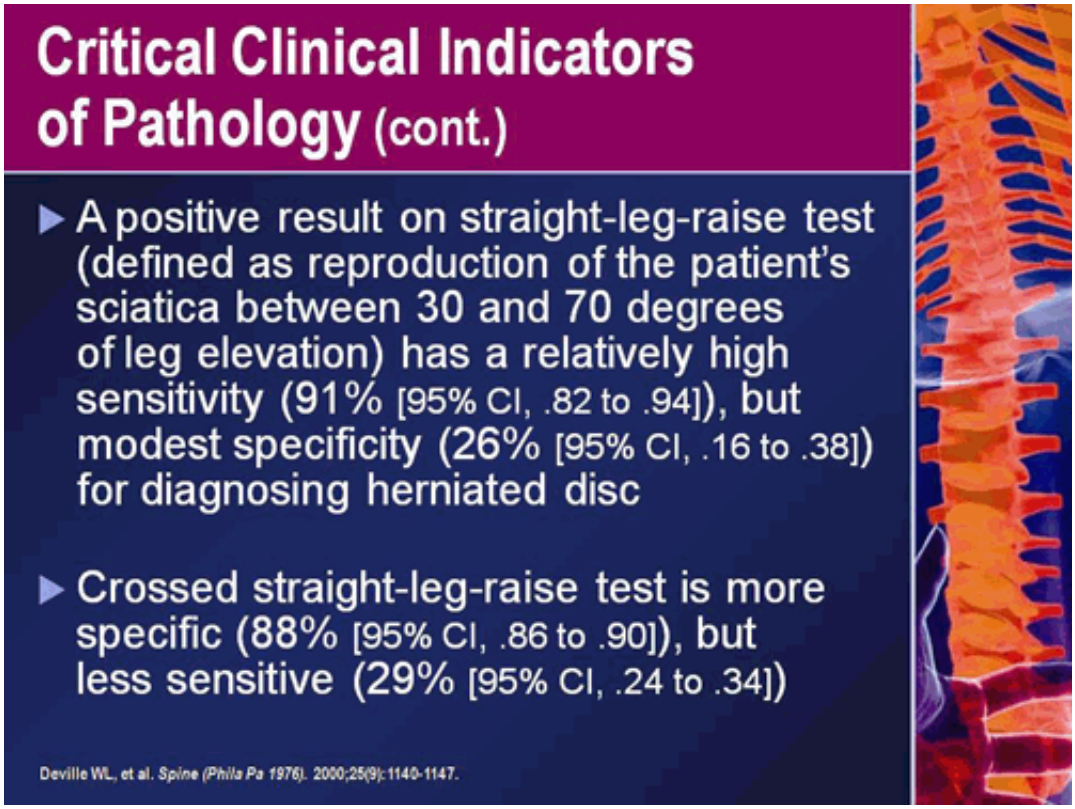
Slide 25.

There are critical clinical indicators of pathology we need to keep our eyes open and really be looking for. In patients with back and leg pain, a typical history of sciatica has a fairly high sensitivity, but it's not necessarily that specific for herniated disc. And, how interesting that 90% of symptomatic lumbar disc herniations will be occurring at really just 2 contiguous levels—L4/5 and L5/S1—so it's like we only have to really zone in, think about 2 inches of the lower back, and that may be a 90% probability of where all the problems are going to be.



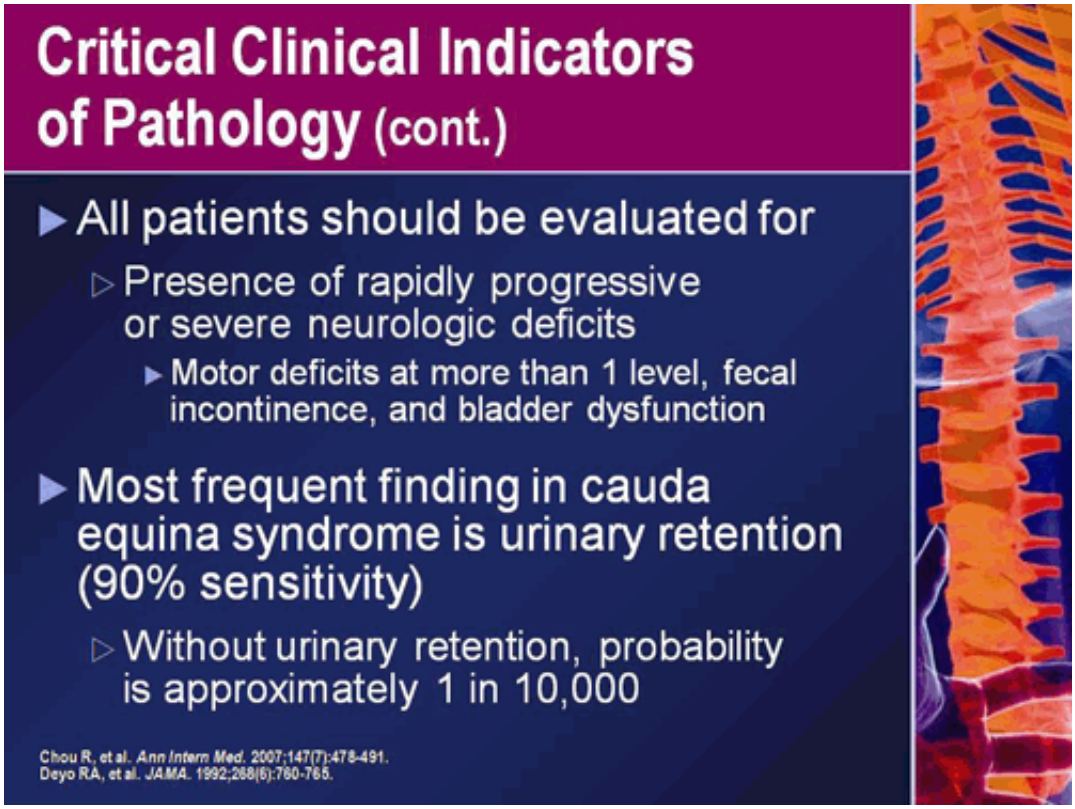
Slide 26.

