

Background Information

ACKNOWLEDGEMENTS

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THE RCGP GUIDELINES

In July 1995, the National Health Service Executive commissioned the Quality Improvement Group of the Royal College of General Practitioners to develop evidence-based clinical practice guidelines for the management of acute low back pain. These were intended to benefit the range of clinicians involved in first contact care using a multidisciplinary approach based on the latest international research evidence.

The present guideline (copy enclosed in this pack) was developed by a multi-disciplinary group. The advisory group was drawn from the RCGP, the Chartered Society of Physiotherapy, the British Chiropractic Association, the Osteopathic Association of Great Britain, the Clinical Standards Advisory Group (CSAG) sub-committee on low back pain and patient representation from the National Back Pain Association. Observers attended from the Department of Health and the National Health Service Executive. The guideline was published in September 1996, updated in 1998 and re-issued in February 1999.

The first task in developing the guideline was to update the evidence review in the U.S. guideline published by the Agency for Health Care Policy and Research (AHCPR 1994) and to build on the Clinical Standards Advisory Group report on low back pain (CSAG 1994). Members of the guideline development group carried out systematic reviews of four key areas of management:

- **bed rest**
- **advice on staying active**
- **manipulation**
- **exercise**

Other areas of management, such as epidural steroids and traction, were covered in a number of systematic reviews. Evidence-linked statements were produced for each area of care and small, multi-professional groups prepared recommendations which were discussed, revised where appropriate and agreed by the whole group.

There are, in many areas, strong links between appropriate evidence-based care for acute back pain and better outcomes over 1 to 2 years. It has been recommended (CSAG 1994) that for the vast majority of acute cases, primary care management is the most appropriate. Moreover, delay in applying appropriate care can lead to long-term disability. The guideline, therefore, emphasises evidence-based recommendations for primary care management.

An Audit Toolkit for the UK National Guideline for Acute Low Back Pain

The recommendations include, in the first instance:

- **diagnostic triage**
- **psychosocial assessment**
- **appropriate use of medication**
- **avoidance of bed rest**
- **encouragement of normal activity.**

Evidence Ratings

The evidence was rated on a three star system:

- ☆☆☆ **Strong Evidence:** Generally consistent finding in a majority of multiple acceptable studies.
- ☆☆ **Moderate Evidence:** Either based on a single acceptable study or a weak and inconsistent finding in some of multiple acceptable studies.
- ☆ **Limited Evidence:** Does not meet all the criteria of acceptable studies.

'Acceptable' studies of therapy are:

- randomised controlled trials of acute or recurrent low back pain, relevant to primary care with at least ten patients in each group and with patient centred outcomes.

'Acceptable' studies of assessment and natural history are:

- prospective cohort studies of acute or recurrent low back pain, relevant to primary care, containing at least 100 patients and at least 1 year follow up.

References

AHCPR (1994) *Management Guidelines for Acute Low Back Pain*. Agency for Health Care Policy and Research, US Department of Health and Human Services.

Clinical Standards Advisory Group (1994) *Report on Back Pain*. London: HMSO.

DEVELOPING AN AUDIT FOR THE RCGP GUIDELINES

This audit tool was developed by a multidisciplinary Development Group, supported by an Advisory Group, over 2 years starting in March, 1998. The project was funded by the NHSE's National Sentinel Audit Programme, the administration of which passed to the National Institute for Clinical Excellence in 1999.

The purpose of the package is to help local practitioners to identify the standards of care they are achieving for acute back pain compared with national, evidence-based criteria.

The project surveyed all Health Authority Audit Advisory Groups in England to estimate the current and previous audit activity for low back pain. We then formulated 6 audit criteria which adhere closely to the Guideline's recommendations. These are:

- **Assessment at the First Consultation (Diagnostic Triage)**
- **Assessment for Psychosocial Risk Factors**
- **Medication**
- **Avoidance of Bed Rest**
- **Advice on Staying Active**
- **Referral for other Investigations or Treatment**

Testing the Audit Toolkit

A basic audit of first contact events was initially piloted in general practice, through a small group of health authorities. A suitably adapted version was also piloted in chiropractic, osteopathy and manipulation physiotherapy. After feedback and adaptations, which incorporated minor revisions to the Guideline made in 1999, a further version was tested by over 900 practitioners of these disciplines in a 2-round audit cycle of their practices. The general practice audit was administered by 6 health authority audit groups and the physical therapist audits by central agencies. The toolkit was formally evaluated by all the practitioners during both audit rounds. The present version represents a minor adaptation of the test version, which was found acceptable to the vast majority of practitioners and all the health authority audit groups.

