



# LOW BACK PAIN - WHAT WORKS AND WHAT IS COMMONLY PRESCRIBED DESPITE NO EVIDENCE

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# 1<sup>ST</sup> LINE RX FOR ALBP

Focus on patients fears and misconceptions

Provide confident explanations


Empower to resume or restore normal activity with graduated activity

Light activity helps heal the spine the key message

It is not serious, keep moving and will take < 6/52 to recover. But don't spend too much time on reassurance as it doesn't change outcomes (Cashin et al'21)

# NO EVIDENCE FOR EXERCISE FOR ACUTE BACK PAIN

- The irony is many physios keep prescribing exercise therapy for acute back pain when there is no evidence to support it, but think that there is..... and won't use manual therapy because they think there is no evidence, yet there is!!!!
- In the newest Cochrane Review the primary focuses of the review were pain, functional status, and perceived recovery, while secondary considerations included return to work, health-related quality of life, and adverse events.
- The key comparisons made were between exercise therapy versus sham/placebo treatment and exercise therapy versus no treatment.
- A total of 23 studies involving 2674 participants were incorporated into the analysis. The authors concluded that, when compared with sham/placebo treatment, **exercise therapy may exhibit no clinically significant effects on pain or functional status in the short term among individuals with acute non-specific low back pain.** However, they emphasised the uncertainty of the evidence.
- Similarly, when compared to no treatment, exercise therapy may not yield clinically relevant improvements in pain or functional status in the short term for individuals with acute non-specific low back pain, but the evidence is characterised by a high level of uncertainty.
- The review reaffirms previous evidence that exercise therapy has little evidence to support in acute back pain.

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[Intervention Review]  
**Exercise therapy for treatment of acute non-specific low back pain**

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**ABSTRACT**

**Background**  
Low back pain (LBP) is the leading cause of disability globally. It generates considerable direct costs (healthcare) and indirect costs (lost productivity). The many available treatments for LBP include exercise therapy, which is practised extensively worldwide.

**Objectives**  
To evaluate the benefits and harms of exercise therapy for acute non-specific low back pain in adults compared to sham/placebo treatment or no treatment at short-term, intermediate-term, and long-term follow-up.

**Search methods**  
This is an update of a Cochrane Review first published in 2005. We conducted an updated search for randomised controlled trials (RCTs) in CENTRAL, MEDLINE, Embase, four other databases, and two trial registers. We screened the reference lists of all included studies and relevant systematic reviews published since 2004.

**Selection criteria**  
We included RCTs that examined the effects of exercise therapy on non-specific LBP lasting six weeks or less in adults. Major outcomes for this review were pain, functional status, and perceived recovery. Minor outcomes were return to work, health-related quality of life, and adverse events. Our main comparisons were exercise therapy versus sham/placebo treatment and exercise therapy versus no treatment.

**Data collection and analysis**  
We used standard Cochrane methods. We evaluated outcomes at short-term follow-up (time point within three months and closest to six weeks after randomisation; main follow-up), intermediate-term follow-up (between nine months and closest to six months), and long-term follow-up (after nine months and closest to 12 months); and we used GRADE to assess the certainty of the evidence for each outcome.

**Main results**  
We included 23 studies (13 from the previous review, 10 new studies) that involved 2674 participants and provided data for 2637 participants. Three small studies are awaiting classification, and four eligible studies are ongoing. Included studies were conducted in Europe (N = 9), the Asia-Pacific region (N = 9), and North America (N = 5); and most took place in a primary care setting (N = 12), secondary

Exercise therapy for treatment of acute non-specific low back pain (Review)  
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## SOME DON'T RECOVER AT 4-6/52

- 20-30% don't recover and become chronic
- The best Rx for chronic back pain is to prevent it
- Identification is critical for those at risk
- Some of the largest significant risk factors
  - Use of radiology when unnecessary
    - Scans are NOT recommended for the majority of back pain unless 'specific' pathology is suspected.
    - The problem with scans is that most people without back pain have age-related changes to discs such as degeneration (up to 80%) and disc bulges (50-60%).

## OTHER PREDICTIVE FACTORS

- Low self-efficacy
- Fear-avoidance behaviour
- Resting in bed as therapy

1<sup>ST</sup> LINE FOR  
CLBP  
CFT IS A  
COMBINATION



Keep active or graduated increase in activity



Education



Exercise therapy



Cognitive Behavioural Therapy

# MAXIMISING EFFECTS?



- A meta-analysis in '20 revealed that completing exercises 3–5 times per week yielded the most substantial improvement in both pain intensity and disability. However, exceeding five training sessions per week resulted in a diminished effect.
- However Neason et al '24 recently has shown even twice a week is sufficient
- And missing a few sessions during a program does not have adverse effects, provided they restart ASAP
- Sessions can be short- even 20'

## 2<sup>ND</sup> LINE RX FOR CLBP

- Spinal mobilisation and manipulation
- Massage
- Acupuncture
- Yoga
- Mindfulness-based stress reduction
- Multidisciplinary rehab
- NSAIDS
- Selective norepinephrine reuptake inhibitors, e.g. Cymbalta, Effexor



# LIMITED USE

- Epidural steroid injections (for herniated disc with nerve root compression)
- Yet is often prescribed for many other pain presentations with poor evidence

**NOT  
RECOMMENDED**



Paracetamol



Pregabalin/gabapentin for radicular pain



Spinal epidural and PIV steroid injections for LBP alone

Associated with rare but serious adverse events, including

- Death
- Blindness
- Stroke
- Paraplegia

**NOT  
RECOMMENDED**



Radiofrequency denervation



Spinal fusion for degenerative Lx is costly and greater risk of adverse events with no proven benefit over conservative Rx.

# QUESTIONS?

*“You can’t start the next chapter of your life if you  
keep re-reading the last one  
- Anonymous -*

## FOR MORE INFORMATION

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