This means when we do that focused evaluation, we really need to look critically for people with LBP to the 90% probability level—what's the function of L4, the function of L5, and the function of S1 nerve roots? So, be sure to look at the specific assessment methods needed for those, and then think about the sensory examination that's appropriate for L4, L5, or S1.



Slide 27.

A positive result on a straight-leg-raise test of and by itself may be of some importance, but it's not the absolute marker. And, it's interesting that we can say that a straight leg raise occurring with pain at 30 to 70 degrees has a fairly high sensitivity, but again, not absolutely specific in all cases. The cross straight-leg-raise test is probably more specific, but it may unfortunately be a little less sensitive—so again, no absolutes.



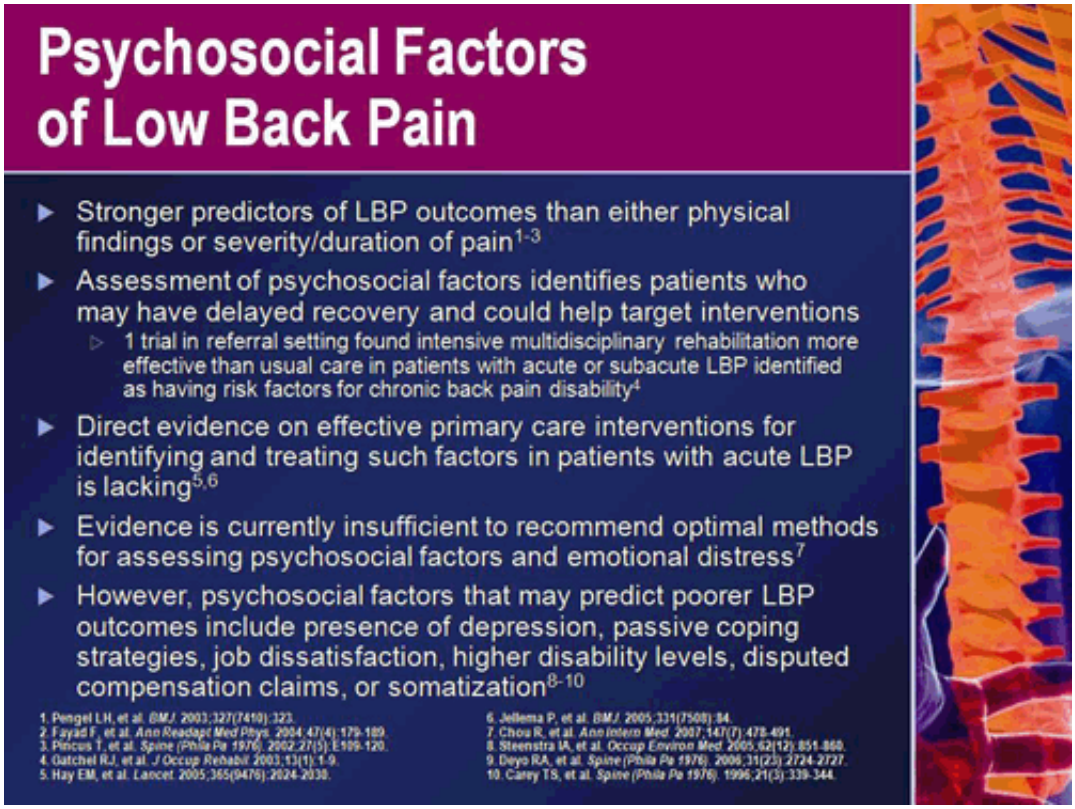
Slide 28.

