

New perspectives on pain management, including the roles of opioids and medical cannabis

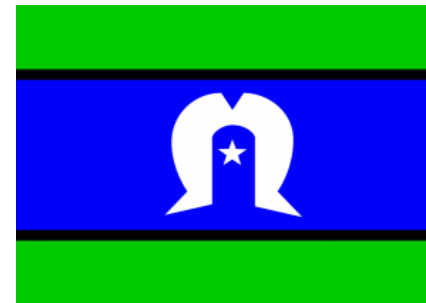
Thursday 31 August 2023

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



Housekeeping – Zoom Meeting

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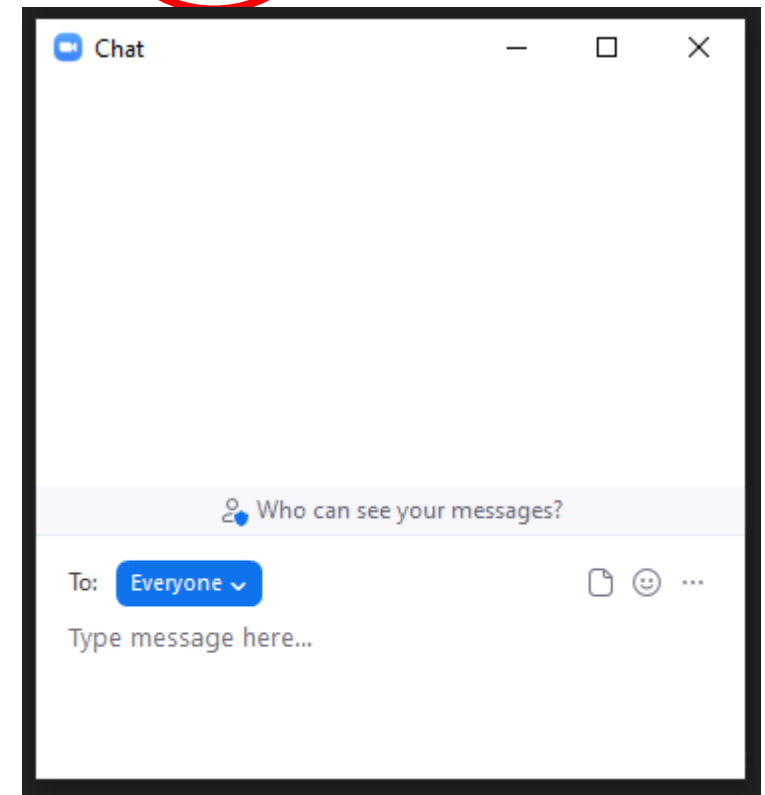
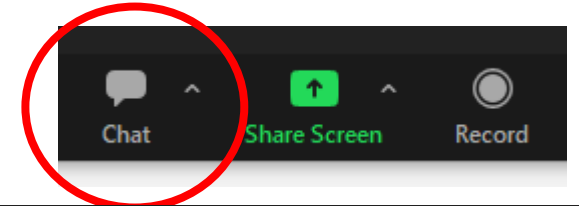
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Please ask questions via the Chat box

This session is being recorded

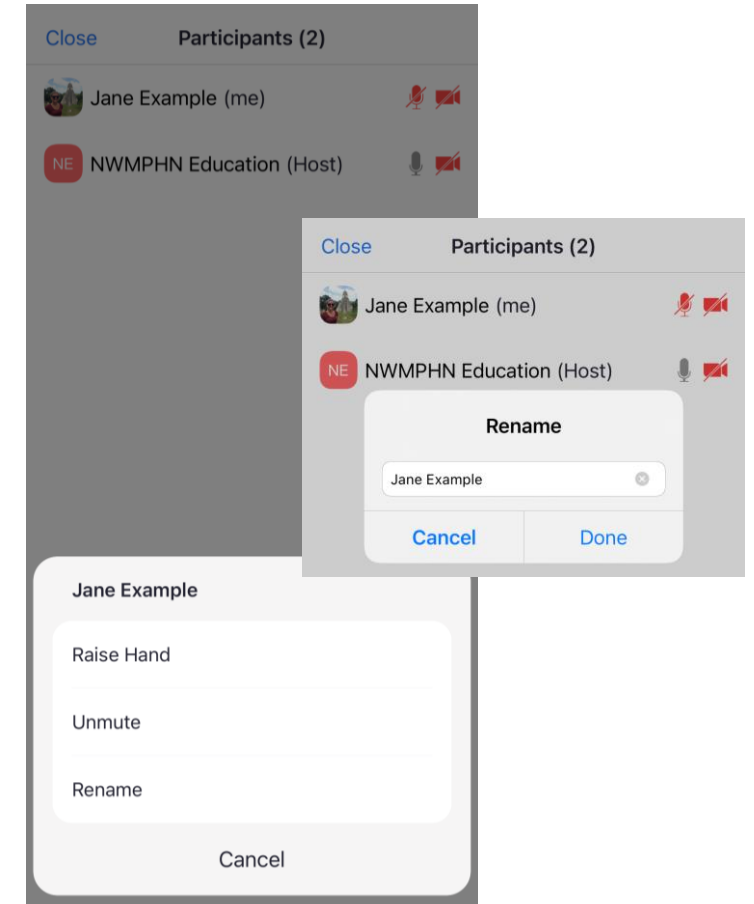
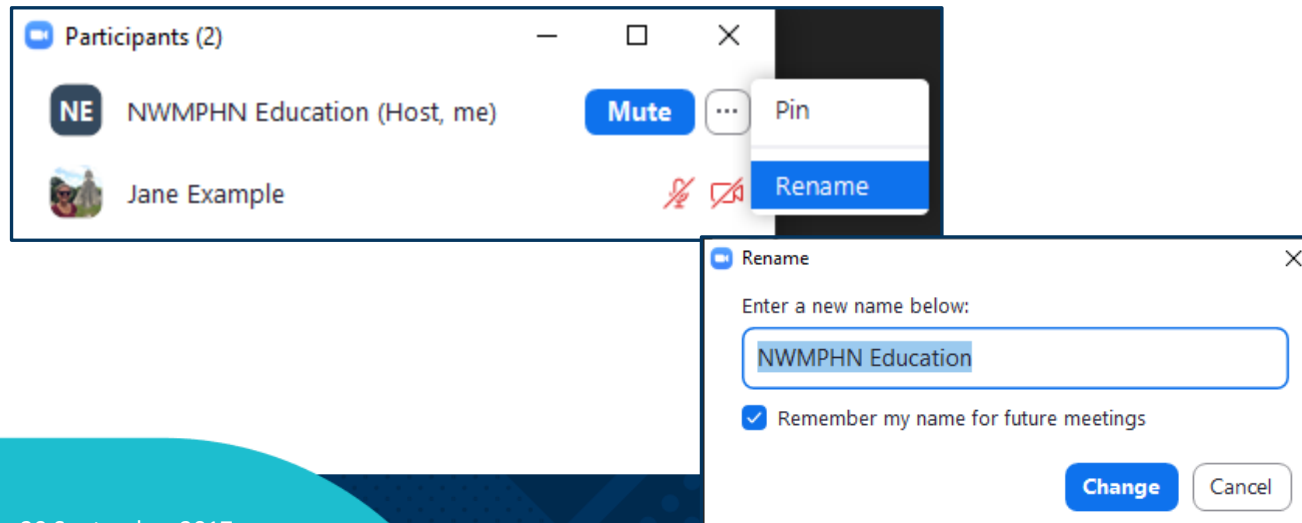
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How to change your name in Zoom Meeting

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Desktop: hover over your name and click the 3 dots
Mac: hover over your name and click *More*
3. Click on **Rename**
4. Enter the name you registered with and click
Done / Change / Rename



Speakers

Associate Professor Dr Malcolm Hogg, Staff Specialist, Anaesthesia and Pain Management, *Royal Melbourne Hospital*, Head of Pain Services, *Melbourne Health* & Clinical Associate Professor, *University of Melbourne*.

Nicole Moore - Senior Pain Physiotherapist and Project Lead, *Merri Health*, Lecturer, Doctor of Physiotherapy, *University of Melbourne* & Director, *mindfulBeing Melbourne*.



COMMON
BELIFS BUSTED

WATCH
YOUR
BACK!

Nicole Moore
Pain Physiotherapist (APA, MACP)
Merri Community Health Centre
nicole.moore@merrihealth.org.au





ROADMAP

- What have we been doing to manage low back pain (LBP)...
- ... and what have we got?
- Common societal beliefs about LBP put into question
- Considerations for high value LBP care

PAINFUL BACK-FACTS

- Australian population prevalence:
 - accounts for 1 / 6 (4 million Aussies)
 - over-represented in people with low economic status
 - the second most common reason people go to their GP
 - one of the top 5 reasons people present to the ED



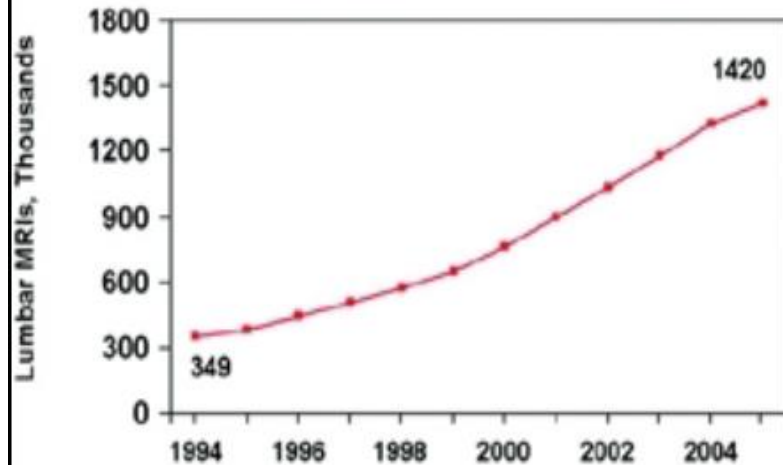
(O'Sullivan et al BMC Pub Hlth 2011; Stanton et al. Spine (Phila Pa 1976). 2008;33:2923-8)

**WHAT HAVE WE BEEN DOING
TO MANAGE LBP?...**

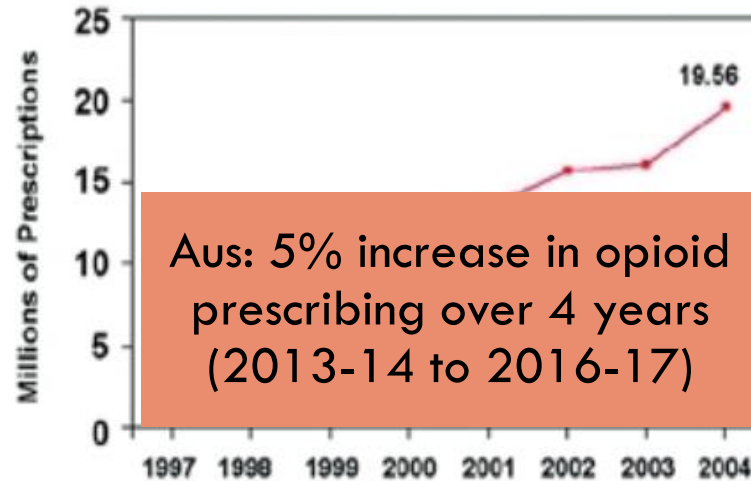


MEDICALISED MANAGEMENT

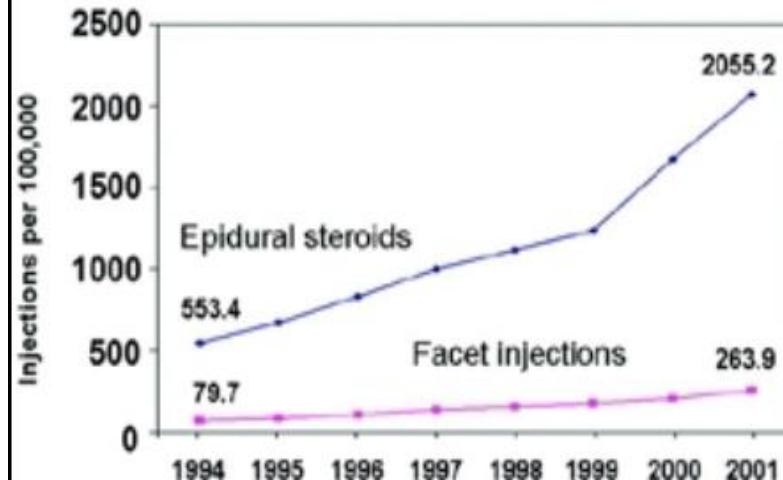
a Lumbar spine MR imaging, Medicare



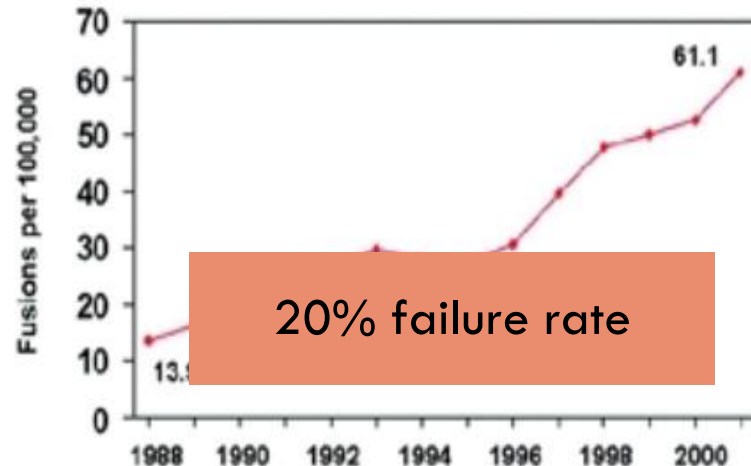
b Opioid analgesic prescriptions for spine problems