IMPLEMENTING THIS AUDIT

Problems With Use - General Practitioner Audits

1. One problem which the general practitioners who helped to test this audit encountered was abstracting the required information from their case records. As compliance with some of the Guidelines' recommendations was not usually evident from records, it was necessary to devise an *aide-memoire*, which would have the combined function of a data collection form, as well as a supplement to the patient record itself. The Green Card, enclosed in this pack, was a solution which was strongly supported by the general practitioners who tested the audit.
2. GPs found it best to transfer the information from the Green Cards to the Data Collection forms themselves, rather than to delegate this. This may also have been of value as a vehicle for reflection.
3. During testing, it was feasible for practitioners to see 5 eligible patients over 6 weeks. However, this small number gave rise to questions about representativeness. Therefore, consideration needs to be given to the number of patients required for the audit in terms of striking a balance between this and the practicalities of time.
4. Another problem could be the availability of manipulation and reactivation/rehabilitation in primary care for unresolving acute simple backache. This did not, however, reveal itself during the testing of the toolkit.

COMP Audits

1. A modified version of the audit was concurrently tested by chiropractors, osteopaths and manipulation physiotherapists. Their main difficulty during testing was that the Guideline does not refer to, or explicitly define, treatments which they regarded as important. It may, therefore, be helpful to re-iterate the Guideline's emphasis on evidence-based recommendations about particular aspects of assessment, natural history and care, which influence outcomes.

All Groups

1. The audit addresses the first visit of an acute back pain patient only, rather than the whole process of care. The reason for this is that the Guideline itself is mainly concerned with initial events, which have a role in preventing chronicity. This is different to the treatment algorithms which might sometimes be expected.
2. The number of cases to be audited is a consideration. Whatever number is chosen, the process should leave time for practitioner education by encouraging reference to the Guideline's recommendations, context and supporting evidence (see Information Sections).

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Education

The information packs were designed as educational tools (i.e. as rapid reference to elements of the Guidelines' Evidence Review). Similarly, the green card could also be used as an aid for GPs in the treatment of all acute back pain patients, irrespective of whether audit is being conducted. We hope that users of this toolkit will exploit its educational components in the interests of implementing best practice using the evidence-based guidance as a matter of course.

Standards

Standards are an integral part of audit. However, as national standards for acute low back pain have not been investigated or set, this toolkit does not specify a standard for each criterion. Nevertheless, it would not be unreasonable to expect practitioners to triage patients 100% of the time. For the other criteria, the desired standards may need to be attained incrementally, bearing in mind current local practice and what can be done practically. However, improved standards should be a continuing process.

RCGP Guideline

For photocopy

KEY PATIENT INFORMATION POINTS

◆ Simple Backache

- give positive messages

- ◆ There is nothing to worry about. Backache is very common.
- ◆ No sign of any serious damage or disease. Full recovery in days or weeks - but may vary.
- ◆ No permanent weakness. Recurrence possible - but does not mean re-injury.
- ◆ Activity is helpful, too much rest is not. Hurting does not mean harm.

◆ Nerve Root Pain

- give guarded positive messages

- ◆ No cause for alarm. No sign of disease.
- ◆ Conservative treatment should suffice - but may take a month or two.
- ◆ Full recovery expected - but recurrence possible.

◆ Possible Serious Spinal Pathology

- avoid negative messages

- ◆ Some tests are needed to make the diagnosis.
- ◆ Often these tests are negative.
- ◆ The specialist will advise on the best treatment.
- ◆ Rest or activity avoidance until appointment to see specialist.

PATIENT BOOKLET

The above messages can be enhanced by an educational booklet given at consultation. *The Back Book* is an evidence-based booklet developed for use with these guidelines, and is published by The Stationery Office (ISBN 011 702 0788).

These brief clinical guidelines and their supporting base of research evidence are intended to assist in the management of acute low back pain. It presents a synthesis of up-to-date international evidence and makes recommendations on case management. Recommendations and evidence relate primarily to the first six weeks of an episode, when management decisions may be required in a changing clinical picture. However, the guidelines may also be useful in the sub-acute period.

These guidelines have been constructed by a multi-professional group and subjected to extensive professional review. They are intended to be used as a guide by the whole range of health professionals who advise people with acute low back pain, particularly simple backache, in the NHS and in private practice.