All patients should be evaluated for the presence of rapidly changing neurologic status—especially severe neurologic deficits—especially if you start seeing loss of function, 1 side vs the other. We see fecal incontinence, we see bladder dysfunction. It is said that probably the most critical thing is bladder dysfunction because without

urinary retention, the probability of cauda equina syndrome drops to < 1 in 10,000. So, if we see retention of urine, fecal incontinence, we're talking about something that is severely compromising the spinal cord.

Slide 29.

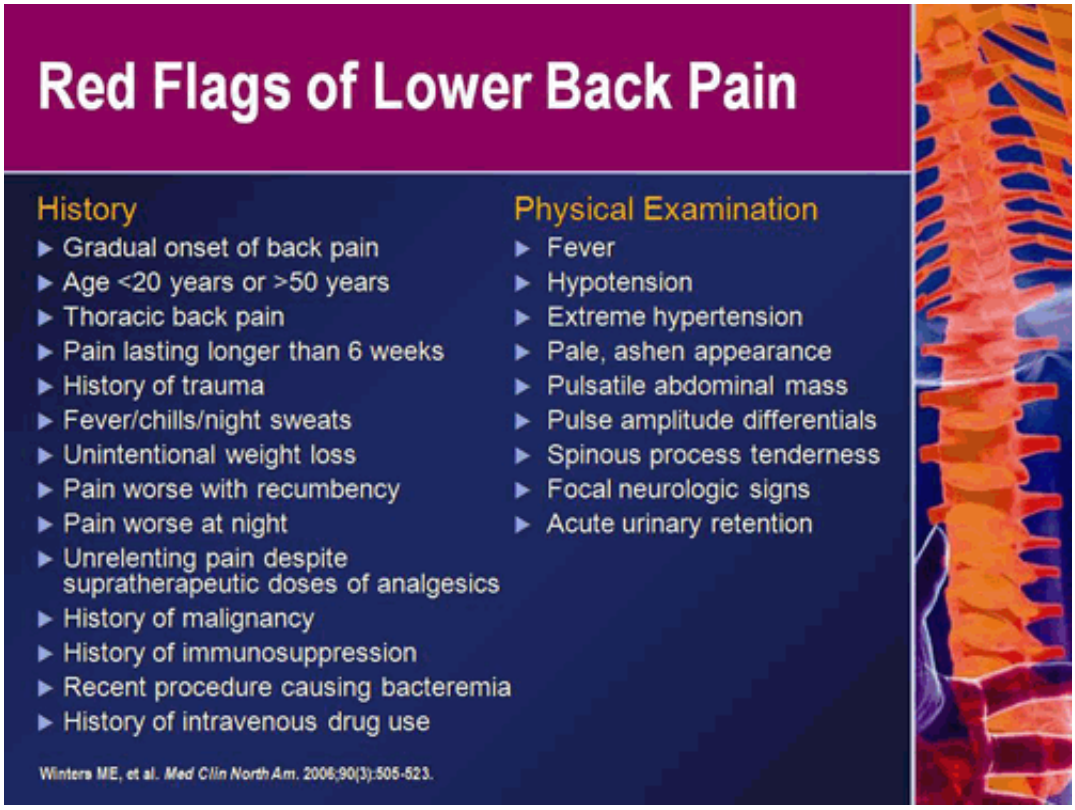
Yellow flags are important. There are red flags, yellow flags, blue flags, black flags, and I guess the white flag of surrender when we have to just give up sometimes. We need to identify the psychosocial problems—the yellow flags—and understand that slow progress to recovery. They're just not getting where we need to see them getting as quickly as we expected them to do. That may be indication of a psychosocial issue. And, it's interesting when we give the advice that we often give, like take it easy, go to bed, do not push things too much, give up painful activities. You know, that may start them on this downward trajectory. We'd be better off saying, "Hey look, everything's neurologically fine, get back to whatever you're doing in 2 days," not to give people advice to throw in the towel, the white flag of surrender, because they probably will never get back to work if they're not told to go back to work. They may not even get back to walking around in their house if somebody doesn't specifically say to do that.



Slide 30.

There are some psychosocial factors that will be important for lower back pain, and certainly it is thought that the psychosocial factors may be so significant and maybe more significant, in fact, than some of the physical findings for the severity and duration of pain. Currently, we don't have spectacular recommendations to offer in terms of optimal measures for psychosocial assessment or emotional distress assessment, but we can't be remiss about it because we know that psychosocial factors may predict a poorer outcome in LBP when you're looking for things like depression. Well, that's 50% of people, I think, in chronic pain according to Dave Fishbain.