c Lumbosacral injection rates, Medicare



d Lumbar fusion rates, degenerative spine conditions



- 👉 MRI's 300%
- 👉 Procedures 130-700%
- 👉 Surgeries 300%
- 👉 Opioids 690+%

- Friedly, J., Standaert, C., & Chan, L. (2010). Epidemiology of spine care: the back pain dilemma. *Physical Medicine and Rehabilitation Clinics*
- Mafi, J. N., McCarthy, E. P., Davis, R. B., & Landon, B. E. (2013). Worsening trends in the management and treatment of back pain. *JAMA internal medicine*
- Atluri, S., Sudarshan, G., & Manchikanti, L. (2014). Assessment of the trends in medical use and misuse of opioid analgesics from 2004 to 2011. *Pain physician*
- Sehgal, N., Colson, J., & Smith, H. S. (2013). Chronic pain treatment with opioid analgesics: benefits versus harms of long-term therapy. *Expert Review of Neurotherapeutics*

VARIATION IN CARE OF LBP BETWEEN AUSTRALIAN LGA'S

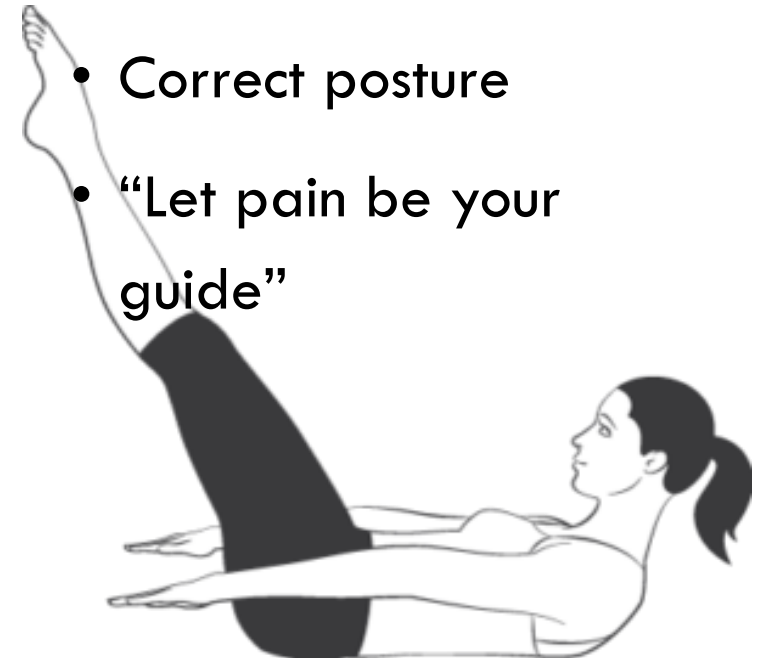
**11.8% variation
in CT imaging
for lumbar spine**


**4.8% variation
in lumbar spine
surgery
admissions**



MESSAGING

- Protect
- Avoid
- Stabilize
- Correct lifting
- Correct posture
- “Let pain be your guide”





**IN 2018–19, MORE MONEY
WAS SPENT ON MANAGING
MUSCULOSKELETAL
DISORDERS, INCLUDING
BACK PROBLEMS, THAN ANY
OTHER CATEGORY OF
DISEASE, CONDITION OR
INJURY IN AUSTRALIA**

Australian Bureau of Statistics (ABS) 2017–18 National Health Survey (NHS); Australian Institute of Health and Welfare. Disease expenditure in Australia 2018-19. Canberra: AIHW; 2021; GP ref - Britt et al. 2016 General practice activity in Australia 2015–16; Australian Institute of Health and Welfare. Australian hospital statistics: emergency department care 2020–21.

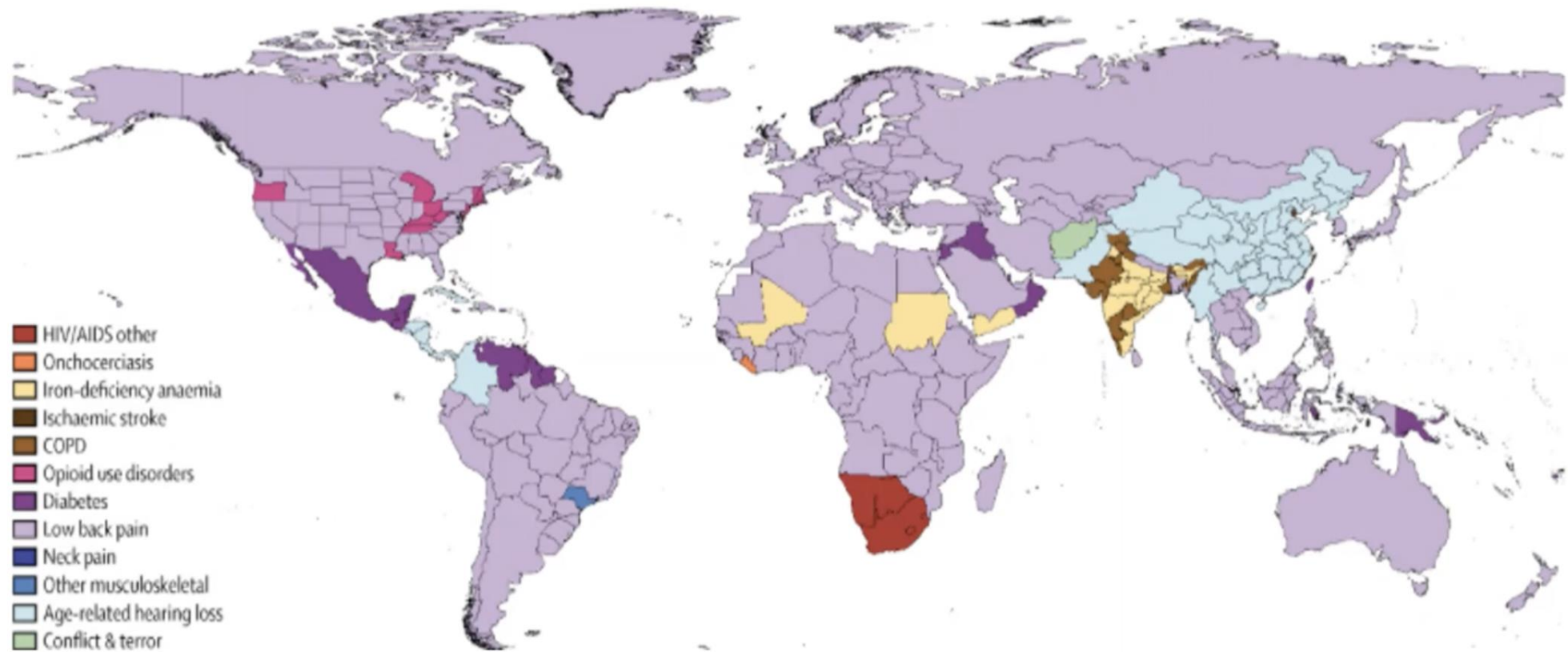


.. AND WHAT HAVE WE GOT?

COST/BENEFIT

Photograph taken by Aarón Blanco Tejedor; Street art in Utö, Finland

LBP - LEADING CAUSE OF DISABILITY WORLDWIDE (AND INCREASING)



Vos T et al, . Lancet 2017;390:1211–1259 Schofield DJ et al, Spine 2012;37:1156–63 Schofield DJ et al, Med J Aust 2015;203:e26-6.

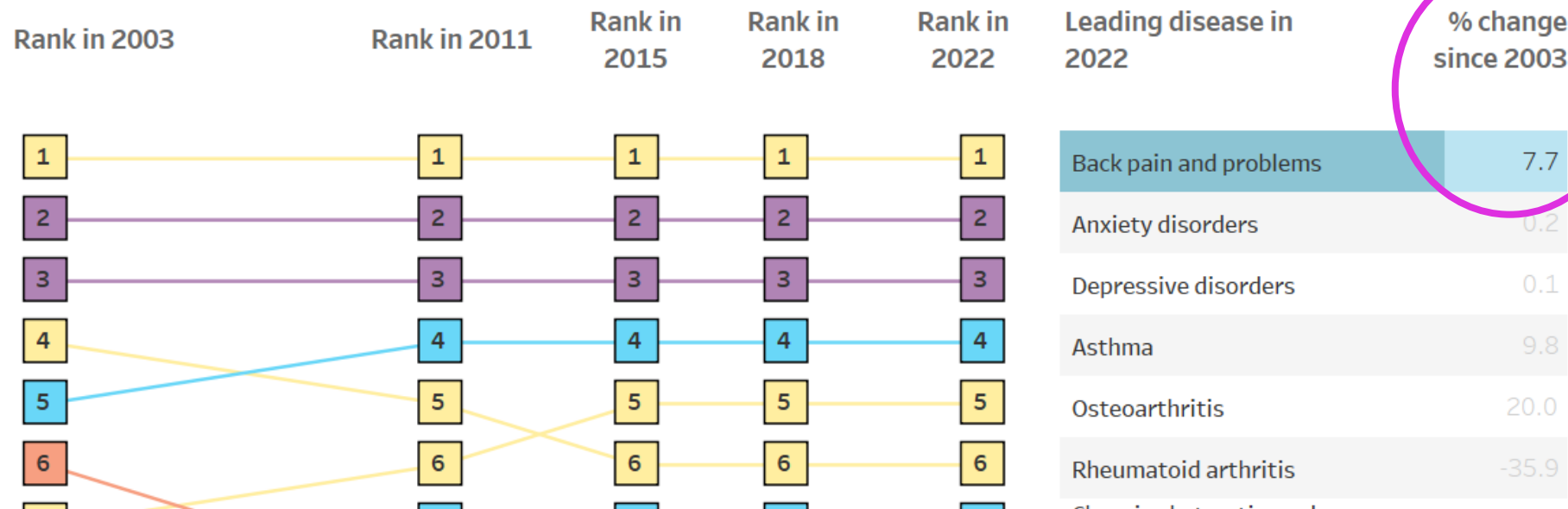
GBD Disease & Injury Incidence & Prevalence 2019 *Lancet*

AU BURDEN OF DISEASE STUDY

Ranking by age-standardised YLD rate: Persons

Disease groups

Cardiovascular diseases	Injury (external cause)	Oral disorders
Endocrine disorders	Mental and substance use disorder	Reproductive and maternal conditions
Hearing and vision disorders	Musculoskeletal disorders	Respiratory diseases
Infectious diseases	Neurological conditions	Skin disorders



THE 2018 LANCET LOW BACK PAIN SERIES

Low back pain 1

What low back pain is and why we need to pay attention

Jan Hartvigsen, Mark J Hancock*, Alice Kongsted, Quinette Louw, Manuela L Ferreira, Stéphane Genevay, Damian Hoy, Jaro Karppinen, Glenn Pransky, Joachim Sieper, Rob J Smeets, Martin Underwood, on behalf of the Lancet Low Back Pain Series Working Group†*

