

New ACP Guidelines for Nonradicular Low Back Pain

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The American College of Physicians (ACP) has released updated guidelines for the noninvasive treatment of nonradicular subacute, acute, and chronic low back pain in primary care. The guidelines, along with updated evidence reviews, are [published online](#) February 13 in the *Annals of Internal Medicine*.

Overall, the new guidelines emphasize conservative treatment. First-line therapy should incorporate nondrug therapies. Nonsteroidal anti-inflammatories (NSAIDs) or muscle relaxants should be considered when nondrug therapy fails. The guidelines strongly discourage the use of opioids.

"For treatment of chronic low back pain, clinicians should select therapies that have the fewest harms and lowest costs because there were no clear comparative advantages for most treatments compared with one another. Clinicians should avoid prescribing costly therapies; those with substantial potential harms, such as long-term opioids (which can be associated with addiction and accidental overdose); and pharmacologic therapies that were not shown to be effective, such as [tricyclic antidepressants] and [selective serotonin reuptake inhibitors]," write Amir Qaseem, MD, PhD, MHA, chair of the ACP guidelines committee, and colleagues.

Lower back pain is one of the most common reasons for clinic visits in the United States. It is associated with increased healthcare costs as well as lost wages and decreased work productivity.

Acute back pain generally lasts less than 4 weeks and usually resolves on its own. Subacute low back pain is defined as lasting 4 to 12 weeks, while chronic back pain lasts over 12 weeks. Up to 30% of patients report persistent low back pain up to 1 year after experiencing an acute episode. One in five report substantial limitations in activity, according to background information in the article.

To develop the guideline, the ACP reviewed randomized controlled trials and systematic reviews of studies evaluating noninvasive, nondrug, and drug therapy for low back pain in adults. To be included, studies had to be published in English between January 2008 and November 2016. The authors identified earlier studies using the 2007 ACP/American Pain Society systematic reviews. The guidelines and evidence reviews also underwent peer review and a public comment period.

While no therapy was clearly better than any other, new evidence supports mindfulness-based stress reduction and tai chi in chronic low back pain and acupuncture in acute low back pain.

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Also, new research suggests lack of benefit for acetaminophen in acute low back pain and supports use of duloxetine in chronic low back pain. By contrast, tricyclic antidepressants appear to be no better than placebo in this setting.

The ACP made the following strong recommendations:

- Most patients with acute or subacute low back pain improve over time regardless of treatment and can avoid potentially harmful and costly treatments and tests. First-line therapy should include nondrug therapy, such as superficial heat (moderate-quality evidence), massage, acupuncture, or spinal manipulation (low-quality evidence). When nondrug therapy fails, consider NSAIDs or skeletal muscle relaxants (moderate-quality evidence).
- For chronic low back pain, consider nondrug therapy, such as exercise, multidisciplinary rehabilitation, acupuncture, mindfulness-based stress reduction (moderate-quality evidence), tai chi, yoga, motor control exercise, progressive relaxation, electromyography biofeedback, low-level laser therapy, operant therapy, cognitive-behavioral therapy, or spinal manipulation (low-quality evidence).
- For chronic low back pain that does not respond to nondrug therapy, consider NSAIDs as first-line therapy. For second-line, consider tramadol or duloxetine. Consider opioids only in patients in whom first- and second-line therapy has failed, in whom the risk outweighs the benefits, and only after full discussion of the potential risks and benefits.

The recommendations stress that clinicians should reassure patients that acute and subacute back pain usually resolves on its own, and they should provide patients with relevant information for self-care. They also note that, overall, studies poorly report harms.

The guideline does not address topical drugs, epidural injections, or cyclo-oxygenase-2 selective NSAIDs.

In a [linked editorial](#), Steven J. Atlas, MD, MPH, from Massachusetts General Hospital in Boston, points out that the initial focus on nondrug therapy may be "reasonable" but represents a "major change for primary care clinicians" because research in real-world settings is lacking.

"This change in emphasis partly reflects the limited pharmacologic choices — nonsteroidal anti-inflammatory drugs and skeletal muscle relaxants, with acetaminophen no longer being recommended. It also may represent a shift toward efforts to prevent progression to chronic low back pain by identifying patients at increased risk for persistent pain," he writes.

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The main problem with nondrug therapies lies in insurance coverage issues, he stresses, and whether such treatments are available and affordable for patients.

He also casts doubt on whether these new recommendation are enough to improve guideline-oriented care.

"Likely what is needed is an 'all of the above' approach: more pragmatic trials to evaluate proven therapies and their combinations in real-world settings; efforts to reduce the use of low-value services, such as payer coverage policies based on guideline recommendations; patient engagement through shared decision making; and pressure on insurers to cover nonpharmacologic, noninvasive therapies that have shown benefit," he writes.

Nevertheless, he concludes that evidence reviews and guidelines like these can "drive efforts" to decrease use of therapies with no clear benefit and improve outcomes in low back pain.

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