Back pain

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James talks to Professor Jane Bleasel about an approach to the common condition of back pain.

Professor Jane Bleasel is a Rheumatologist and Staff Specialist at Royal Prince Alfred Hospital. Jane was the Head of Department of Rheumatology for the last 15 years. She has recently taken up appointment at the University of Sydney as Co-Director of the Sydney Medical program and is also Professor of Medicine. Jane has published guidelines on back pain and red flag conditions and was part of an NHMRC grant looking at back pain presenting to GPs, Physiotherapist and Chiropractors.

Back pain

With Professor Jane Bleasel, Rheumatology Physician at Royal Prince Alfred Hospital, New South Wales, Australia

Introduction

Back pain is a common condition and a primary cause of disability in people less than 50 years of age.It is a symptom, not a diagnosis. This podcast discusses an approach to a patient with back pain and important questions in the evaluation of further investigations and management for the same.

Case 1 – You are a junior doctor working in a busy Emergency Department. You are asked to review a 60 year old male who has presented with back pain.

1. Outline your assessment approach at the bedside

- **History:**
  - Acute or chronic pain
  - Onset and relation to physical activity
  - Character of the pain
  - Radiation (radicular nerve pain vs. somatic or musculoskeletal radiation)
  - What makes the pain worse, does analgesia relieve the pain

    - Important to identify red flags that suggest a cause other than acute, non-specific back pain
        - Age < 20 years or > 50 years
        - Significant weight loss
        - Fevers
        - Intravenous drug use
        - Constant or nocturnal pain
        - Known history of malignancy
        - Systematic symptoms (e.g. cough, dysuria)
        - Neurological impairment (numbness, weakness, bowel or bladder impairment)
        - Severe, highly localised pain
- **Examination:**
    - Examination of the back (including palpation of spine)
    - Neurological examination: tone, power, reflexes and dermatomal distribution; peri-anal sensation to assess for cauda equina syndrome
    - Straight-leg raise test (lift leg straight off bed to assess whether the movement reproduces pain that radiates posteriorly to the ankle)

2. Investigations

- Usually no investigations are required for acute, non-specific back pain
- Blood investigations: FBC (leukocytosis), ESR and CRP; EUC, CMP may be indicated if malignancy is suspected
- Imaging:
    - X-ray film(spine and/or pelvis) if pain suggestive of fracture or malignancy or inflammatory process (e.g. sacroilitis)
    - MRI if neurological signs or symptoms suggestive of cauda equina syndrome

3. Management

- Key message: keep active, reassure the patient, simple analgesia
- Analgesia: paracetamol, NSAIDs (if no contraindications); may require codeine (in conjunction with aperients)
- Radiculopathy: analgesic adjuvants (e.g. amitriptyline, gabapentin)
- Physiotherapy referral
- Admit to hospital if any features of red flags (outlined above)
- If spinal cord compression, urgent neurosurgical review initially

Take home messages

- History is critical – ask specifically about the red flags of back pain
- A careful neurological exam is required to assess for signs of spinal cord compression
- For non-specific back pain, oral analgesia and reassurance is usually all that is required

References

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