- 3 papers
- 31 authors from disparate disciplines
- 12 different countries

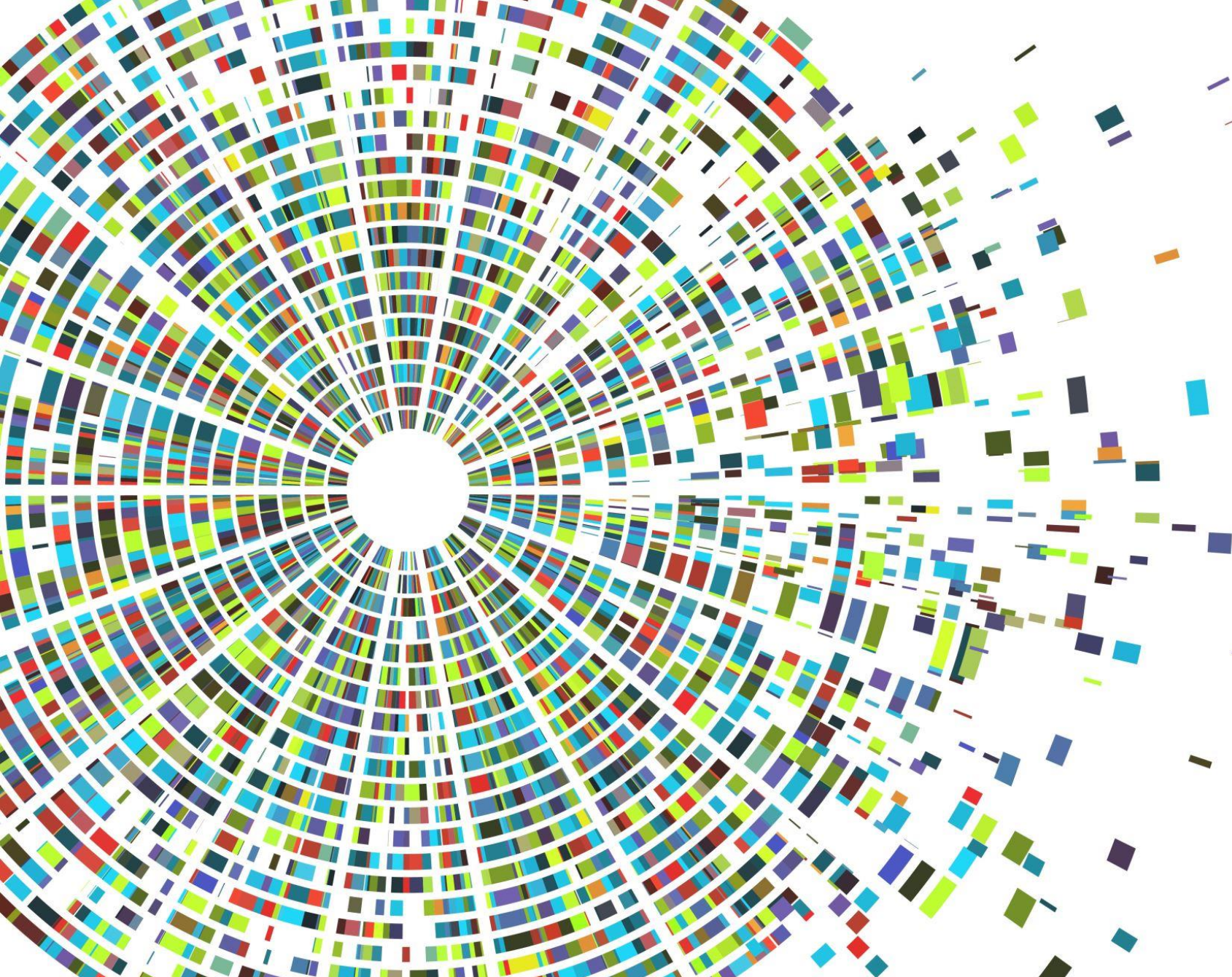
Low back pain 2

Prevention and treatment of low back pain: evidence, challenges, and promising directions

*Nadine E Foster, Johannes R Anema, Dan Cherkin, Roger Chou, Steven P Cohen, Douglas P Gross, Paulo H Ferreira, Julie M Fritz, Bart W Koes, Wilco Peul, Judith A Turner, Chris G Maher, on behalf of the Lancet Low Back Pain Series Working Group**

Low back pain: a call for action

*Rachelle Buchbinder, Maurits van Tulder, Birgitta Öberg, Lucíola Menezes Costa, Anthony Woolf, Mark Schoene, Peter Croft, on behalf of the Lancet Low Back Pain Series Working Group**



2022 AUSTRALIAN BACK PAIN CLINICAL CARE STANDARDS

Low Back Pain Clinical Care
Standard, Aust. Commission on
Safety & Quality in Healthcare,
Sept. 2022.

Peter O'sullivan
Michael Nicholas
Ass Prof Liz Mar
Dr. James Edward

Hopelessness

Confusion

Abuse



PTSD

HOW?

DO YOU UNDERSTAND WHAT
YOU ARE TREATING?

Anger

FEAR

PAIN

ACEs

are

ADVERSE CHILDHOOD EXPERIENCES

ABUSE



Physical



Emotional



Sexual

NEGLECT



Physical



Emotional

HOUSEHOLD DYSFUNCTION



Mental Illness



Mother treated violently



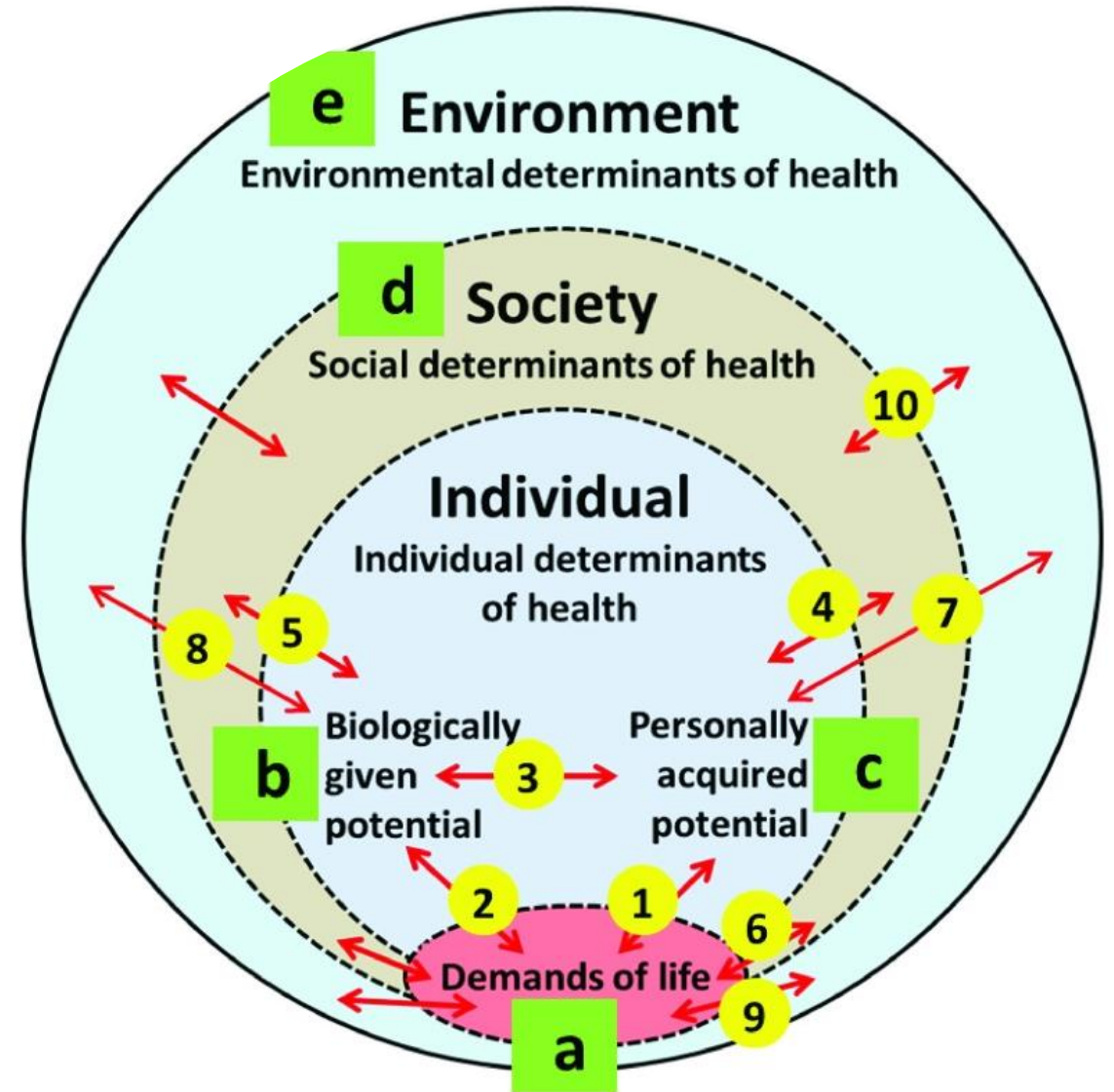
Divorce



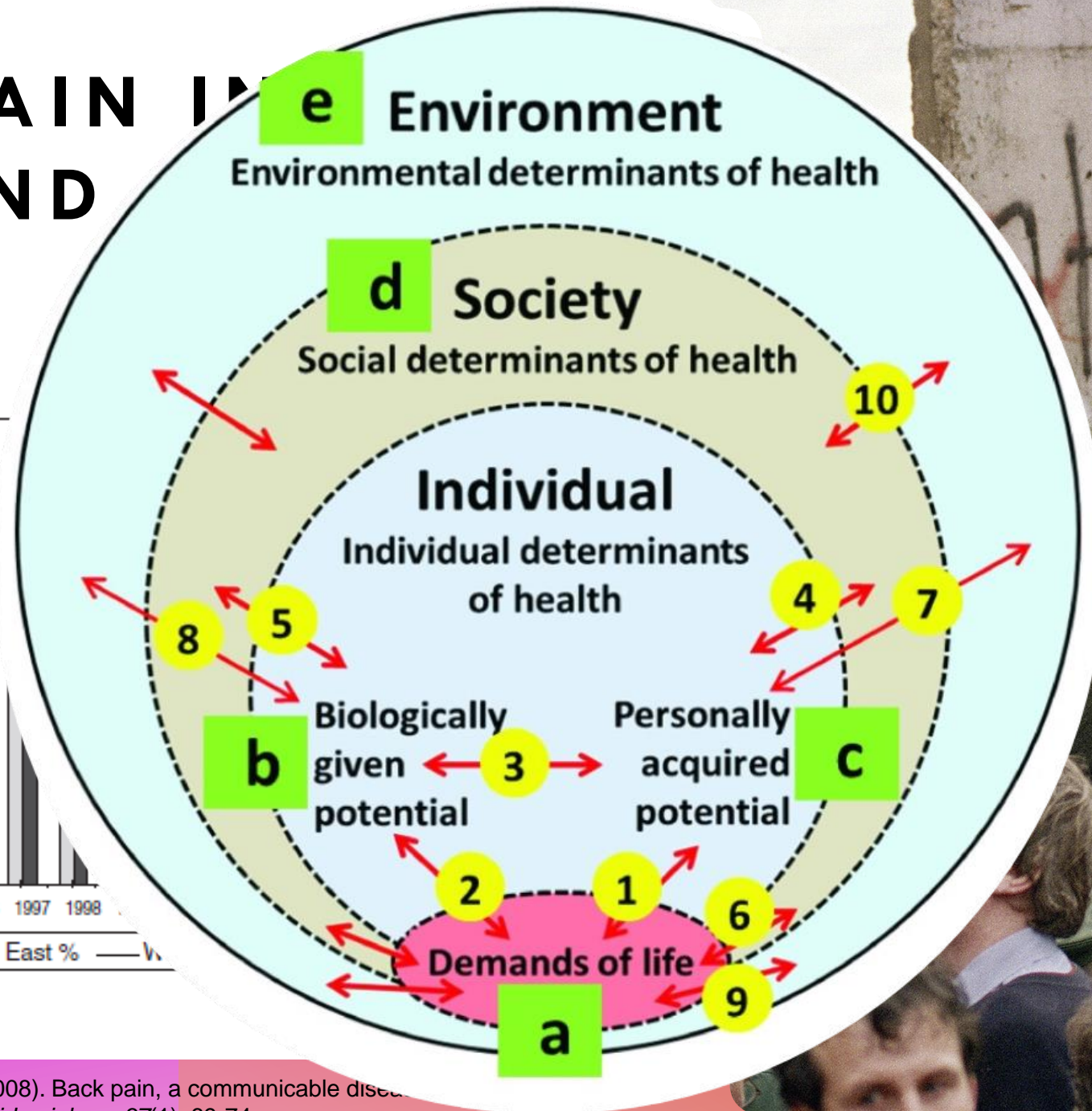
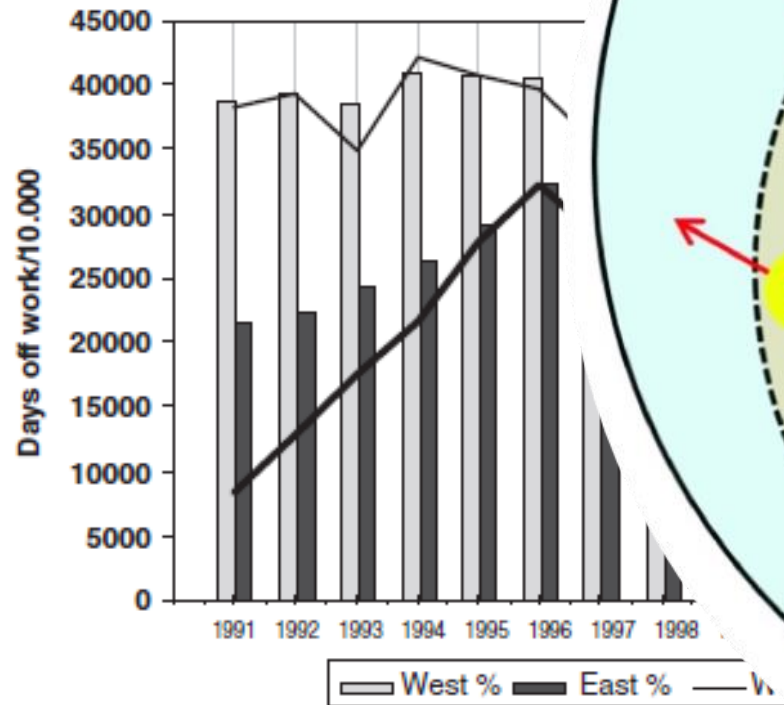
Incarcerated Relative



