June 2026

BACK PAIN GUIDELINES & DIAGNOSTIC TRIAGE

1. IS THE PAIN SPINAL OR ORIGINATING ELSEWHERE? (e.g., abdomen, genitourinary system - investigate as appropriate)
2. DOES THE PATIENT NEED EMERGENCY REFERRAL? (Features suggesting acute spinal cord or cauda equina lesion: Loss of bowel/bladder control, abnormal sphincter tone, gait disturbance, bilateral neurology, saddle sensory loss) ➔ **Emergency referral to Orthopaedic on-call / Neurosurgery.**

Simple Backache / Chronic / Recurrent

Typical Pattern:

- **Age:** 20 to 55 years at onset
- **Onset:** Usually sudden, obvious precipitants
- **Site:** Back only or radiating to upper leg/thigh
- **Behaviour:** Intermittent, no severe night pain
- **Health:** Good general health

NICE Management Protocol: Reassure, mobilize rapidly, avoid bed rest. Use oral NSAIDs (e.g., Naproxen) first-line with PPI if age ≥45. Co-codamol option for severe pain. *Routine X-ray contraindicated.* If no better at 6 weeks, refer to MSK Physio.

Nerve Root Problems

Typical Pattern:

- **Onset:** Recent, well-defined
- **Site:** Back pain initially, progressing to unilateral leg pain
- Radiates to foot/toes; dermatomal numbness/paraesthesia
- Cough/sneeze exaggerates leg pain
- SLR reproduces leg pain
- Diminished deep tendon reflexes

Management Protocol: Encourage activity, analgesia/NSAIDs. If progressive motor weakness or severe neurological loss ➔ **Refer Orthopaedics/Neurosurgery urgently**. If stable but unchanged at 6 weeks ➔ Consider MRI / Secondary Care Physio.

Possible Serious Pathology (Red Flags)

Typical Pattern:

- **Age:** <20 years or >55 years
- **Thoracic pain**
- Past history of Ca or TB
- **Onset:** Gradual or insidious
- **Site:** Worsening stable pain, multiple levels or both legs affected
- **Behaviour:** Unremitting pain, severe night pain
- Systemic weight loss, night sweats
- Inflammatory signs (morning stiffness)

NICE Investigation Protocol: Investigate or refer. Arrange bloods: FBC, PV/ESR, LFT, Calcium. Urgent referral if neoplasia/ suspected serious mechanical or inflammatory lesion.

Initial GP Consultation Principles

- Establish if simple backache or part of a generalized disorder.
- Assess degree of nerve root involvement & look for red flags.
- **Positive Attitude:** Maintain activity levels, encourage early work return. Activity is not harmful.
- **Bed Rest Warning:** Avoid prolonged bed rest; max 1-2 days in simple backache, max 1 week in sciatica.
- Assess and address issues of distress, depression, or psychosocial flags.

Review & Refractory Pain Protocol

- Review initial diagnosis; include psychosocial barriers, patient beliefs.
- Discuss with musculoskeletal (MSK) specialities.
- **NICE Update on Injections:** Facet joint injections, epidurals, and trigger point injections are explicitly **not recommended** for non-specific low back pain.
- If pain persists long term, consider formal multi-disciplinary Pain Clinic referral.
- **Work Absence Risks:** Off work for 6 weeks = 10-40% chance of being off in a year. Off work 6-12 months = 90% chance of never returning.

Clinical Guideline Update Note (June 2026): This layout integrates the text from pages 1 and 2 of the uploaded guideline documents. Outdated pharmacology terms (e.g., routine opiates/nocturnal sedatives for simple backache) have been modernized per current NICE/UK standards: prioritizing oral NSAIDs as first-line with appropriate PPI cover for patients aged 45+, advising regular scheduled medication over PRN dosing, and strictly deprecating routine injections for non-specific lower back pain. All core text structures have been compressed to cleanly fit A4 constraints without losing the primary care procedural steps.