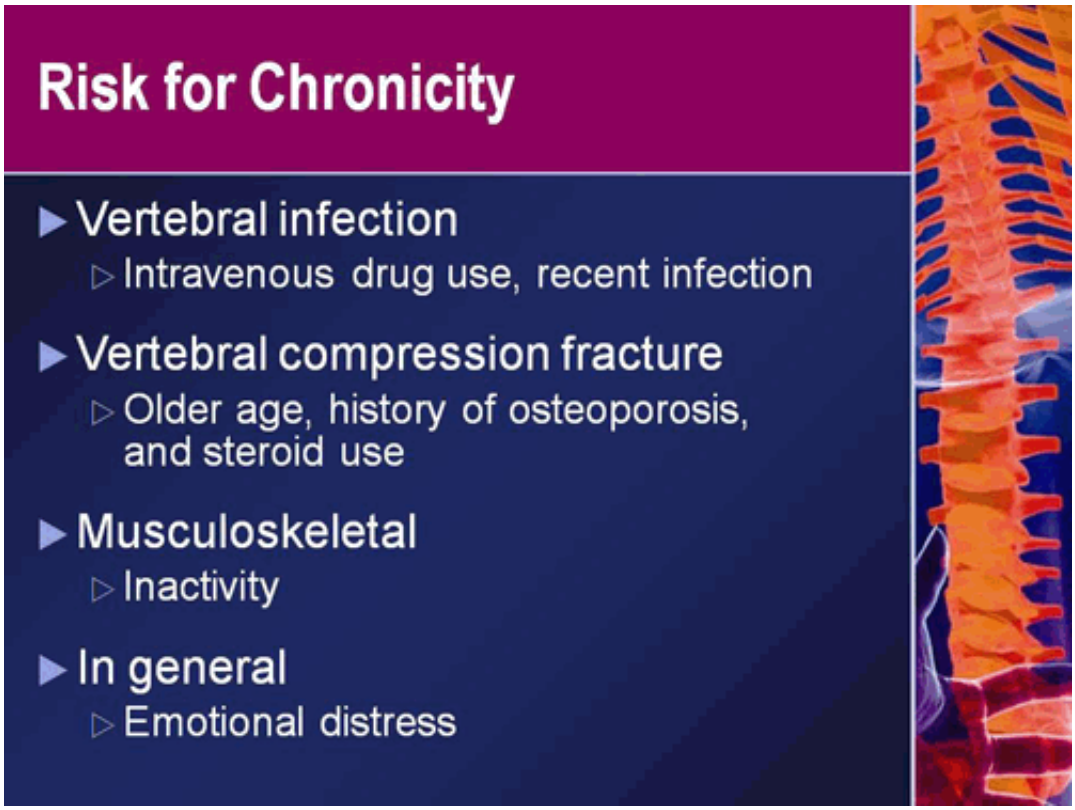
What about passive coping strategies opposed to active coping strategies—searching for the elusive disability label, disputed compensation claims, having somatization as an underlying problem—if we're not attentive to those issues, I think we're going to be thwarted in our best clinical efforts.



Slide 31.

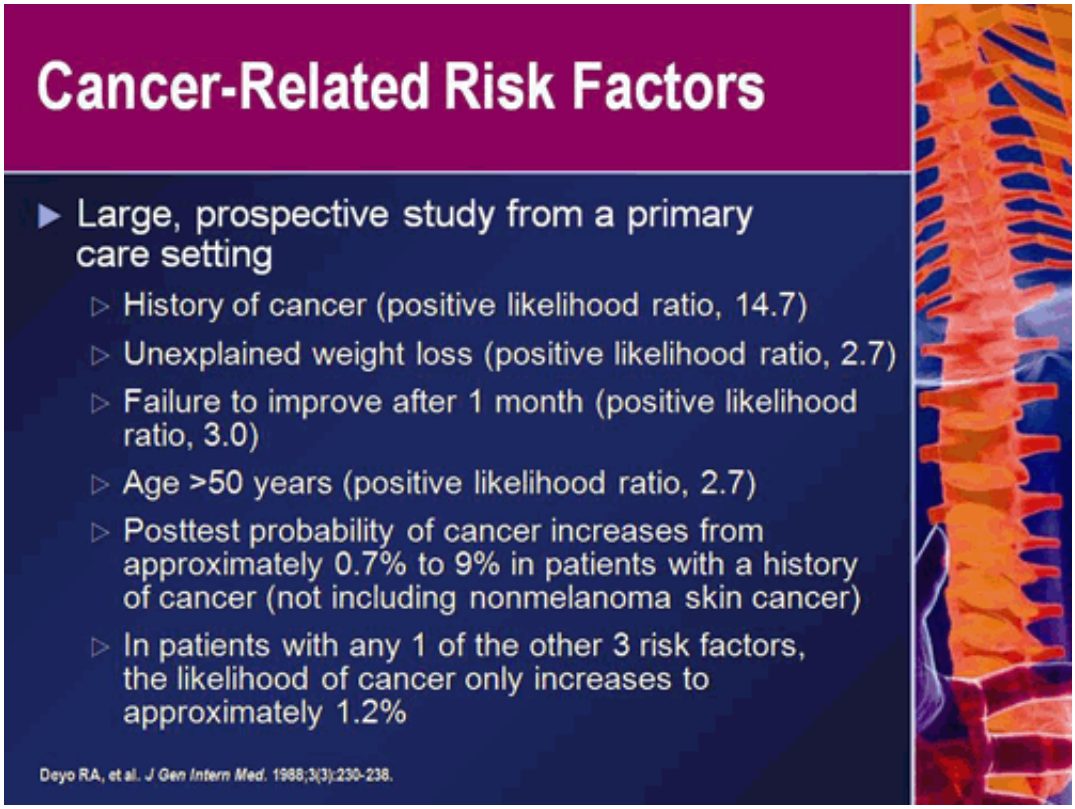
What are the red flags? Well, let me start on the physical exam side. The red flag would be a febrile patient, hypotensive or extreme hypertension, ashen and pale—ooh, that doesn't sound like a normal back patient—having a pulsatile abdominal mass—again, that's not usually in the back—spinous process tenderness, focal neurologic signs, acute urinary retention, or bowel and bladder incontinence. I mean, these are now serious markers that require us to get moving quickly.