Substance Abuse



BACK PAIN IN EAST AND BERLIN



BACK FACTS

[Peter O'Sullivan PT](#)
[JP Caneiro](#)
[Kieran O'Sullivan](#)
[Bunzli S](#)
[KWernliPhysio](#)
[Mary O'Keeffe OOT](#)

1. Persistent back pain can be scary, but it's rarely dangerous

Persistent back pain can be distressing and disabling, but it's rarely life-threatening and you are very unlikely to end up in a wheelchair.



2. Getting older is not a cause of back pain

Although it is a widespread belief and concern that getting older causes or worsens back pain, research does not support this, and evidence-based treatments can help at any age.

3. Persistent back pain is rarely associated with serious tissue damage

Backs are strong. If you have had an injury, tissue healing occurs within three months, so if pain persists past this time, it usually means there are other contributing factors. A lot of back pain begins with no injury or with simple, everyday movement. These occasions may relate to stress, tension, fatigue, inactivity or unaccustomed activity which make the back sensitive to movement and loading.



4. Scans rarely show the cause of back pain

Scans are only helpful in a minority of people. Lots of scary-sounding things can be reported on scans such as disc bulges, degeneration, protrusions, arthritis, etc. Unfortunately, the reports don't say that these findings are very common in people without back pain and that they don't predict how much pain you feel or how disabled you are. Scans can also change, and most disc prolapses shrink over time.



5. Pain with exercise and movement doesn't mean you are doing harm

When pain persists, it is common that the spine and surrounding muscles become really sensitive to touch and movement. The pain you feel during movement and activities reflects how sensitive your structures are – not how damaged you are. So it's safe and normal to feel some pain when you start to move and exercise. This usually settles down with time as you get more active. In fact, exercise and movement are one of the most effective ways to help treat back pain.

6. Back pain is not caused by poor posture

How we sit, stand and bend does not cause back pain even though these activities may be painful. A variety of postures are healthy for the back. It is safe to relax during everyday tasks such as sitting, bending and lifting with a round back – in fact, it's more efficient!



7. Back pain is not caused by a 'weak core'

Weak 'core' muscles do not cause back pain, in fact people with back pain often tense their 'core' muscles as a protective response. This is like clenching your fist after you've sprained your wrist. Being strong is important when you need the muscles to switch on, but being tense all the time isn't helpful. Learning to relax the 'core' muscles during everyday tasks can be helpful.

8. Backs do not wear out with everyday loading and bending

The same way lifting weights makes muscles stronger, moving and loading make the back stronger and healthier. So activities, like running, twisting, bending and lifting, are safe if you start gradually and practice regularly.



9. Pain flare-ups don't mean you are damaging yourself

While pain flare-ups can be very painful and scary, they are not usually related to tissue damage. The common triggers are things like poor sleep, stress, tension, worries, low mood, inactivity or unaccustomed activity. Controlling these factors can help prevent exacerbations, and if you have a pain flare-up, instead of treating it like an injury, try to stay calm, relax and keep moving!



10. Injections, surgery and strong drugs usually aren't a cure

Spine injections, surgery and strong drugs like opioids aren't very effective for persistent back pain in the long term. They come with risks and can have unhelpful side effects. Finding low-risk ways to put you in control of your pain is the key.



This infographic is a summary only. Please consult the full text for clarification and supporting references.

O'Sullivan P, Caneiro JP, O'Sullivan K, Lin I, Bunzli S, Wernli K, O'Keeffe M. Back to Basics: 10 facts about low back pain. BJSM. 2019.

Chronic non-specific low back pain (CNSLBP)

Editorial

Back to basics: 10 facts every person should know about back pain

Peter B O'Sullivan ^{1,2}, JP Caneiro ^{1,2}, Kieran O'Sullivan ^{3,4},
Ivan Lin ⁵, Samantha Bunzli ⁶, Kevin Wernli ⁶, ^{1,2} Mary O'Keeffe ⁷

- Fact 1: LBP is not a serious life-threatening medical condition.
- Fact 2: Most episodes of LBP improve and LBP does not get worse as we age.
- Fact 3: A negative mindset, fear-avoidance behaviour, negative recovery expectations, and poor pain coping behaviours are more strongly associated with persistent pain than is tissue damage.

WHAT I HEAR PEOPLE SAY...

1. “I keep reinjuring myself”
2. “I’m getting old”
3. “I have terrible posture”
4. “I *have* been bending properly!”
5. “I’ve got a labourers back”
6. “I tried exercise and it didn’t work”

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BELIEF 1: BACK PAIN IS CAUSED BY INJURY/DAMAGE

- ‘Pathology’ is very common in people *without* pain
 - Nevertheless, in people younger than 50 years, some MRI abnormalities are more common in those *with* LBP than without: Modic type 1 change (OR 4) Disc bulge (OR 7.5), disc extrusion (OR 4.4), spondylolysis (OR 5) (Brinjikji et al, 2015)
 - Disk herniations are more common in people with radicular pain yet the importance of disc herniations diminishes over time
- Symptom severity does not directly correlate with pathology
- Degree of pathology does not predict future pain or disability
- 30% of individuals who have surgery to ‘fix’ what is seen in a scan don’t do well

WE ALSO KNOW THAT...

- “*What triggered your back pain*”? - 1/3 of people can't recall a mechanical trigger
- Acute LBP linked to periods of high emotional distress linked with somewhat minor, insignificant mechanical stress
- The strongest predictors of a flare-up: (Suri, P., et al. SPINE, 2018)
 - Inactivity
 - stress
 - depression

Pain flares are not just about the 'bio'...

PAIN FLARE

“Out of the blue. I cant think of what I have *done* differently”

