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SPA Specialty Referral Guideline
Evaluation and Management of Low Back Pain in the Primary Care Setting
Developed October 23, 2006

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I. Introduction

Low back pain is the second most common symptomatic reason for office visits to primary care practitioners (PCP's) and the most common reason for office visits to spinal surgeons, neurosurgeons and occupational medicine physicians. Variations in practice and referral patterns significantly influence patient satisfaction as well as the quality and cost of care for the management of low back pain. Improving the efficacy of care for patients with low back pain in the primary care setting is essential.

II. Initial Visit

The initial visit with the primary care practitioner should focus on the detection of “red flags” as indicators of potential spinal pathology or other non-spinal pathology. **IN THE ABSENCE OF RED FLAGS, IMAGING STUDIES ARE NOT INDICATED**

- A) Screen for “red flags” and refer appropriately:
 - 1) Progressive neurological deficit with bladder dysfunction suggestive of cauda equina syndrome.
 - 2) Cancer: Age > 50, history of cancer, unexplained weight loss and failure to improve with conservative care.
 - 3) Infection: History of UTI, skin infection, IV drug use, immunosuppressive therapy, fever and pain increased with rest.
 - 4) Fracture: History of trauma, age >50, potential for osteoporosis
 - 5) Neurological involvement related to HNP or neurogenic claudication (spinal stenosis) suggested by the following:
 - a) Pain radiating below the knee, which is more severe than the low back pain.
 - b) Pain associated with complaints of numbness and weakness
 - c) Physical examination findings of :
 - SLR test reproducing distal symptoms between 45 and 60 degrees
 - Crossed SLR: SLR which reproduces contralateral leg pain
 - Ankle dorsiflexion weakness
 - Great toe extensor weakness
 - Impaired ankle reflex
 - d) Impaired patella reflex for upper lumbar discs.
- B) Provide the patient with a concise, clear explanation regarding the natural history of low back pain, including the time expected for healing, and reassurance that the condition will improve.
- C) Educate the patient on self-care strategies and activity modification.
- D) Empower and encourage the patient to resume normal activities of daily living (ADL's) through the use of simple aerobic exercise and graded activity, increasing their activity as symptoms permit.
- E) Provide patient with additional educational resources: Written material, video and web based education.
- F) Schedule follow-up visit.

III. Follow-up Visits

- A) Improving or slow progress.
 - 1) Provide reassurance and further education about back problems.
 - a) Recovery is expected.
 - b) Support return to work and normal activity as soon as possible.
 - c) Continue aerobic exercise to avoid deconditioning.
 - 2) Review activity limitations due to low back problems.
 - a) Where symptoms are aggravated by sitting or working in a flexed posture, the patient may benefit from the addition of exercise to facilitate lumbar extension (Exercise handout: prone glut sets, prone on elbows, press-ups or standing backward bend)
 - b) Where symptoms aggravated by standing, walking, or working overhead, the patient may benefit from a program to improve lumbar flexion. (Exercise handout: single knee to chest, double knee to chest, hamstring stretch, angry cat stretch).
 - 3) Schedule follow up visit if symptoms do not resolve in 2 weeks with continued conservative management.
- B) Limited progress or deterioration in symptoms and signs after 4 weeks of conservative care: Refer to Physical Therapy

APPROVAL:



SPA Medical Director

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Management of LBP by
 SMF PCP's
 Tuesday, October 10, 2006