The historical phenomena are more on the left side. I think what's important, if you're thinking about infections—history of IV drug use, history of a procedure that would have induced bacteremia, history of being immunocompromised—or if you are thinking malignancy and tumor involving the spine, they have to have a kind of an underlying history usually of having a malignancy. But, lots of things to think about historically, more importantly I think is to observe these serious physiologic markers.



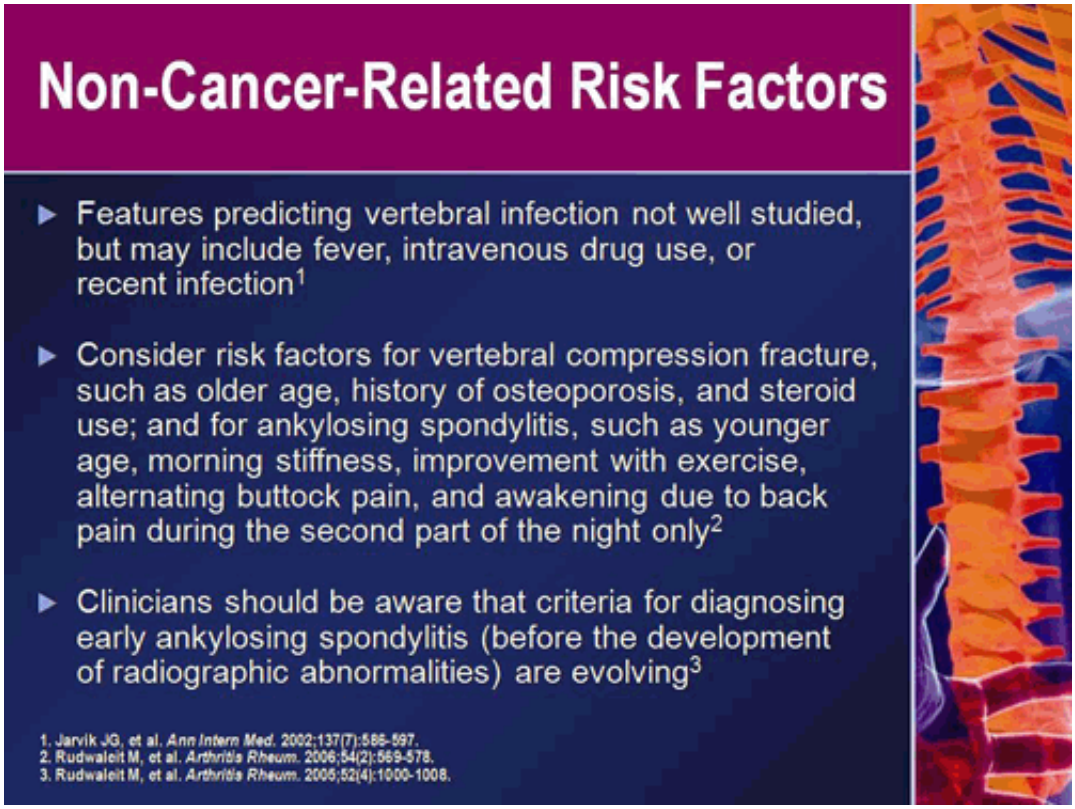
Slide 32.

The risk for chronicity we believe goes up with things like intravenous drug use and having a recent infection. Obviously, that's how you see the blood and you could get, therefore, a vertebral infection. Having recently had an epidural or having an abscess has an unfortunate consequence, as does vertebral fractures occurring because of older age, osteoporotic status, recent steroid use, having musculoskeletal pain perhaps because of inactivity, certain kinds of abnormalities and body mechanics and posture, and, in general, maybe having a risk for chronicity by way of severe emotional distress that's not very well attended to.