Poor night
sleep

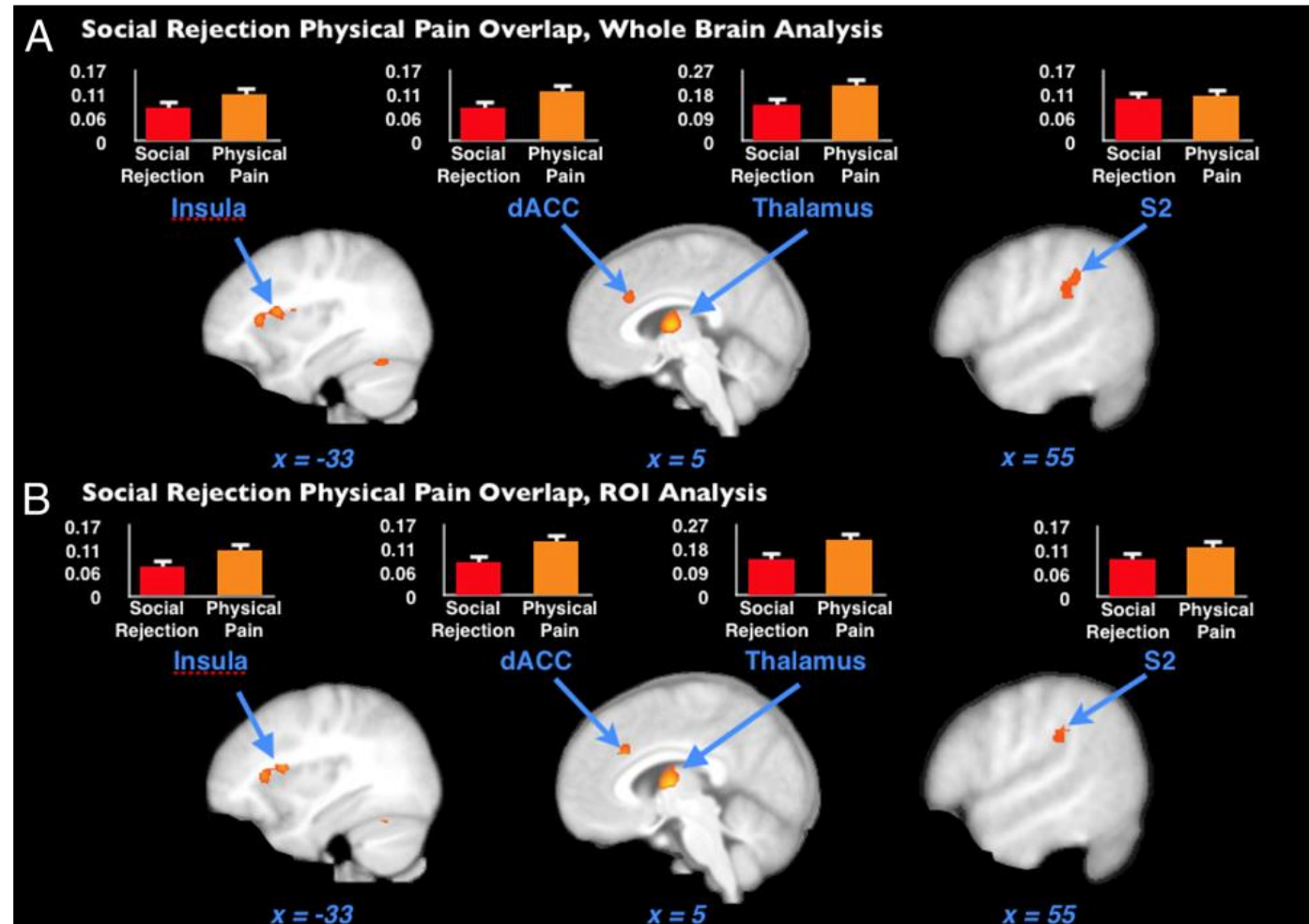
Reduced
exercise
lately

Challenging
phone call to
sister in the UK

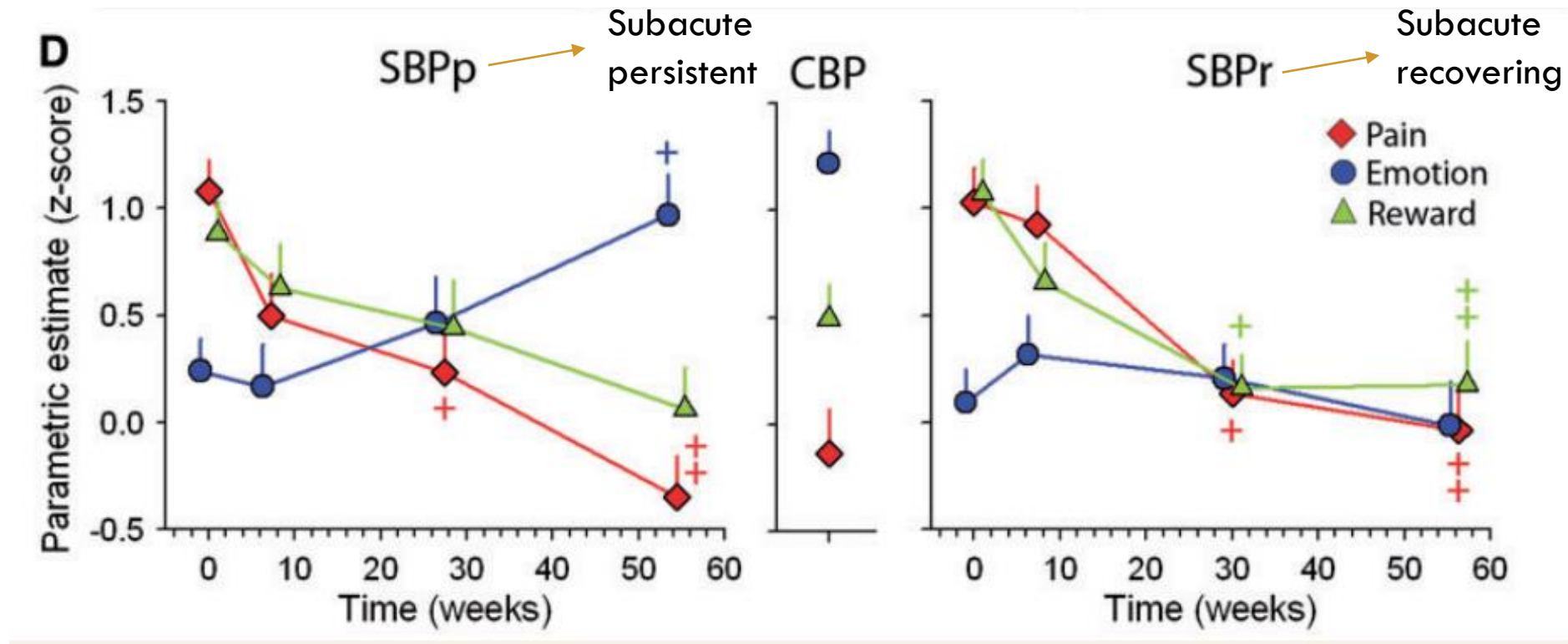
... but
“*how have you
been feeling*”?

Learned news
about other
sister, from
another sister.
Jackpot!!

EMOTIONAL PAIN = PHYSICAL PAIN



ACUTE TO CHRONIC LBP SHIFTS IN BRAIN REGIONS DOMINATED BY SOMATOSENSORY AREAS TOWARD LEARNING, MEANING AND EMOTIONAL AREAS

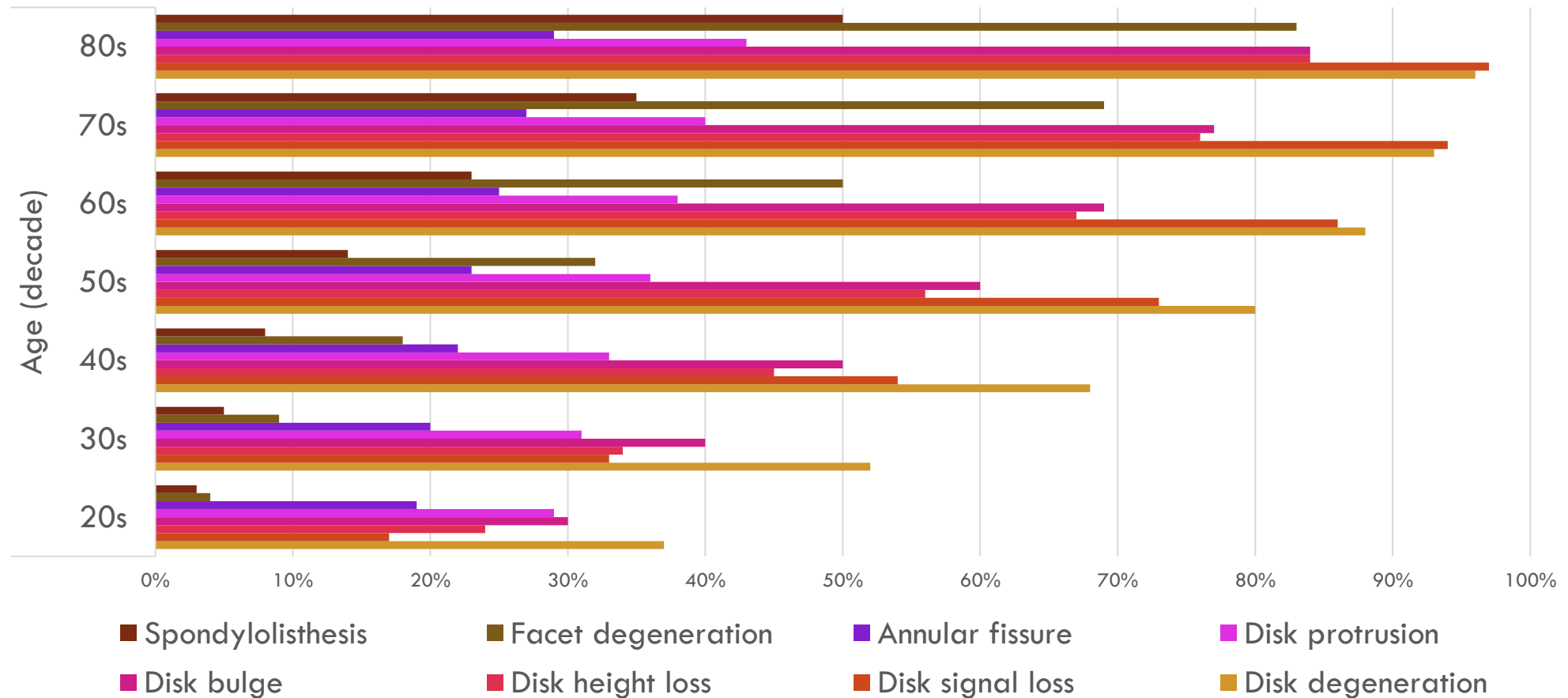


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BELIEF 2: DO BACKS GET WORSE WITH AGE?

Age-specific prevalence estimates of degenerative spine imaging findings
in **asymptomatic** individuals



DO BACKS GET WORSE WITH AGE?

Rev Saúde Pública 2015;49:73

Facts:

- 2015 systematic review demonstrates back pain peaks between 40's – 60's and then tapers off
- LBP can be effectively managed at any age

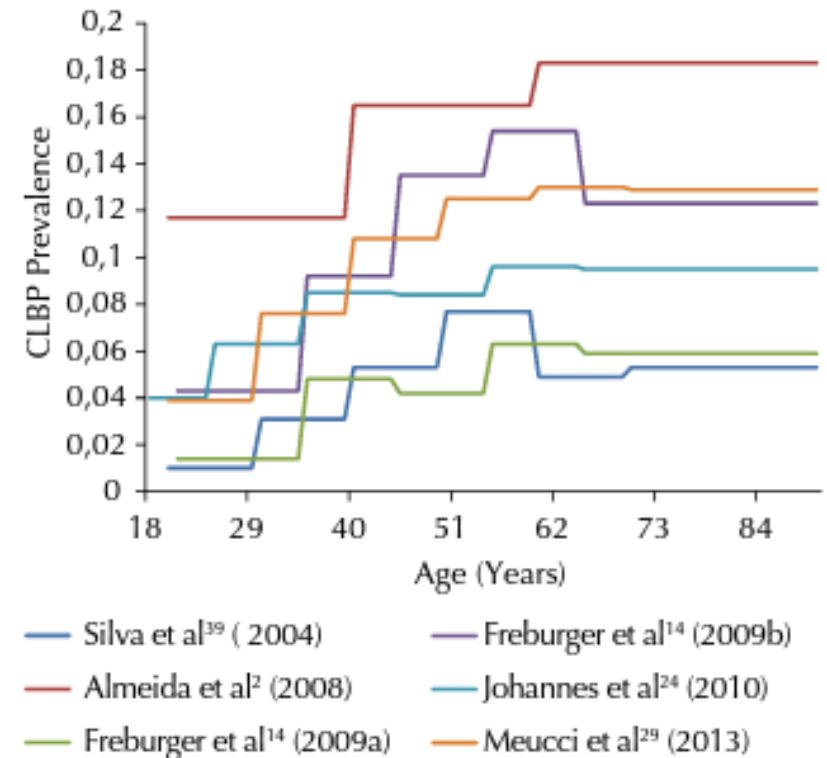


Figure 2. Chronic low back pain prevalence (CLBP) according to age (six estimates).

Table 4. Odds Ratios for Chronic Back Pain in 2013/14 Relative to 2001/02

<i>SUBGROUP</i>		<i>P-VALUE</i>
11-year-olds		
Girls	1.10 (1.05-1.16)	<.001
Boys	1.07 (1.01-1.12)	0.014
13-year-olds		
Girls	1.29 (1.24-1.34)	<.001
Boys	1.10 (1.05-1.15)	<.001
15-year-olds		
Girls	1.44 (1.38-1.49)	<.001
Boys	1.19 (1.14-1.24)	<.001

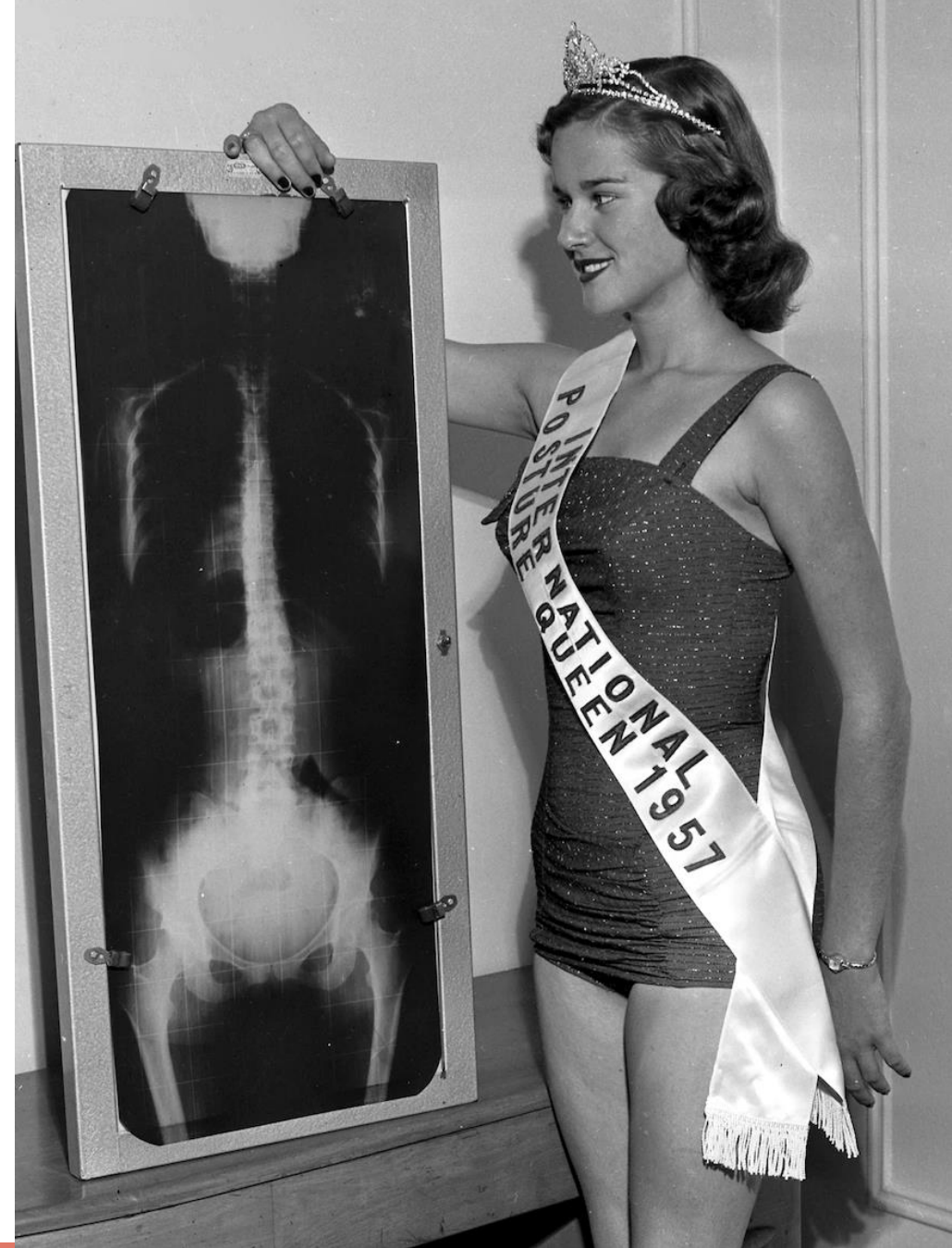
Abbreviations: CI, confidence interval; OR, odds ratio.

