HISTORY TAKING AND CLINICAL EXAMINATION

Always take into account possible differential diagnoses and exclude signs suggestive of possible serious underlying pathology

Presence of red flags

EXIT

Out-of-scope of this guideline

EVALUATION OF THE RISK ON CHRONICITY

LOW RISK
Simple management at low intensity

Perceptions & emotions

Psychiatric symptoms

Perception about work

Contextual obstacles

HIGH RISK
More complex management at higher intensity

SELF-MANAGEMENT

For all patients, provide information and personalised advice, tailored to their needs and capabilities, at all steps of their treatment pathway:

→ Inform them on the benign nature of the low back pain/radicular pain

→ Encourage them to continue their regular activities (as best as the can)

NON-INVASIVE INTERVENTIONS

Exercise programme (following the specific needs, preferences and capabilities of the patient)

± **Manipulation, mobilisation or soft-tissue techniques**

± **Psychological intervention (cognitive behavioural therapy)**

Multidisciplinary rehabilitation programme with physical and psychological component

- if significant psychosocial obstacles

or

- after failure of previous *evidence-based* treatments

PROMOTE AND FACILITATE RETURN TO WORK OR RESUMPTION OF DAILY ACTIVITIES AS SOON AS POSSIBLE

INVASIVE INTERVENTIONS

CHRONIC LOW BACK PAIN

Radiofrequent denervation (only after a diagnostic medial branch block) when:

- suspected facet joint pain
- after failure of non-surgical management
- moderate to severe low back pain

Lumbal artrodesis: Do NOT offer unless:

- after failure of non-surgical management
- after evaluation in a multidisciplinary consultation
- preferably with data registration in a registry

RADICULAIRE PIJN

Epidural infiltrations (local anaesthetics en steroids):

- For (sub)acute and severe pain

Spinal decompression after at least 6 to 12 weeks when:

- After failure of non-surgical management
- Imaging findings are consistent with current clinical symptoms

IMAGING
NOT routinely
Explain to the patient that medical imaging is not necessary

FARMACOLOGICAL INTERVENTIONS
only if required

NSAIDs

- With ongoing monitoring of the risk factors and use of gastro-protective treatment if needed
- At the lowest effective dose for the shortest possible period of time

Opioids:

- weak (with or without paracetamol) for acute low back pain, for the shortest period possible, only if NSAIDs are contraindicated, not tolerated or have been ineffective
- NOT routinely for chronic low back pain

Paracetamol : NOT routinely as the only medication

Antidepressants

- Tricyclic or SNRI : NOT routinely for chronic low back pain
- SSRI : Never

Anticonvulsants : NOT in absence of a neuropathic pain component

Muscle relaxants: Never

DO NOT

→ Electrotherapy
→ Manual traction
→ Belts, corsets, foot orthotics
→ Non-epidural spinal injections
→ Disc prosthesis

Regarding other interventions, such as for example andulla-tion therapy, no recommendation could be formulated be-cause evidence was lacking.

KCE