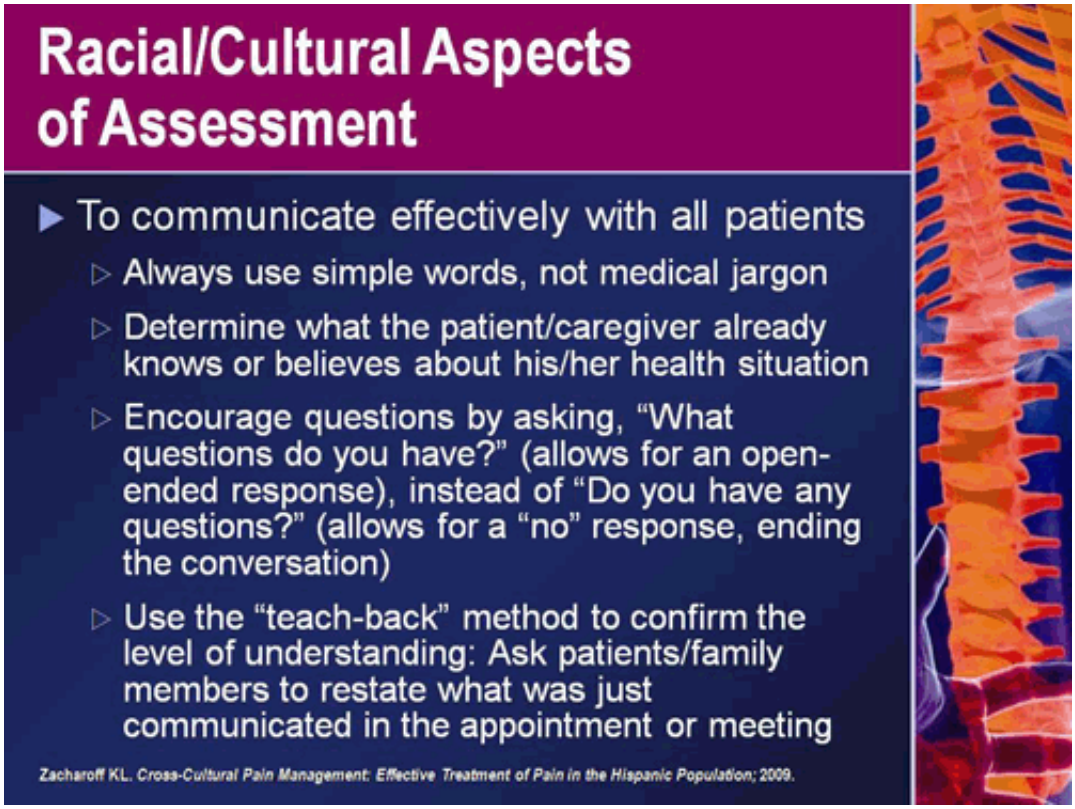
Slide 33.

If we think about cancer-related risk factors, I think maybe the most overt thing we need to pick up is the history of cancer, because notice that the positive likelihood ratio is about 15 when we just know that the patient already has cancer and we're evaluating them with, say, an acute back pain situation. The next 3—unexplained weight loss, failure to improve after a single month, and being over the age of 50—those collectively each are coming in at about a ratio of 3. And then, everything else is lower, so that when we're thinking about someone with a cancer-related cause for back pain, just knowing that they have cancer is already a problem, knowing that they have risks for cancer may be a problem, the man with a 40-year pack risk of smoking.



Slide 34.

Non-cancer–related risk factors that we think raise the risk of having long-term back pain problems are things like the IV drug use I've already spoken about or recent infections giving rise to vertebral infections. Also, consider fracture likelihoods, older patients, steroids, osteoporotic status, and then understand that sometimes with things like ankylosing spondylitis, there can actually be the disease beginning before there's radiologic manifestation, so now the history becomes important. You know, somebody who's talking to you at a younger age about morning stiffness, improvement with exercise, alternating buttocks pain, awakening at night because of pain, especially during the latter part of the night.



Slide 35.

We're asked to give a brief statement about the racial and cultural aspects. Let me just say that this California Assembly Bill 1195 has mandated this because we're talking about clinical care, and it's important when we do clinical care to do the best job we can. It is important that throughout our assessment of any patient, we communicate effectively—the notion that we shouldn't use medical jargon but actually speak in real English words, I would argue maybe smallest words possible in some situations. Aligning ourselves with our patients and their caregivers by finding out, "What do you actually know, now?" You know, "Why are you coming now to see me? What would you like me to be able to provide information about?" This is the aligning with the patient and their family and giving the opportunity to answer questions by asking open-ended, inviting questions, like "What questions do you have for me?" as opposed to, "Do you have any questions for me?" where the answer can only be yes or no and isn't really a conversation encouraging sort of question. It's really more intended to shut the conversation off.

