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NICE low back pain guidelines: opportunities and obstacles to change practice

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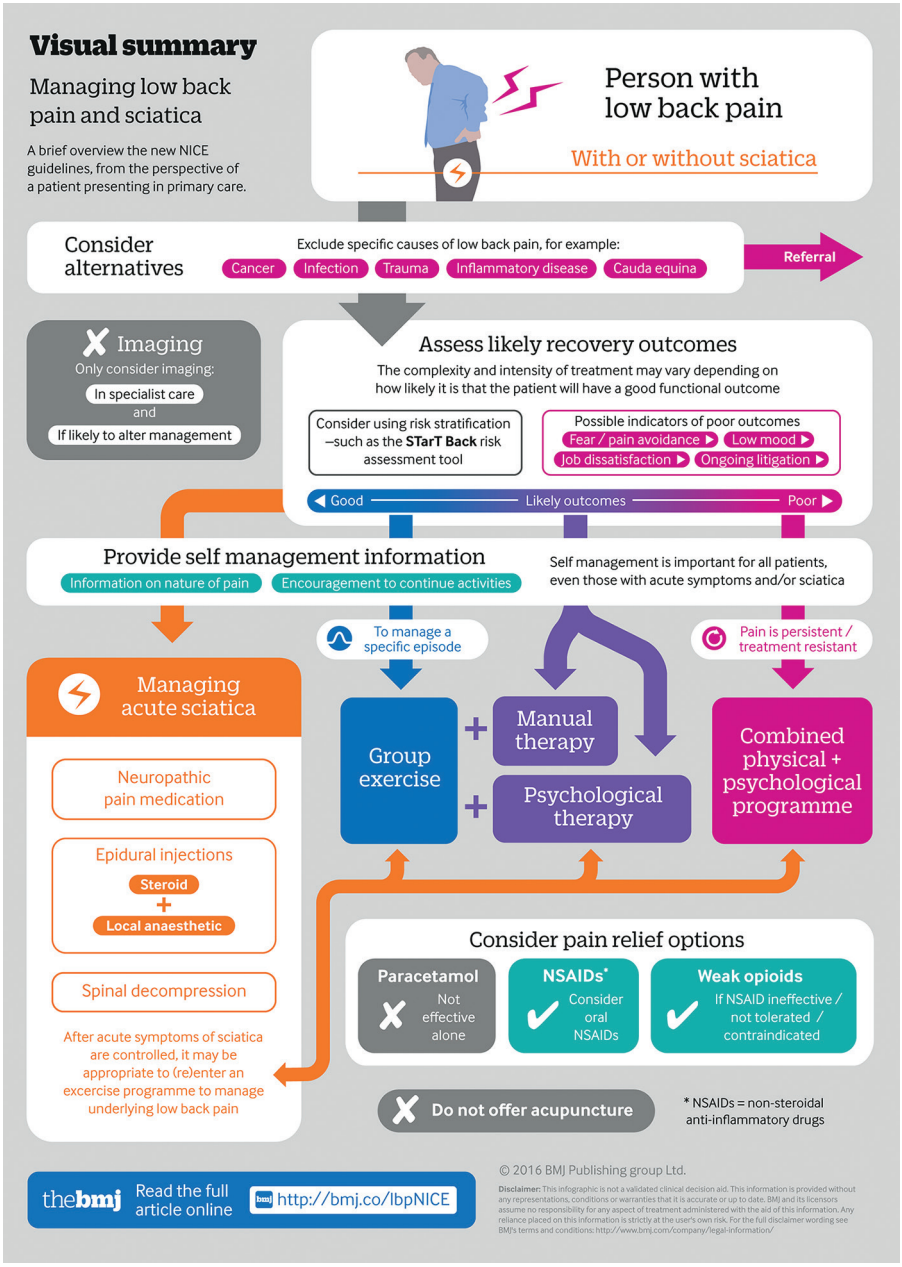
The National Institute for Health and Care Excellence recently updated its low back pain (LBP) guidelines,[1] with the associated infographic developed to assist interpretation of the recommendations. The guidelines are more consistently aligned with Cochrane systematic reviews than the previous version. The guidelines contain several key directives, which, if widely implemented, could significantly impact on the care of individuals with LBP. Established evidence-based messages, including the need for more cautious referral for some investigations and treatments including imaging, medication and surgery, are reinforced, with a clear emphasis on facilitating self-management strategies. Considering psychosocial factors at an early stage is also advocated, rather than waiting for usual care to fail. There is a timely shift to targeting care based on a person's multidimensional risk profile, rather than merely symptom duration.



