1 Guideline title

Low back pain

1.1 Short title

Low back pain

2 Background

a) The National Institute for Clinical Excellence (‘NICE’ or ‘the Institute’) has commissioned the National Collaborating Centre for Primary Care to develop a clinical guideline on low back pain for use in the NHS in England and Wales. This follows referral of the topic by the Department of Health (see appendix). The guideline will provide recommendations for good practice that are based on the best available evidence of clinical and cost effectiveness.

b) The Institute’s clinical guidelines will support the implementation of National Service Frameworks (NSFs) in those aspects of care where a Framework has been published. The statements in each NSF reflect the evidence that was used at the time the Framework was prepared. The clinical guidelines and technology appraisals published by the Institute after an NSF has been issued will have the effect of updating the Framework.

c) NICE clinical guidelines support the role of healthcare professionals in providing care in partnership with patients, taking account of their individual needs and preferences, and ensuring that patients (and their carers and families, where appropriate) can make informed decisions about their care and treatment.
3 Clinical need for the guideline

a) Low back pain (LBP) is not a homogenous condition; it can present in people with different levels of severity (for example, people who work and lead active lives, as well as the severely disabled or unable to work). LBP is very common in working-age adults (particularly between 40 and 60 years of age); a UK survey reported in 1998 that 40% of adults had suffered from LBP lasting longer than 1 day in the previous 12 months. Treating all types of back pain costs the NHS more than £1000 million/year. In 1998 the direct healthcare costs of back pain in the UK were estimated at £1623 million – approximately 35% of costs were related to services provided by the private sector. The costs of care exceed £500 million/year. Lost production as a result of LBP costs at least £3500 million/year in the UK.

b) LBP results in many problems, including impaired quality of life, mobility and daily function; long-term morbidity; a higher risk of social exclusion through inability to work; reduced income; reliance on sickness benefits; and social isolation through disability.

LBP also represents a considerable burden to patients, families, society and the economy (for example, loss of working days, and early retirement).

c) Aims of therapy are to manage disability and pain, help people cope with day-to-day life, reduce distress, enable people to continue with or return to work, and to prevent recurrence. Numerous therapeutic and rehabilitation strategies may be used to treat LBP. These include manual therapies (which may be delivered by chiropractors, massage therapists, osteopaths or physiotherapists), other physiotherapeutic approaches, pharmacological treatments, psychological treatments (for example, cognitive behavioural therapy), acupuncture, complementary therapies, supports/traction, exercise (general or
specific), patient education/‘back schools’, injections (for example, facet joints, epidurals), electrotherapy, relaxation, and occupational health/ergonomics. Surgery may occasionally be performed if specifically indicated.

4 The guideline

a) The guideline development process is described in detail in two publications that are available from the NICE website (see ‘Further information’). ‘The guideline development process – an overview for stakeholders, the public and the NHS’ describes how organisations can become involved in the development of a guideline. ‘The guidelines manual’ provides advice on the technical aspects of guideline development.

b) This document is the scope. It defines exactly what this guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from the Department of Health (see appendix).

c) The areas that will be addressed by the guideline are described in the following sections.

4.1 Population

4.1.1 Groups that will be covered

a) People 16 years and older presenting with symptoms of ‘non-specific’ (simple) LBP; specifically LBP that has not resolved within 6 weeks of initial onset, consultation, or exacerbation, up to a period of 6 months.

b) People who present with ‘non-specific’ lower back pain with or without pain in the lumbosacral area, buttocks and thighs that has not resolved within 6 weeks of initial onset, consultation, or exacerbation, up to a period of 6 months.
4.1.2 Groups that will not be covered

a) Individuals who have LBP because of specific spinal pathologies, including:

- conditions with a select and uniform pathology of a mechanical nature (for example, spondylolisthesis, postoperative pain, osteoporosis, vertebral fracture, congenital diseases)
- conditions of a non-mechanical nature (for example, ankylosing spondylitis, atherosclerosis, diseases of the viscera)
- neurological disorders (including cauda equina syndrome)
- serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse).

b) People with radiculopathy and/or nerve root pain (unilateral leg pain worse than the back pain, pain radiating to the foot or toes, numbness and paraesthesia in same distribution, and localised neurological signs).

c) Children younger than 16 years.

d) People with acute LBP (less than 6 weeks duration).

4.2 Healthcare setting

a) Diagnosis, treatment and management in primary and secondary care, referral to tertiary centres if appropriate.

b) Care received from healthcare professionals who have direct contact with, and make decisions concerning, the care of people who have LBP for longer than 6 weeks.

4.3 Clinical management

a) A systematic assessment approach to confirm the diagnosis of LBP and to identify any prognostic factors that could guide management. This would include relevant clinical examination and
assessment (for example physiological testing and psychosocial assessment methods).

b) Use of pharmacological treatments. For example:

- analgesics
- non-steroidal anti-inflammatory drugs
- muscle relaxants
- antidepressants.

Advice on treatment options will be based on the best evidence available to the development group. Note that guideline recommendations will normally fall within licensed indications; exceptionally, and only if clearly supported by evidence, use outside a licensed indication may be recommended. The guideline will assume that prescribers will use a drug’s summary of product characteristics to inform their decisions for individual patients.

c) Non-pharmacological interventions used within the primary care and secondary care setting, and the appropriate environment for the interventions. These will include:

- exercise therapies (for example, general exercise in the management of LBP; specific exercises for the lower back; group-based and individualised exercise programmes)
- manual therapies
- physical therapies (for example, spinal manipulation, electrotherapeutic devices and traction).

d) In some cases, the use of invasive procedures, if the intervention can be used within the primary or secondary care setting. For example:

- acupuncture
- injection therapies.
e) Consideration of indications for referral for surgery and the discharge of patients from specialist care. However, detailed recommendations of different surgical procedures/techniques will not be included.

f) Implementation of lifestyle interventions as part of clinical treatment. For example:

- ‘back schools’
- patient education and advice
- cognitive behavioural pain management
- workplace interventions/return-to-work interventions (for example, occupational/ergonomic interventions).

g) The guideline development group will consider making recommendations on the principal complementary and alternative interventions or approaches to care relevant to the guideline topic.

h) The guideline development group will take reasonable steps to identify ineffective interventions and approaches to care. If robust and credible recommendations for re-positioning the intervention for optimal use, or changing the approach to care to make more efficient use of resources, can be made, they will be clearly stated. If the resources released are substantial, consideration will be given to listing such recommendations in the ‘Key priorities for implementation’ section of the guideline.

### 4.4 Status

#### 4.4.1 Scope

This is the consultation draft of the scope. The consultation period is 5 February to 2 March 2007.
NICE has published the following related guidance.

- Referral practice: a guide to appropriate referral from general to specialist service (acute low back pain section; pilot version, 2000).

### 4.4.2 Guideline

The development of the guideline recommendations will begin in May 2007.

### 5 Further information

Information on the guideline development process is provided in:

- ‘The guideline development process – an overview for stakeholders, the public and the NHS’
- ‘The guidelines manual’.

These booklets are available as PDF files from the NICE website ([www.nice.org.uk/guidelinesmanual](http://www.nice.org.uk/guidelinesmanual)). Information on the progress of the guideline will also be available from the website.
Appendix – Referral from the Department of Health

The Department of Health asked the Institute:

To prepare a clinical guideline on the acute management of patients with chronic (longer than 6 weeks) low back pain. To include indications for referral and pathways of care.