◆ Psychosocial 'Yellow Flags'

When conducting assessment, it may be useful to consider psychosocial 'yellow flags' (beliefs or behaviours on the part of the patient which may predict poor outcomes). The following factors are important and consistently predict poor outcomes:

- ◆ a belief that back pain is harmful or potentially severely disabling
- ◆ fear-avoidance behaviour and reduced activity levels
- ◆ tendency to low mood and withdrawal from social interaction
- ◆ expectation of passive treatment(s) rather than a belief that active participation will help

Further information and copies of the full evidence base for these guidelines are available from:

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This document may be photocopied freely

Clinical Guidelines for the Management of

Acute Low Back Pain

Contributing Organisations

Royal College of General Practitioners
Chartered Society of Physiotherapy
British Osteopathic Association
British Chiropractic Association
National Back Pain Association

Review Date: December 2001

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1999

A C U T E L O W B A C K P A I N

DIAGNOSTIC TRIAGE

Diagnostic triage is the differential diagnosis between:

- ◆ Simple backache (non specific low back pain)
- ◆ Nerve root pain
- ◆ Possible serious spinal pathology

Simple backache: *specialist referral not required*

- ◆ Presentation 20-55 years
- ◆ Lumbosacral, buttocks & thighs
- ◆ “Mechanical” pain
- ◆ Patient well

Nerve root pain: *specialist referral not generally required within first 4 weeks, provided resolving*

- ◆ Unilateral leg pain worse than low back pain
- ◆ Radiates to foot or toes
- ◆ Numbness & paraesthesia in same distribution
- ◆ SLR reproduces leg pain
- ◆ Localised neurological signs

Red flags for possible serious spinal pathology: *consider prompt investigation or referral (less than 4 weeks)*

- ◆ Presentation under age 20 or onset over 55
- ◆ Non-mechanical pain
- ◆ Thoracic pain
- ◆ Past history - carcinoma, steroids, HIV
- ◆ Unwell, weight loss
- ◆ Widespread neurological symptoms or signs
- ◆ Structural deformity

Cauda equina syndrome: *emergency referral*

- ◆ Sphincter disturbance
- ◆ Gait disturbance
- ◆ Saddle anaesthesia

The evidence is weighted as follows:

- *** Generally consistent finding in a majority of acceptable studies.
- ** Either based on a single acceptable study, or a weak or inconsistent finding in some of multiple acceptable studies.
- * Limited scientific evidence, which does not meet all the criteria of ‘acceptable’ studies.

PRINCIPAL RECOMMENDATIONS

◆ **Assessment**

- ◆ Carry out diagnostic triage (see left).
- ◆ X-rays are not routinely indicated in simple backache.
- ◆ Consider psychosocial ‘yellow flags’ (see over).

◆ **Drug Therapy**

- ◆ Prescribe analgesics at regular intervals, not p.r.n.
- ◆ Start with paracetamol. If inadequate, substitute NSAIDs (eg ibuprofen or diclofenac) and then paracetamol-weak opioid compound (eg codydramol or coproxamol). Finally, consider adding a short course of muscle relaxant (eg diazepam or baclofen).
- ◆ Avoid strong opioids if possible.

◆ **Bed Rest**

- ◆ Do not recommend or use bed rest as a treatment.
- ◆ Some patients may be confined to bed for a few days as a consequence of their pain but this should not be considered a treatment.

◆ **Advice on Staying Active**

- ◆ Advise patients to stay as active as possible and to continue normal daily activities.
- ◆ Advise patients to increase their physical activities progressively over a few days or weeks.
- ◆ If a patient is working, then advice to stay at work or return to work as soon as possible is probably beneficial.

◆ **Manipulation**

- ◆ Consider manipulative treatment for patients who need additional help with pain relief or who are failing to return to normal activities.

◆ **Back Exercises**

- ◆ Referral for reactivation / rehabilitation should be considered for patients who have not returned to ordinary activities and work by 6 weeks.

EVIDENCE

- * Diagnostic triage forms the basis for referral, investigation and management.
- * Royal College of Radiologists Guidelines.
- *** Psychosocial factors play an important role in low back pain and disability and influence the patient’s response to treatment and rehabilitation.

S I M P L E B A C K A C H E

- ** Paracetamol effectively reduces low back pain.
- *** NSAIDs effectively reduce pain. Ibuprofen and diclofenac have lower risks of GI complications.
- ** Paracetamol-weak opioid compounds may be effective when NSAIDs or paracetamol alone are inadequate.
- *** Muscle relaxants effectively reduce low back pain.

- *** Bed rest for 2-7 days is worse than placebo or ordinary activity and is not as effective as alternative treatments for relief of pain, rate of recovery, return to daily activities and work.

- *** Advice to continue ordinary activity can give equivalent or faster symptomatic recovery from the acute attack and lead to less chronic disability and less time off work.

- *** Manipulation can provide short-term improvement in pain and activity levels and higher patient satisfaction.

- ** The optimum timing for this intervention is unclear.
- ** The risks of manipulation are very low in skilled hands.

- *** It is doubtful that specific back exercises produce clinically significant improvement in acute low back pain.
- ** There is some evidence that exercise programmes and physical reconditioning can improve pain and functional levels in patients with chronic low back pain. There are theoretical arguments for starting this at around 6 weeks.