AREAS OF DEBATE

1. Which treatment option for whom?
   - Many treatments are proposed as worthy of consideration, including exercise as a key component, with manual therapy and psychological therapy as potential adjuncts to exercise, but not in isolation. A cautious, stepwise approach to medications is recommended. The guidelines suggest patient needs, preference and capability are taken into account, which appears sensible and allows clinical flexibility — appreciating it is not used to excuse the use of ineffective treatments. It remains less clear how these options should be tailored to individual patients.
2. Will baseline screening help?
   - Profiling patients according to their predicted prognosis might optimise outcomes and reduce the worrying trend of overtreatment.[2] However, such screening tools better predict disability rather than pain,[3] and may be less useful in both the first 2 weeks of an acute episode of pain and in persistent pain populations,[4] with patient scores fluctuating considerably.[5] Lessons might be learnt from the limitations of once-off baseline screening for injury in athletes.[6]
3. What are the key knowledge gaps?
   - All five key research recommendations relate to further evaluation of medications or procedures (including injections, radiofrequency denervation and fusion surgery). Clarifying whether these treatments are effective is a worthwhile particularly given potentially high costs and some risk. However, a more radical departure might be to consider the management of persistent LBP as a chronic condition using long-term behavioural strategies.

This would be consistent with conditions such as diabetes or asthma, in that patients are rarely 'cured', but instead supported to live healthy lives with personalised self-management plans, intermittent monitoring and support as needed.

CONSIDERATIONS FOR FUTURE IMPLEMENTATION

1. Can clinicians do this?
   - Given that adherence to guidelines is often poor, individual clinicians, through their training and practice, may not be adequately confident and skilled to implement these guidelines. Will our education systems and professional bodies adjust their focus in accrediting programmes to reflect the evolving evidence? Significantly, the guideline developers differentiate between expertise in health-related psychology (eg, reducing fear about back pain) and treating psychopathology (eg, treatment of suicidal ideation).
2. Will healthcare systems facilitate this?
   - Will they up-skill clinicians and limit unwarranted imaging and invasive treatments while discouraging reliance on passive treatments that focus on symptom amelioration? Will they mandate multidimensional screening, facilitate effective referral networks and care pathways, and give clinicians the time required to provide effective self-management approaches? Will clinical records be audited to ensure guidelines are being adhered to? Will the guidelines be resisted by 'for-profit' healthcare interests who might benefit from providing care not aligned to the guidelines?
3. Are patients ready for this?
   - While patient expectations for imaging, symptom amelioration and invasive treatments are understandable, they present challenges to implementing self-management programmes. Effective public engagement, including mass media campaigns and education, may be needed to prepare the public for evidence-based guidelines such as these.
   - In conclusion, while these guidelines are a major step in the right direction, there are clearly many challenges ahead.

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Correction notice This paper has been amended since it was published Online First. Owing to a scripting error, some of the publisher names in the references were replaced with 'BMJ Publishing Group'. This only affected the full text version, not the PDF. We have since corrected these errors and the correct publishers have been inserted into the references.

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REFERENCES

1 NICE. Low back pain and Sciatica in Over 16s: assessment and Management. *National Institute for Health and Care Excellence: Clinical Guidelines*. 2016. London: National Institute for Health and Care Excellence (UK), 2016.
2 Hill JC, Whitehurst DG, Lewis M, *et al*. Comparison of stratified primary care management for low back pain with current best practice (STarT back): a randomised controlled trial. *Lancet* 2011;378:1560–71.
3 Karran EL, McAuley JH, Traeger AC, *et al*. Can screening instruments accurately determine poor outcome risk in adults with recent onset low back pain? A systematic review and meta-analysis. *BMC Med* 2017;15:13.
4 Kendell M, Beales D, Smith A, *et al*. The predictive ability of the start back screening tool was limited in a cohort with chronic low back pain. *Man Ther* 2016;25:e37–8.
5 Bergbom S, Boersma K, Linton SJ. When matching fails: understanding the process of matching Pain-Disability treatment to risk Profile. *J Occup Rehabil* 2015;25:518–26.
6 Bahr R. Why screening tests to predict injury do not work—and probably never will…: a critical review. *Br J Sports Med* 2016;50:776–80.

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