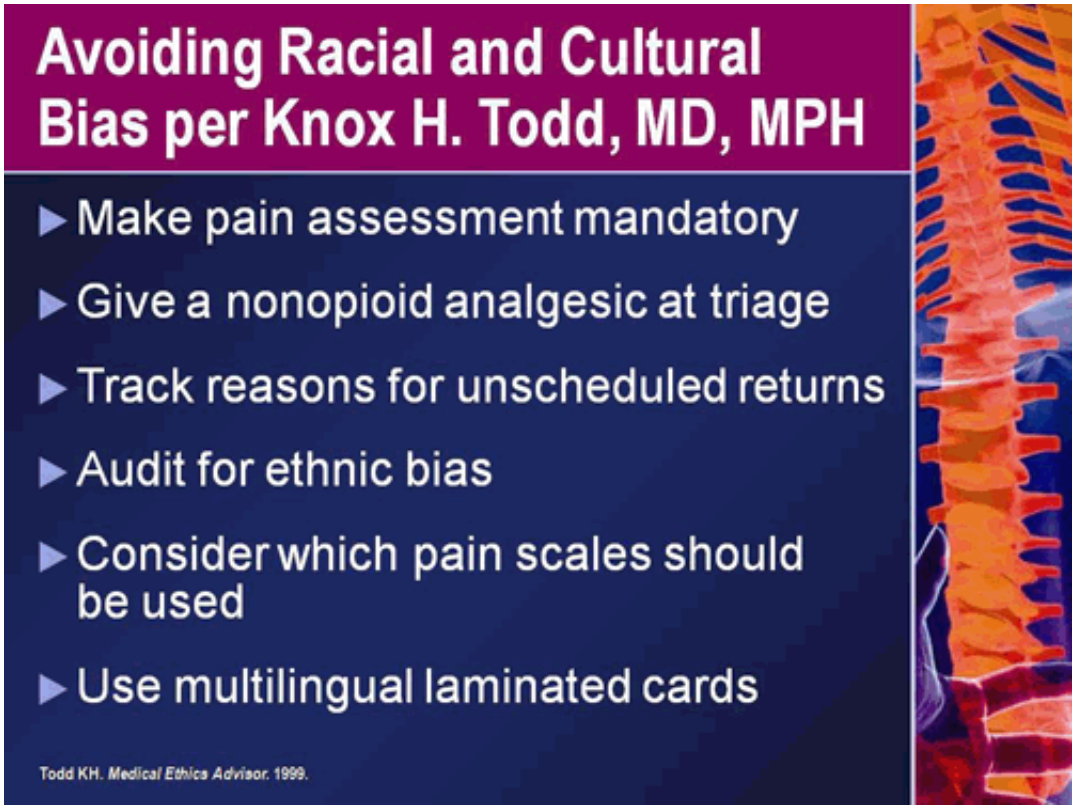
And then, I love this notion of the "teach-back" technique. I've explained something to the patient; I want to know if they actually understood it, so I'll ask them to explain it back to me. And, I think it's always interesting when I ask patients, "Do you do your physical therapy exercises?" You always get an affirmative, "Yes doctor, I always do them. I do them 4 times a day just like you told me to." It would be better to say, "Would you please demonstrate how you do your exercises?" Then, you realize they have no idea how to do the exercises, they've been to PT 3 or 4 times. So, that "teach-back" method really is a great reality check.

Slide 36.

We need to ensure that people get effective care, that they understand what's happening, that the care provided is done in a respectful way, and it's provided in a manner that's compatible with their cultural background, and hopefully in a language that they speak. I don't know about you, but I've actually had the interesting occurrence of having to work with 2 translators to communicate with the patient because there was no translator where I practiced who spoke that language and English. So, it went from English to another language—I think it was Cambodian—to some dialect of Laotian, to the patient, and then back to me. It was quite interesting to watch this thing, and I was thinking it's like the game telephone where you start whispering in 1 person's ear, it goes around the table, do you even get the same message back that you sent out? So, after a couple of translators walked all over the conversation in both directions, I wasn't sure what was being translated.

Also, I get concerned whenever there's translation, and I say something, the translator says something, the patient starts talking animatedly for several minutes, it seems, and the translator says, "No." Okay, I don't think he said "No," but I don't know what he said.

Implement strategies as best you can to get diversity in your institution so the kind of care you provide for a diverse population is being provided by a diverse care team. Wouldn't that be fantastic? And then, ensuring that staff at all levels across the disciplines receives training about, and education in, what is called CLAS delivery, which is Culturally and Linguistically Appropriate Services. There's actually a federal Web site you can go to get more information about that.

