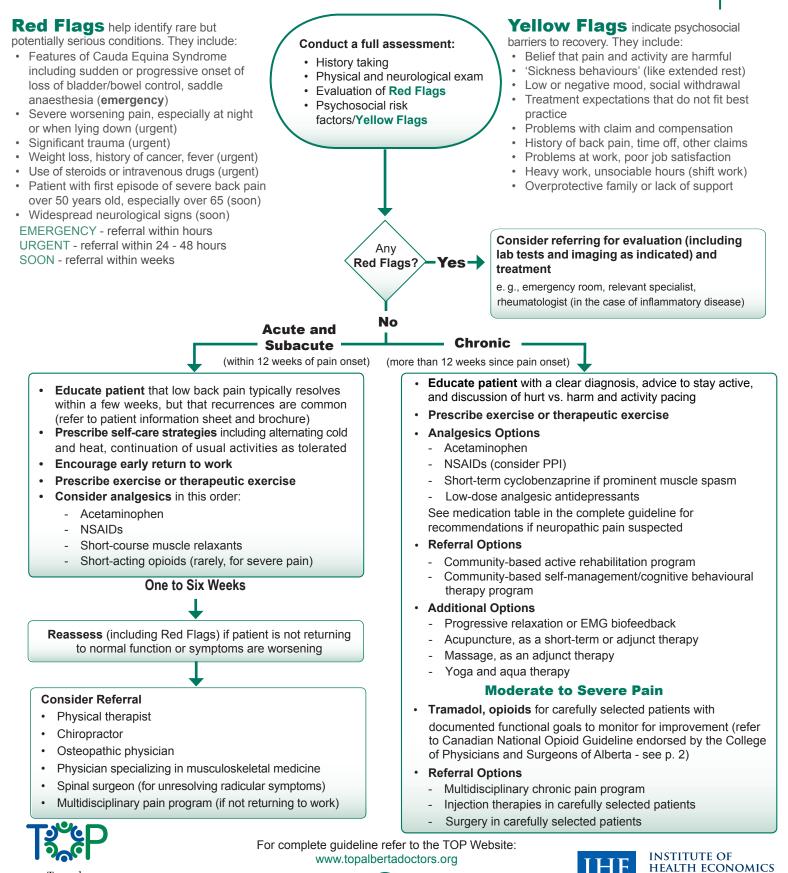
A Summary of the Guideline for the Evidence-Informed Primary Care Management of Low Back Pair

3rd Edition, 2015 (Minor Revision 2017)

ALBERTA CANADA

This evidence-informed guideline is for non-specific, non-malignant low back pain in adults only



Toward Optimized Practice (1

## Low Back Pain

## **Key Messages**

- Do a full clinical assessment; rule out red flags and yellow flags
- In the absence of red flags, reassure the patient there is no reason to suspect a serious cause
- Reinforce that pain typically resolves in a few weeks without intervention, but may recur
- · Recommend exercise and therapeutic exercise
- If pain continues beyond six weeks, reassess and consider additional treatment and referrals
- The goal of chronic pain management is improved quality of life
- Check for yellow flags and if present, follow good clinical practice\*
- Encourage and support pain self-management
- Monitor patient for relative benefit versus side effects
- Lab tests and diagnostic imaging in the absence of red flags
- Epidural steroid injections in the absence of radicular pain

\*See the guideline's companion documents 'Clinical Assessment

of Psychosocial Yellow Flags' and

'Management of Psychosocial Yellow Flags' on the TOP website

- TENS for acute pain
- TENS as solo treatment for chronic pain

ontrainaloutions
Evidence indicates these
actions are ineffective or

raindications

ve or Prolonged bed rest

- Traction (including motorized)
- Ultrasound
- Oral and systemic steroids

Pain Type		Medication		Dosage Range
Acute and sub- acute low back pain or flare-up of chronic low back/ spinal pain		1st line	Acetaminophen	Up to 1000 mg QID (max of 3000 mg/day long-term)
		2nd line NSAIDs (consider PPIs if >45 years of age)	Ibuprofen	Up to 800 mg TID (max of 800 mg QID)
			Diclofenac	Up to 50 mg BID
		Add: Cyclobenzaprine for prominent muscle spasm		10 to 30 mg/day; Greatest benefit seen within one week; therapy up to 2 weeks may be justified
		If already on a controlled release opioid: add a short-acting opioid or increase controlled release opioid by 20 to 25%		See opioids below
Chronic low back/spinal pain	TRICYCLICS AND OPIOIDS	1st and 2nd lines	See acute pain, above	
		<b>3rd line</b> Tricyclics (TCAs)	Amitriptyline Nortriptyline* *fewer adverse effects	10 to 100 mg HS
		<b>3rd line</b> Weak Opioids	Codeine	30 to 60 mg every 3 to 4 hours
			Controlled release codeine	50 to 100 mg Q8h, may also be given Q12h
		<b>4th line</b> Tramadol**		Slow titration max 400mg/day. Note: Monitor total daily acetaminophen dose when using tramadol - acetaminophen combination
		<b>5th line</b> Strong Opioids** (controlled release)	Morphine sulfate	15 to 45 mg BID
			Hydromorphone HCI	3 to 10 mg BID
			Oxycodone HCI	10 to 30 mg BID
			Fentanyl patch	12.5 to 25 mcg/hr Q3 days

\*\* for carefully selected patients with documented functional goals to monitor for improvement

- This guideline was written to provide primary healthcare providers and patients with guidance about appropriate prevention, assessment, and intervention strategies
- It was developed by a multidisciplinary team of Alberta clinicians and researchers
- This guideline is for adults 18 years of age or older with low back pain and is not applicable to pregnant women
- · It is recognized that not all recommended treatment options are available in all communities
- See the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, available at: http://nationalpaincentre.mcmaster.ca/guidelines.html
- · For further details on the recommendations visit: http://tinyurl.com/top-lowbackpain

harmful