

Low Back Pain

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Chronic LBP – What have we learned?

In my early days of treating low back pain, the hardest thing to deal with was the fear I could sense in my patient. It would become my fear, and it was heightened by the fact I didn't understand what I was dealing with, or how best to treat it. This didn't instill a lot of confidence in the poor patient! 25 plus years later, and confident the patient has "come to the right place", I know the best thing I can do for them is to allay their fear, and start to reverse misconceptions that are at the heart of the chronic low back pain dilemma...

The low back pain journey

With all the research into its management, and detailed imaging now available to assess the causes of low back pain (LBP), there is overwhelming evidence that this epidemic is getting worse (Bishop et al 2008; Lin, et al 2013; O'Sullivan, 2012). In the U.S., LBP is the second greatest cause of disability (O'Sullivan et al 2012). One in four LBP sufferers will report significant disability, and up to 75% will have long-lasting symptoms (Bishop et al 2008). They will visit their GP or allied health practitioner with recurrent or chronic LBP. At some point, they will be sent for imaging, and in all likelihood these findings, combined with the practitioner's experience, will lead to an explanation of the underlying structural damage. They will then be given a range of opinions on the cause, prognosis, and treatment options.

This is the biomedical model of LBP. Evidence has been mounting for 30 years that this model is flawed, and the search for a pathological cause for the problem is often fruitless. There are numerous

possible patho-anatomical explanations for LBP – disc herniation or degeneration, facet joint syndrome, spondylosis, annular tears and fissures, musculo-ligamentous strain... However even when demonstrated on imaging, none of these findings are predictive of the incidence of LBP (Jarvik et al 2005). It is estimated that over 50% of asymptomatic individuals have abnormal CT findings, and that at least 75% of spinal X-rays present no useful clinical information (McGill, 2002). Chances are what shows on their X-ray or scan is unrelated to their current symptoms. In fact, symptoms of depression or high stress levels are much more predictive of who is likely to develop chronic LBP (Lin et al 2013; O'Sullivan, 2012). So you'll get more useful information from a patient's psychosocial profile than you will from their CT report.

Why do people go on to develop recurrent or chronic low back pain? For many it has been shown that the most important factor is their attitude to the injury. Those with high 'fear avoidance' strategies and 'catastrophising attitudes' to pain are likely to recover more slowly, take longer to return to work, and have ongoing symptoms beyond normal tissue healing times.

While many practitioners continue to place emphasis on imaging findings and the severity of tissue damage (Bishop et al 2008), for many patients the results of spinal imaging and ensuing biomedical diagnoses will add fuel to the fire. It is not enough that our society stigmatizes LBP as a serious condition. If the treating practitioner communicates their own negative feelings about the injury, this

greatly reinforces the patients fear & perception of a poor outcome. The reality is that the attitudes and beliefs of the health care provider may be integral to the success or failure of treatment, and for some patients the disability due to chronic LBP is partly iatrogenic (Bishop et al 2008; Lin et al 2013).

The road back...

In the majority of cases, early investigation and specialist referral are unwarranted, (Buchbinder et al 2009), & for many patients will be counter-productive. A positive attitude and advice to stay active and resume normal activities will benefit the patient a lot more. It has been shown that patients with chronic LBP have maladaptive movement behaviors that affect their day-to-day activities, and produce a vicious cycle of fear avoidance, heightened sensitization to pain, and further disability. In other words, chronicity is a learned response.

While the search for a structural cause for LBP is unreliable, a mechanical cause is less difficult to find. The vast majority of my work is acute and chronic LBP. In virtually every case, even when there are associated psychosocial factors, there is a functional or postural cause to the problem. The reason they have ongoing back pain is not because of their bulging disc, but because they haven't been taught how to sit. The pain on bending isn't because of underlying instability. It's because they don't move the right way. Spondylosis or disc degeneration may not be the reason they are stiff. Rather, it could be because they regularly adopt static postures that overload these tissues.

When the patient first comes to see me with chronic LBP, I can identify many correctable faults with their posture and movement, factors which haven't been dealt with before. But first, I have to address their fear and pessimistic outlook. I spend a great deal of energy convincing most of my patients that their problem is not permanent, because for one reason or another they've been led to believe that it is. For many this takes some convincing. One of the most essential aspects of good LBP management is the experience and confidence to successfully communicate this belief to the patient.

Stay tuned. I have many more interesting things to tell you about low back pain.

References:

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