Acute Low Back Pain Treatment

see Chronic Low Back Pain Treatment

Not recommended

Not recommended by the AHCPR panel [1] for treatment of acute low back pain in the absence of "red flags"

Medications

a) oral steroids: no difference was found at one week and 1 year after randomization to receive 1-week therapy with oral dexamethasone or placebo [2]

b) colchicine: conflicting evidence shows either some [3] or no [4] therapeutic benefit. Side effects of N/V and diarrhea were common [5].

c) antidepressant medications: most studies of these medications were for chronic back pain. Some methodologically flawed studies failed to show benefits when compared to placebo for chronic (not acute) LBP [6].

Physical treatments

TENS

TENS (Transcutaneous electrical nerve stimulation):not statistically significantly better than placebo, and added no benefit to exercise alone [7]

Traction

(including pelvic traction): not demonstrated to be effective. [8].

One possible explanation for lack of benefit is that due to the sizable paraspinal muscles and ligaments (as compared to the cervical spine) the amount of weight required to distract the intervertebral disc space is approximately ≥ 2/3 of the patient's body weight, which is painful and/or pulls the patient to the foot of the bed

Physical agents and modalities

Including heat (including diathermy), ice, ultrasound. The benefit is insufficiently proven to justify their cost; however, self-administered home programs for the application of heat or cold may be

considered. Ultrasound and diathermy should not be used in pregnancy

Lumbar corsets and support belts

Not proven beneficial for acute back problems. Prophylactic use has been advocated to reduce time lost from work by individuals doing frequent lifting as part of their job, but this is controversial [9].

Biofeedback

Biofeedback: has not been studied for acute back problems. Primarily advocated for chronic LBP, where effectiveness is controversial [10].

Injection therapy

a) trigger point and ligamentous injections: the theory that trigger points cause or perpetuate LBP is controversial and disputed by many experts. Injections of local anesthetic are of equivocal efficacy (saline may be as effective [11] and are mildly invasive)

b) (zygapophyseal) facet joint injections: theoretical basis is that there exists a “facet syndrome” producing LBP which is aggravated by spine extension, with no nerve root tension signs. No studies have adequately investigated injections for pain < 3 months duration. For chronic LBP, neither the agent nor the location (intrafacet or pericapsular) made a significant difference in outcomes [12] [13].

c) epidural injections in the absence of radiculopathy.

d) acupuncture: no studies were found that evaluated the use in acute back problems. All randomized clinical trials found were for patients with chronic LBP, and even the best studies were felt to be mediocre and contradictory. A meta-analysis found acupuncture was more effective in relieving chronic LBP than sham or no treatment, [14] but there was no comparison to other therapies

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