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BELIEF 3: LBP, CAUSED BY 'POOR POSTURE'?

- Little-no evidence for:
 - preventative benefit from: shoe insoles, back belts, ergonomic furniture (Steffens D, et al. systematic r/v. JAMA Intern Med 2016)
 - the way we sit or stand
 - poor alignment
 - trunk, pelvic and spinal asymmetries or scoliosis
 - leg length difference
- as a cause for LBP



FACTS

People in pain are more tense, stiff, hold more upright postures, are more guarded and rigid and protective!

(Smith et al. JOSPT 2017)

People with back pain move slower, have reduced range of movement and don't relax

(Laird et al BMC MS 2014)

Getting a variety of *“movement nutrients”* may be the key

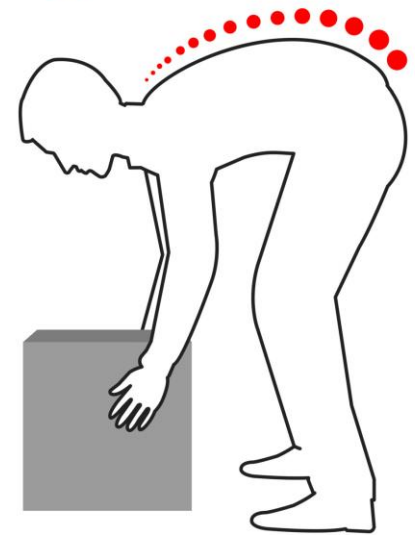
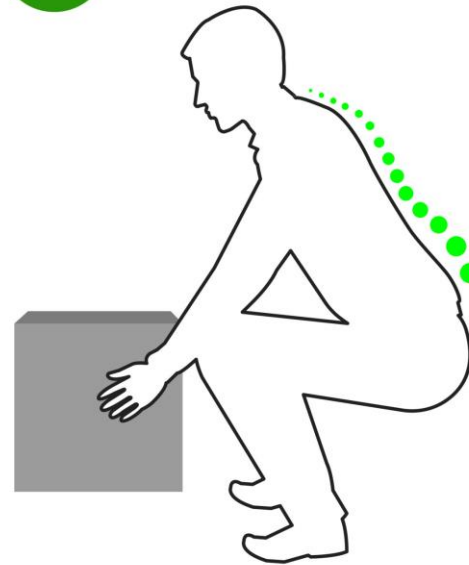
Spine posture during sitting, standing and lifting does not predict LBP or its persistence

(Abenhaim et al., 2000)

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BELIEF 4: IT DANGEROUS TO BEND WITH A FLEXED SPINE?



People with disabling LBP bend less
(Nolan et al SJP 2019)

[LITERATURE REVIEW]

NIC SARACENI, PT¹ • PETER KENT, PhD^{1,2} • LEO NG, PhD¹
AMITY CAMPBELL, PhD¹ • LEON STRAKER, PhD¹ • PETER O'SULLIVAN, PhD^{1,3}

Saved to W: Drive

To Flex or Not to Flex? Is There a Relationship Between Lumbar Spine Flexion During Lifting and Low Back Pain? A Systematic Review With Meta-analysis

“There is no credible in vivo evidence to support the dogma that lumbar spine flexion should be minimized when lifting to prevent LBP onset, persistence or recurrence”

Effect of training and lifting equipment for preventing back pain in lifting and handling: systematic review

Kari-Pekka Martimo, medical specialist,¹ Jos Verbeek, team leader,² Jaro Karppinen, medical specialist,³ Andrea D Furlan, associate scientist,⁴ Esa-Pekka Takala, medical specialist,¹ P Paul F M Kuijer, senior researcher,⁵ Merja Jauhiainen, information specialist,⁶ Eira Viikari-Juntura, research professor¹

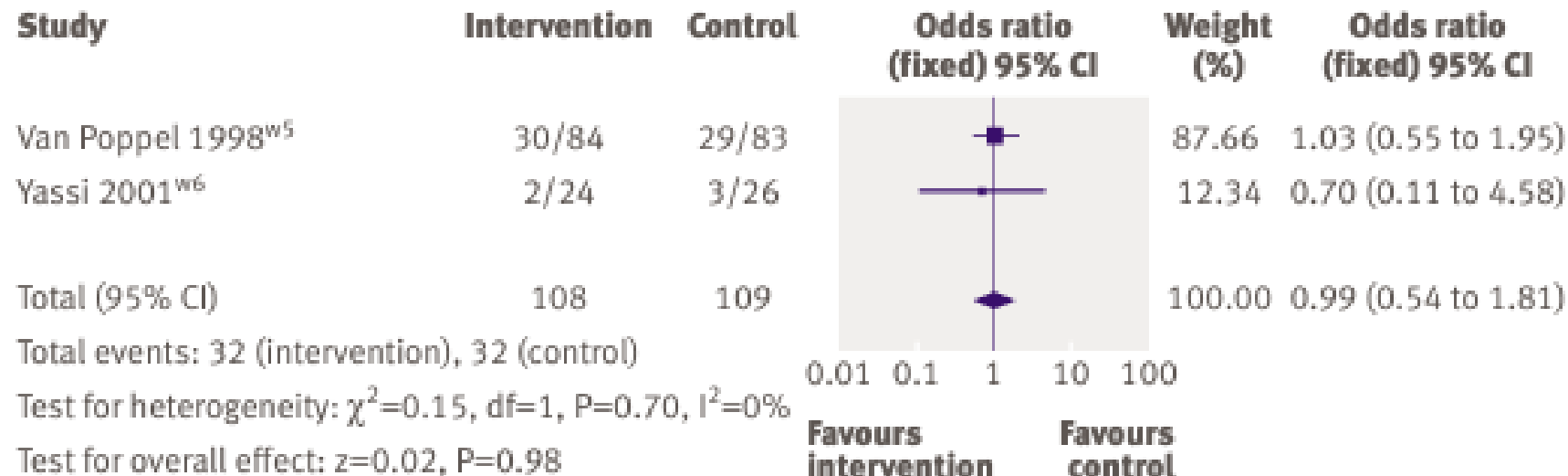


Fig 2 Meta-analyses of two trials (adjusted for effect of clustering) on advice on lifting and handling compared with no advice in prevention of back pain or back injury at intermediate follow-up

PAIN-FREE BIOMECHANICAL STUDIES

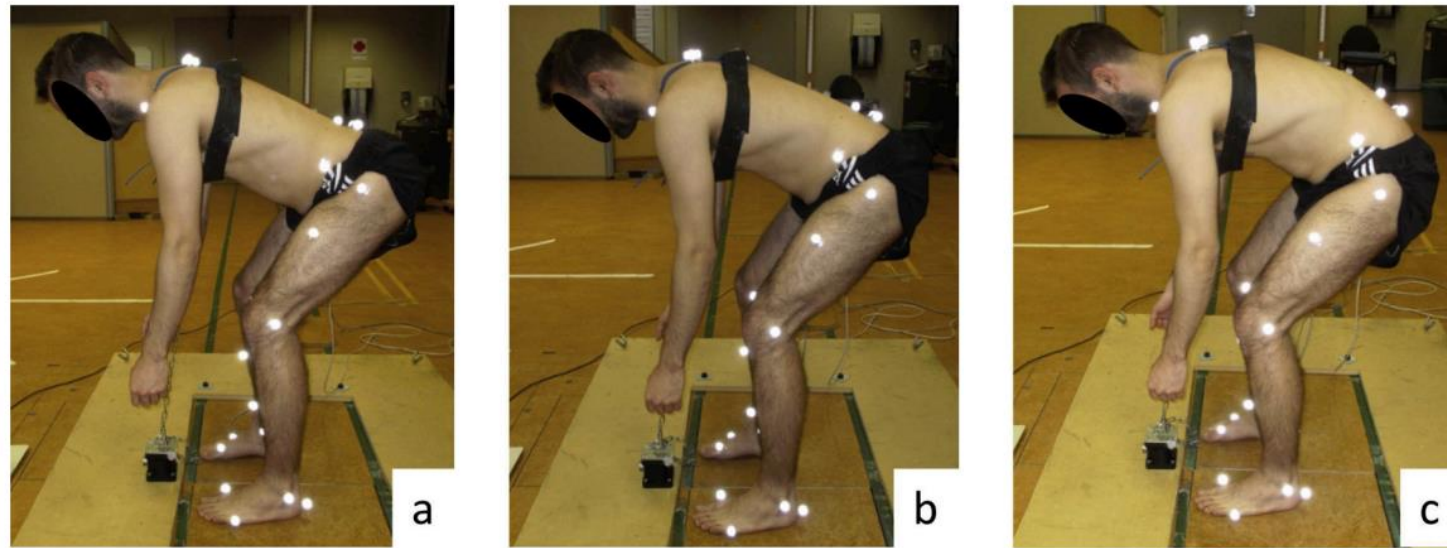


Fig. 1. The three lumbar postures adopted by participants: a) extended; b) mid-range; and c) flexed.

- Do not support an increase in disc pressure, compression or shear strain when lifting with a flexed versus a straight spine
- Lifting with a lordotic posture (a) resulted in **reduced** neuromuscular efficiency
- Lifting with a **flexed** spine (c) significantly improved overall strength and neuromuscular efficiency when lifting

EDDIE HALL DEADLIFT WORLD RECORD 500KG (2016)



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6. “I tried exercise and it didn’t work”

BELIEF 5: REPEATED SPINAL LOADING CAUSES PERSISTING BACK PAIN

“I have a ...”

...nurses back

...runners back

...labourers back

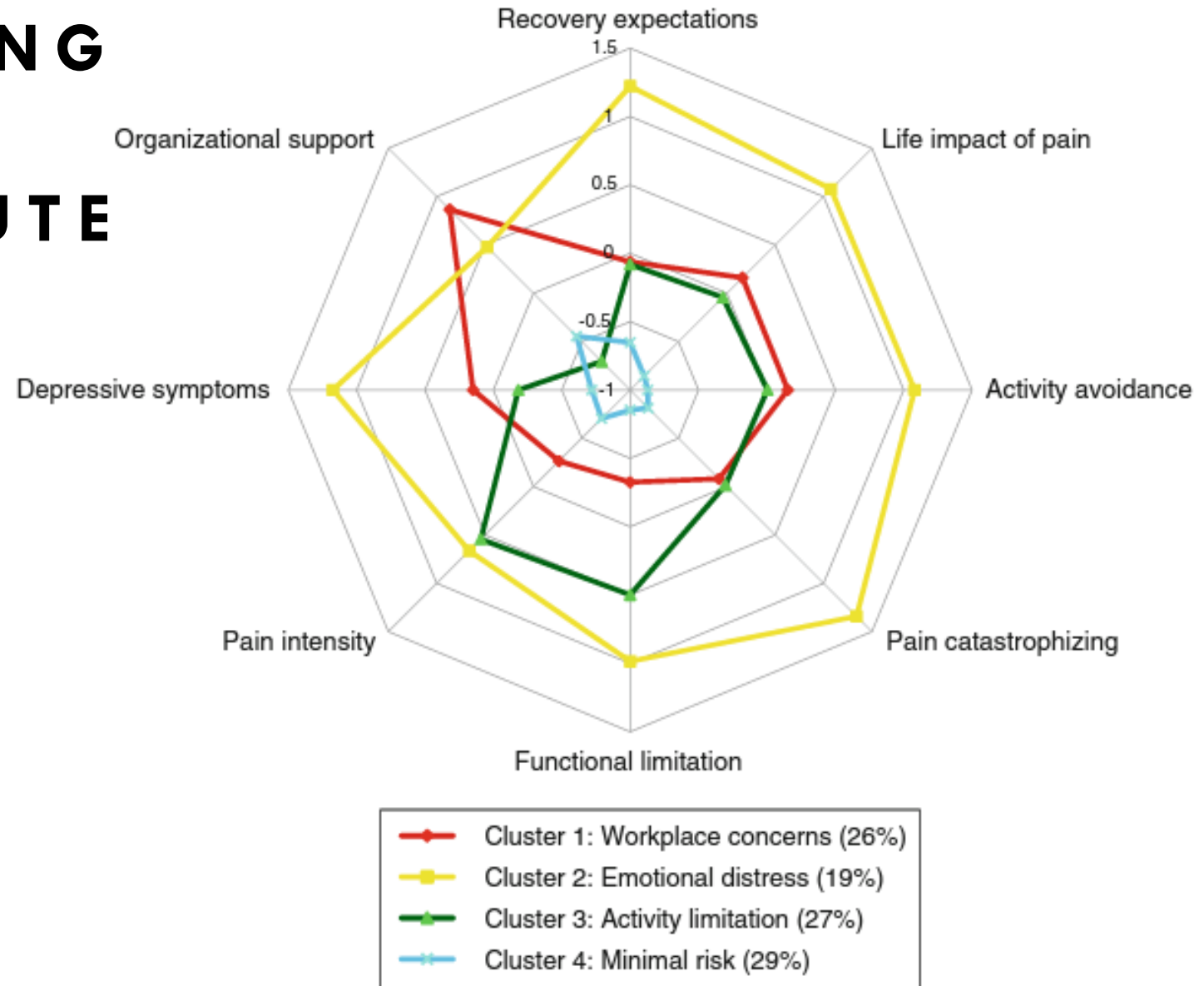
...farmers back

“Psychological stress and mental processing during lifting resulted in an increase in spinal compression associated with increases in trunk muscle co-contraction and less controlled movements”