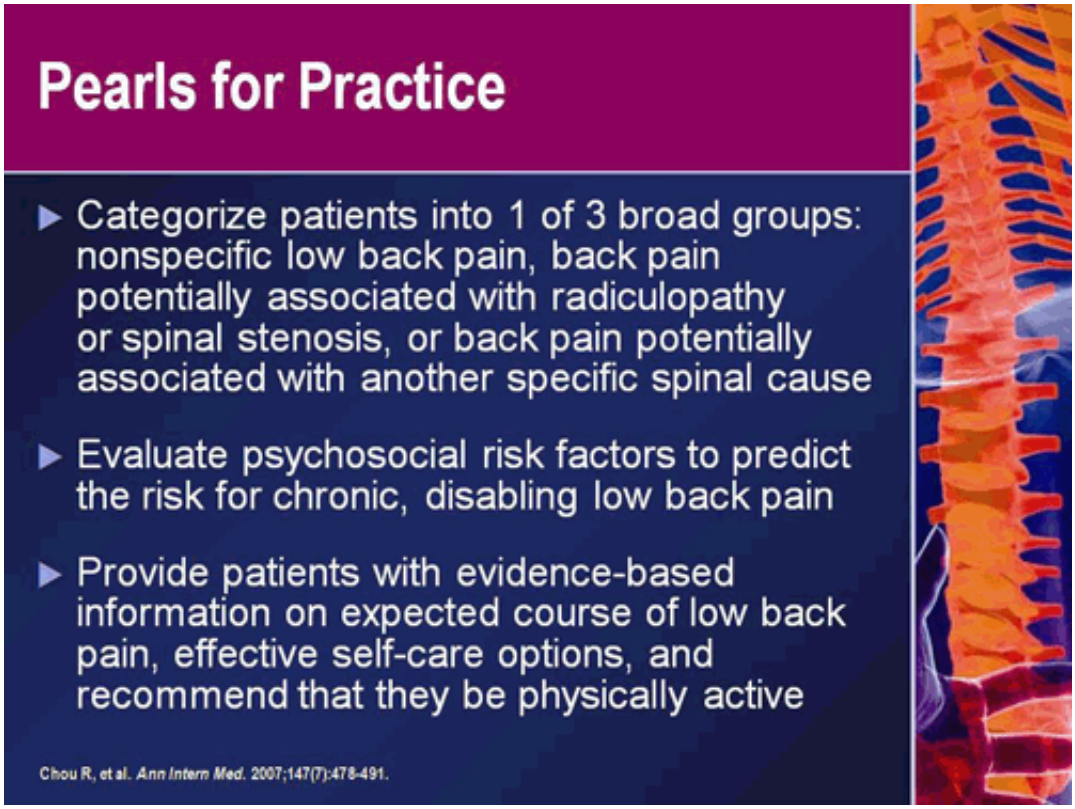


Slide 37.

Dr Knox Todd, someone who's quite familiar to many of us, really talks to us about the importance of avoiding racial and cultural bias, obviously within the context of emergency rooms, make good pain assessments mandatory. It's not thinking about pain assessments for some people but not necessarily others. You just do it the same way every time for every person, and that doesn't matter who or what they are. They are getting the same kind of care. Perhaps immediately get some nonopioid analgesics at the level of triage and then start deciding what needs to be added to that. Start looking at why people have unscheduled returns—is it just bad Karma, phases of the moon, or is there a reason why people are coming back? Try to do audits as best as possible, looking for ethnic biases or a way that maybe we could detect that.

Consider which pain scale you are using, because some are just not appropriate for some populations. I mean, you've looked at the adult—especially the geriatric—pain assessment literature. You'll see that some pain techniques like the Visual Analog Scale (VAS) just are challenging to work with in an older person immediately postsurgery. Maybe that old numeric rating scale would be more appropriate. Look at the development of multilanguage laminated cards; these are downloadable from the Internet and then you can get some laminating paper.

Summary



Slide 38.

So, our final tips, some pearls for practice, again, go back to the 3 buckets. Theoretically, we can get past LBP, a place that they hurt, to LBP of a nonspecific origin, LBP because of radiculopathy or spinal stenosis, or LBP because of another spinal problem and/or a serious underlying medical problem. Evaluate everyone psychosocially to predict the risk for chronicity as well as the disability associated with LBP. And then, certainly always try to provide patients with evidence-based information about the expected course of their LBP, effective self-care options, and recommend that they remain physically active—don't let them go to bed, don't let them sit in the rocker, keep them up and about as best we can.

And now, Dr Chou is going to come up and give us the next presentation, which will be on the subject of treatment of LBP: pharmacologic and nonpharmacologic actions or options.

This article is part of a CME/CE certified activity. The complete activity is available at: http://cme.medscape.com/viewprogram/31426

Contents of *Low Back Pain: Evaluation, Management, and Prognosis* [http://cme.medscape.com/viewprogram/31426]

All sections of this activity are required for credit.

4. Current Understanding of the Prevention of Chronicity of Low Back Pain [http://cme.medscape.com/viewarticle/726141]
5. Question and Answer Session [http://cme.medscape.com/viewarticle/726142]

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