Acute Back pain

1. Exclude red flags for acute back pain **– MIMICS**

Massive abdominal aortic aneurysm

Infective cause

Malignancy

Inflammatory cause

Cauda equina syndrome

Spinal trauma

2. Pain Management- Pharmacotherapy (systemic and local), Adjuvant therapy (Physiotherapy)

- If there are red flags- need further evaluation
- If there is neuropathic pain without red flags - add gabapentin
- If no red flags assess yellow flags with socio-demographic history
- If no yellow flags consider discharge with pharmacotherapy and adjuvant
- therapy If there are yellow flags +/- admission and VP OPD referral

Table 5.2 Red flags for back pain

Possible diagnosis	Red flags
Vertebral fracture	History of trauma (this may be minimal in the elderly or those with osteoporosis) Prolonged steroid use
Tumour	Age <20 or >50 History of malignancy Non-mechanical pain Thoracic pain Systemically unwell Weight loss
Spinal infection	Fever Systemically unwell IVDU Immunosuppression HIV Recent bacterial infection Non-mechanical pain Pain worse at night
Cauda equina syndrome	Saddle anaesthesia Bladder or bowel dysfunction Gait disturbance Widespread or progressive motor weakness Bilateral sciatica
AAA	Systemically unwell Cardiovascular compromise Pulsatile abdominal mass
Inflammatory rheumatic disease (e.g. ankylosing spondylitis)	Age <20 Structural deformity of the spine Systemically unwell

Acute back pain

Indications for admission

1. Presence of red flag symptoms; Cauda equina syndrome and paravertebral abscess are neurosurgical emergencies
2. Presence of yellow flags (can consider discharge with VPOPD referral)

Red flags

- Severe or progressive neurologic deficits (e.g., bowel or bladder function, saddle parasthesia)
- Fever
- Sudden back pain with spinal tenderness (especially with history of osteoporosis, cancer, steroid use)
- Trauma
- Serious underlying medical condition (e.g., cancer)

Yellow flags

- a belief that back pain is harmful and potentially severely disabling
- a tendency to lowered mood and withdrawal from social activity
- an expectation that passive treatments will help more than active participation (passive coping strategies)
- fear avoidance behaviour (avoiding activities for fear of damaging the back)
- past history of chronic pain (anywhere in the body)
- negative attitudes and outlook
- somatisation and preoccupation with health

Indications for X ray of the spine

-Chronic back pain lasting more than 6 weeks
-Back pain < 6 weeks with red flags
-history of cancer
-significant trauma
-unexplained weight loss (4.5 kg in < 6 months)
-temperature 37.8°C
-risk factors for infection
-neurological deficit
-minor trauma in patients – over 50 years of age – known to have osteoporosis – taking corticosteroids

Discharge planning

1. Pain relief

Mechanical pain

-First line: paracetamol 500–1000 mg every 4 hours up to 4 g per daynonsteroidal anti-inflammatory drug (NSAID) in addition to paracetamol where there is inflammation. History of peptic ulcer disease – consider COX-2 selective drug.
-Third line – add codeine 30–60 mg 4 hourly or tramadol 50 mg 6 hourly. Use for 2 weeks to assist activation. Warn about constipation.
- Avoid the use of muscle relaxants including diazepam (significant incidence of side effects compared to placebo and their effectiveness is lost)
-Heat compress for 48h

Neuropathic pain

1. -Gabapentin/Pregabalin/Amitriptyline
2. Rescue therapy at home-Tramadol limited prescription to be used PRN.
3. Address fears and patient education.
4. Review in 4 weeks, refer to VPOPD clinic.
5. If no response in 6 weeks, consider pain clinic referral.