(Davis et al., 2002)

INDIVIDUALS SEEKING TREATMENT FOR WORK-RELATED ACUTE LBP

- 1,225 participants who completed a screening questionnaire and were followed up at 3 months
- Revealed 8 measures with significant associations with functional recovery and return-to-work.



FACTS

Spine loading
does not predict
MRI findings

(Battiè et al Spine 2009)

Backs get
stronger with
graded
movement &
loading

(Belavy et al Scientific
Reports 2017)

The use of
degenerative
language such as
wear and tear with
OA patients is
associated with
passive behaviours
and a poor
perceived prognosis

(Darlow, B et al 2018)

Long distance
runners and
joggers have
improved IVD
composition than
non-athletic
individuals

(Belavy et al. 2017)

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BELIEF 6:
IT IS NOT
SAFE TO
EXERCISE IF
PAIN
INCREASES



FACTS

Review



OPEN ACCESS

Should exercises be painful in the management of chronic musculoskeletal pain? A systematic review and meta-analysis

Benjamin E Smith,^{1,2} Paul Hendrick,³ Toby O Smith,⁴ Marcus Bateman,¹ Fiona Moffatt,³ Michael S Rathleff,^{5,6} James Selfe,⁷ Pip Logan²

Regular exercise
can reduce central
facilitation of pain

(Lima et al, 2017)

When we restrict
people from their
usual activity and
exercise, they
become more
anxious, tired,
depressed and have
increased pain

(Smith et al. BJSM 2017)

Increased pain is
to be expected
with exercise.
Learn to exercise
with pain and
avoid *pushing*
through pain

Painful exercises
offered a small
but significant
benefit over pain-
free exercises in
the short-term

(Smith et al. Systematic
Review, BJSM 2017)

WHAT'S THE *RIGHT* TYPE OF EXERCISE?

▶ Walking

“Low quality evidence that walking is as effective as other non pharmacological management methods for NSCLBP. Lawford et al, Clin Rehabil 2015

▶ Pilates

“Some evidence for the effectiveness of Pilates... no conclusive evidence that it is superior to other forms of exercise. The decision to use Pilates may be based on the patient's preference and costs” (Yamato et al, Cochrane 2015)

▶ Core Stability

“Strong evidence that stabilisation exercises are **not** more effective than other forms of active exercise in the long-term” Smith et al, BMC Musc Disord 2015

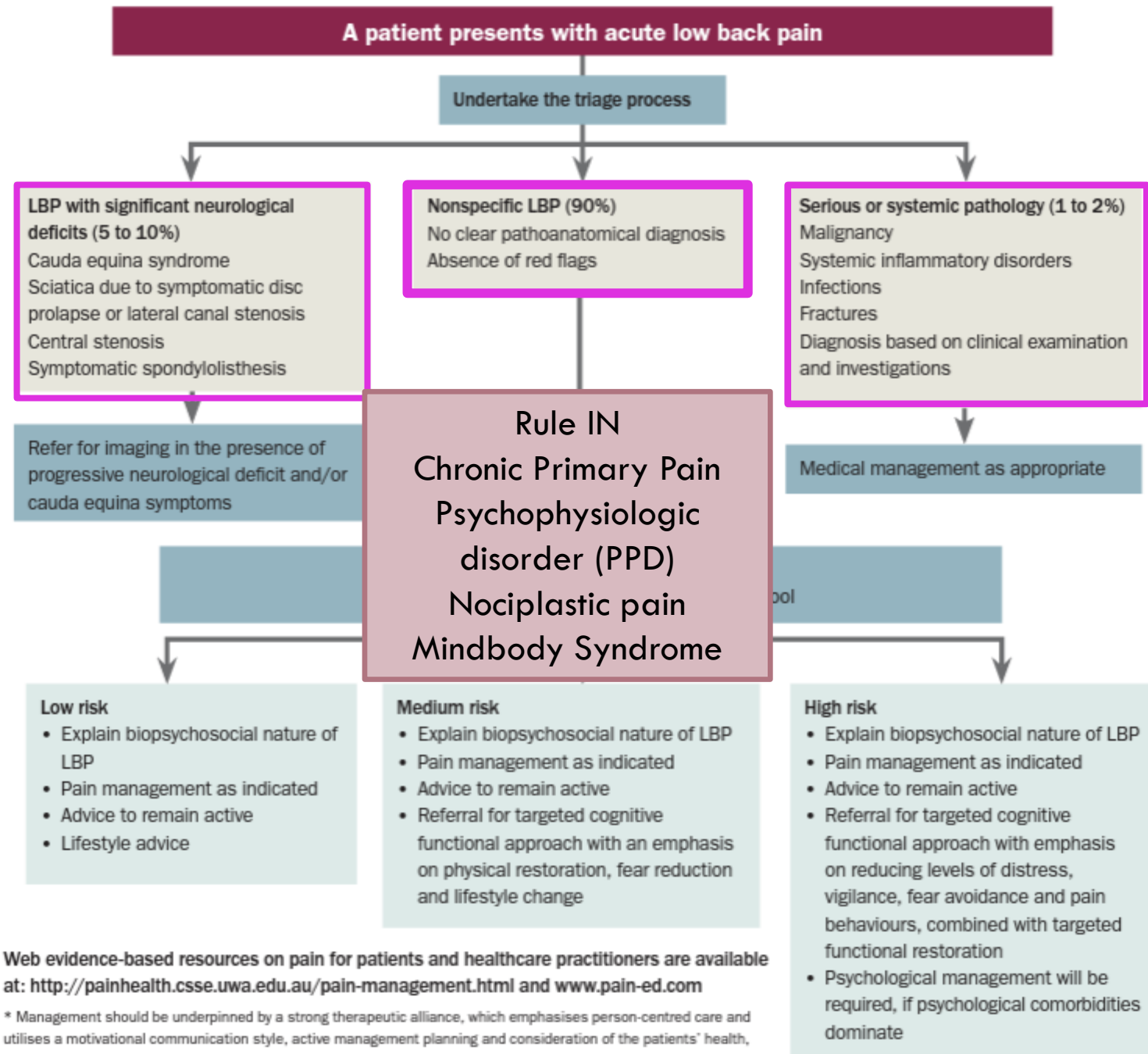
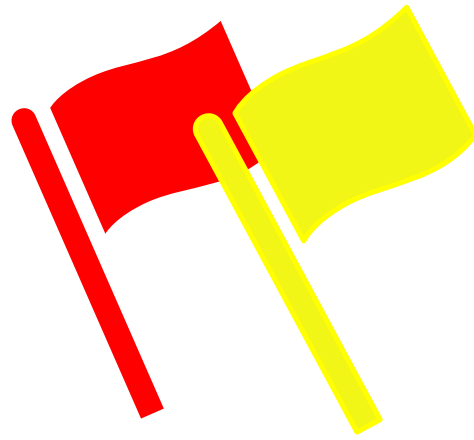
EXERCISE FOR MENTAL HEALTH

- Much lower 'dosage' than for physical gains
- New set of guidelines need to be created
- *"Some is better than none"*
- Best is interval training

The background features a series of overlapping, wavy, liquid-like shapes in shades of purple, blue, and green, creating a sense of movement and depth. The colors transition from deep purple on the left to bright blue and green on the right. The text is centered over this dynamic background.

HIGH VALUE CARE FOR LBP

Framework for assessment and targeted management of patients with low back pain (LBP)*



Clinical Study

What does the patient with back pain want? A comparison of patient preferences and physician assumptions

Matthew Smuck, MD^{a,*}, Kevin Barrette, MD^b, Agnes Martinez-Ith^{a,b,c},
Geoffrey Sultana, MD^c, Patricia Zheng, MD^b

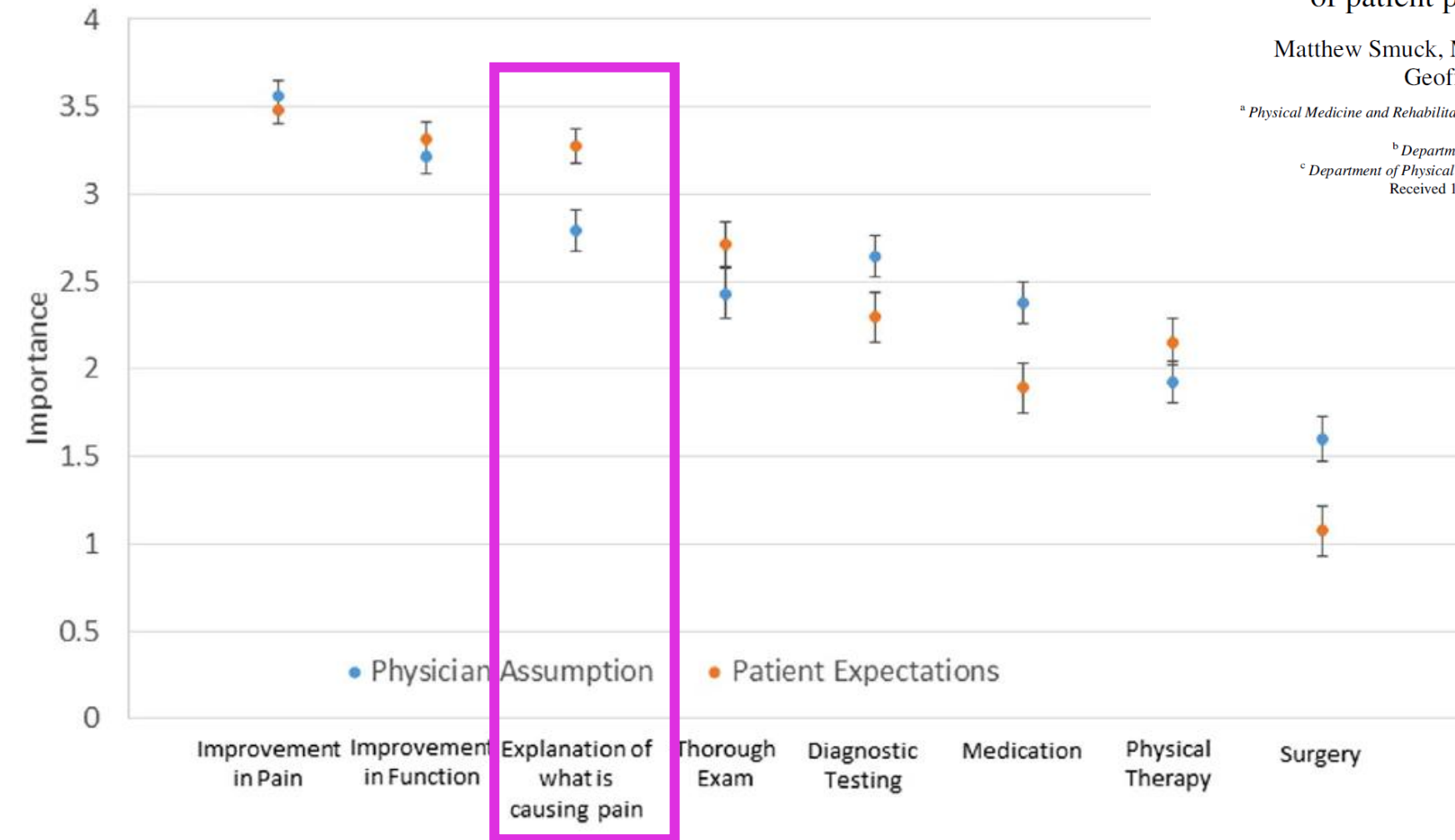
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^c Department of Physical Medicine and Rehabilitation, University of Michigan, Ann Arbor, MI 48104, USA

Received 17 May 2021; revised 30 August 2021; accepted 14 September 2021

M. Smuck et al. / The Spine Journal 22 (2022) 207–213



BMJ Open Do physical therapists follow evidence-based guidelines when managing musculoskeletal conditions? Systematic review

Joshua Zadro , Mary O'Keeffe, Christopher Maher

“Many physical therapists seem not to follow evidence-based guidelines when managing musculoskeletal conditions”.

REFER INTO MERRI HEALTH'S PAIN SERVICE

- Info about the service including brochures and referral form: [Merri Health | Support to help you manage persistent pain](#)
- Nicole Moore nicole.moore@merrihealth.org.au
- Referral via Healthpathways



THANK YOU

Nicole Moore
Pain Physiotherapist (APA, MACP)
Merri Community Health Centre
nicole.moore@merrihealth.org.au





Pain management

31 August 2023



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Carer Stress and Wellbeing

Delirium

Cognitive Impairment and Dementia

5 Minute Neurological Exam for Patients with Possible Dementia

Behavioural and Psychological Symptoms of Dementia (BPSD)

Medications for Dementia

Depression in Older Adults

Antidepressants for Older Adults

Elder Abuse and Neglect

Falls Prevention, Assessment, and Management

Balance and Strength Tests

Frailty in Older Adults

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Medication Management and Polypharmacy in Older Adults


Older Adult's Weight and Nutrition


Older Adults with Behavioural Disorders


RACF Related Care

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Victoria DHHS – Coronavirus COVID-19 Daily Update [\[link\]](#)

Latest News


12 July

 **health.vic**

[Health alerts and advisories](#) 

10 July

Ayurvedic medicines possibly containing Scheduled Poisons and heavy metals

The Department of Health advises that some Ayurvedic medicines for sale in Victoria contain dangerous ingredients, including lead. Screen anyone taking unapproved medicines with potential symptoms of lead poisoning for lead toxicity. [Read more...](#) 

23 June

Current disruption to medication supply

Pathway Updates

Updated – 13 July

[Pain Medications in Palliative Care](#)

Updated – 13 July

[Medications in COVID-19](#)

Updated – 12 July

[Navigating Services for Older Adults](#)

Updated – 12 July


[Mycoplasma Genitalium](#)


Updated – 7 July


[Candidiasis \(Genital\)](#)


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- **clear and concise, evidence-based medical advice**
- **Reduce variation in care**
- **how to refer to the most appropriate hospital, community health service or allied health provider.**
- **what services are available to my patients**

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Victoria DHHS – Coronavirus COVID-19 Daily Update

Latest News

14 August

health.vic

Health alerts and advisories

8 August

Cardiovascular disease (CVD) risk guidelines update

The 2023 Australian Guideline for Assessing and Managing CVD Risk and associated Aus CVD Risk Calculator are now available. The Absolute Cardiovascular Disease Risk Assessment pathway will be unavailable while we update this pathway.

31 July

Notification of rheumatic heart disease (RHD) and acute rheumatic fever (ARF) cases

As of 31 July 2023, ARF and RHD have become routine notifiable conditions in Victoria. Practitioners who reasonably believe that a patient has, or may have, ARF or RHD must notify the Victorian Department of Health within 5 days. Read more...

17 July

Flu vaccination for children and adolescents

Influenza activity is continuing across Victoria, with many cases in children and adolescents. Encourage flu vaccination for everyone aged over 6 months, particularly in children and adolescents as coverage is low in these age groups. Read more...

11 July

Health warning on antibiotic resistant Shigella

There is increasing antibiotic resistance being detected in infections of Shigella bacteria. Clinicians should reserve antibiotic

Pathway Updates

Updated – 25 August

Diabetic Retinopathy

Updated – 24 August

Opioid Use and Dependence

Updated – 24 August

Epididymo-orchitis

Updated – 24 August

Antenatal - Second and Third Trimester Care

Updated – 23 August

COVID-19 Vaccination

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- [Low Back Pain in Adults](#)
- [Neurosurgery Referrals](#)
 - [Acute Neurosurgery Referral or Admission \(Same-day\)](#)
 - [Non-acute Neurosurgery Referral \(> 24 hours\)](#)
- [Pain Management](#)
 - [Analgesia](#)
 - [Analgesia in Adults with Acute Pain](#)
 - [Analgesia in Children with Acute Pain](#)
 - [Chronic Non-cancer Pain](#)
 - [Medications in Chronic Pain](#)
 - [Neuropathic Pain](#)
 - [Chronic or Persistent Pain Referrals](#)
 - [Opioid Use and Dependence](#)
 - [Medicinal Cannabis](#)



Lower back pain in Adults

Lower back pain in Adults - assessment

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Low Back Pain in Adults

Assessment

Practice point

Do not routinely arrange investigations
Investigations for **low-risk** patients with non-specific and non-radicular **back pain** are mostly not required.

1. Take a history:

- Always screen for key [symptoms](#) and ask about [risk factors](#).
- Distinguish between [radicular \(neurogenic\)](#) and [somatic symptoms](#).
- Aim to determine if the **pain** is:
 - [specific](#).
 - [radiating to the lower limbs](#).
 - [non-specific](#).

2. Assess **pain** severity, duration, radiation, and progressive neurological symptoms.

3. Determine the level of functional impairment and impact on activities of daily living, social connection, relationships, and employment. Consider using the [Oswestry Low Back Pain Disability Questionnaire](#).

4. Assess previous interventions tried, including physiotherapy, exercise therapy, medications, psychology, and previous participation in **pain** management programs.

5. Screen for [psychosocial risk factors](#), using:

- specific [psychological risk factor questions](#).
- [confidence screening tools](#).
- [alcohol misuse or abuse](#).
- drug use:
 - Prescribed and non-prescribed analgesia
 - [Opioid use or dependence](#).
 - Recreational or illicit drug use.
 - Check [SafeScript](#) for prescription and dispensing history for monitored medications.

6. Perform an examination:

- Perform a [5-minute back examination](#). See also Sheffield [Back Pain – Examination techniques](#).
- Take the patient's blood pressure and temperature.

7. Arrange investigations:

- Do not arrange [investigations for low-risk patients](#) who experience non-specific and non-radicular **back pain** without [red flags](#).
- If suspected cancer, arrange bone scan, [CT abdomen](#) and pelvis, and laboratory tests.
- If neurological claudication, arrange MRI lumbar spine (preferred) or CT lumbar spine with standing plain X-ray.
- If suspected spondyloarthritis, refer for plain X-ray of sacroiliac joints, inflammatory markers, and HLA B27.

8. Avoid labelling the cause of mechanical **low back pain** as an injury, disc problem, degenerative disease, or wear and tear, as these terms may imply a poor likelihood of recovery.

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Low Back Pain in Adults

o. Avoid labelling the cause of mechanical **low back pain** as an injury, disc problem, degenerative disease, or wear and tear, as these terms may imply a poor likelihood of recovery.

Management

1. Manage **back pain** with serious pathology:

• Refer for [acute orthopaedic referral or admission](#) or [acute neurosurgical referral or admission](#) if suspected:

- cauda equina syndrome, cord compression, or severe or progressive neurological deficit.
- spinal infection.

• If spinal cancer, ensure appropriate analgesia and refer promptly for [non-acute oncology referral](#).

• If inflammatory arthropathy, refer for [non-acute rheumatology referral](#).

• If stable osteoporotic fractures in the lumbo-sacral spine, manage as per [Osteoporosis](#) pathway.

2. Provide [education about low back pain](#) to correct [misconceptions](#), calm fears, and encourage the patient to participate in their own recovery:

• Set the expectation that **pain** and disability from **low back pain** will improve with time as this expectation is vital to recovery.

• With simple treatment, most patients with **low back pain** will start to improve within a few days or weeks.

3. Discuss **back pain** management strategies for **low back pain** < 6 weeks, including **low back pain** with radiculopathy and spinal canal stenosis:

• Exercise and maintenance of [normal activity and movement](#).

• [Weight loss](#) when indicated.

• [Pharmacological therapies](#) (to allow active therapy).

• Trial heat or ice therapy, depending on what offers relief.

4. Offer a review within 1 to 2 weeks of onset of **low back pain** to facilitate trust and check improvement. Assess for red flag conditions again if no incremental improvement in **pain** and disability.

5. Advise about [prevention of low back pain](#) and long-term strategies to manage recurring episodes.

6. Consider other options if **pain** and disability are not improving with guided self-management, education, and simple measures as above:

• Provide coordination of a multidisciplinary approach to **back pain** management. Multidisciplinary treatment programs are effective in assisting with recovery, especially return to work.

• Consider referral for [physical therapies](#), especially to therapists with an interest in functional restoration and expertise in **pain** management.

• Consider short, time-limited trial of [NSAIDs, or weak oral opioids](#).

• Offer support and ongoing encouragement that recovery is likely. Consider individualised support, e.g. psychological counselling. [Confidence screening tools](#) may assist in review process.

7. Consider referral to a [pain management program](#) (also known as a health independence program) if **pain** is persistent or chronic (> 3 months duration) and:

• symptoms impact on daily activities.

• there has been an adequate trial of treatment in previous 12 months (exercise and analgesia).

• at risk of functional or psychological deterioration or medication dependence.

• willing to explore living well with **pain**.

• willing to self-manage **pain**.

noting that [statewide referral criteria](#) exist for public hospital based health independence services and indicate on referral if the patient is from a [vulnerable population](#).

8. Manage further according to **pain** type:

• [Mechanical low back pain](#)

• [Radiculopathy and predominant leg pain](#)

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Low Back Pain in Adults

Radiculopathy and predominant leg pain

Referral

Refer for [acute orthopaedic referral](#) or [admission](#) or [acute neurosurgical referral](#) or [admission](#) if suspected:

- cauda equina syndrome, cord compression, or severe or progressive neurological deficit.
- spinal infection.

If spinal cancer, ensure appropriate analgesia and refer promptly for [non-acute oncology referral](#).

If inflammatory arthropathy, refer for [non-acute rheumatology referral](#).

If spinal canal stenosis:

- without neurogenic claudication, refer for [physiotherapy](#).
- with limitation in standing or walking, refer for [non-acute neurosurgery referral](#) or [non-acute orthopaedic referral](#).

If radiculopathy, consider referral for [CT-guided nerve sheath steroid injection](#).

If radiculopathy, and the patient is a candidate for spinal surgery, consider referring for prompt [non-acute orthopaedic referral](#) or prompt [non-acute neurosurgery referral](#) if any of:

- foot drop.
- progressive motor signs.
- persisting severe **pain** > 4 weeks despite conservative measures.

If mechanical **low back pain** is severe, unresponsive, or progressive, consider referring for [non-acute **pain** specialist referral](#), [non-acute neurology referral](#), [non-acute rheumatology referral](#), [sports physician assessment](#), or [musculoskeletal physician assessment](#).

Consider referral to:

- manual therapy, e.g. [physiotherapist](#)
- exercise therapy, e.g. [physiotherapist](#) or [exercise physiologist](#)
- acupuncture
- hydrotherapy
- individualised support, e.g. cognitive behavioural therapy via either psychological counselling, or a [pain management specialist](#).

Consider referral to a [health independence **pain** management program](#) if **pain** is persistent or chronic (> 3 months duration) and:

- symptoms that impact on daily activities.
- adequate trial of treatment in previous 12 months (exercise and analgesia).
- at risk of functional or psychological deterioration or medication dependence.
- willing to explore living well with **pain**.
- willing to self-manage **pain**.
- noting that [statewide referral criteria](#) exist for public hospital-based services.

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