

**BACK PAIN**

(The following is a summary of Allan Panting's presentation to the Friday lunchtime meeting Feb. 2005)

**Case Study 1:**

40 year old process worker, same work > 5 years

Twisting at work moving bag of ice, severe low back pain

Continued to work over next two days despite pain, but then developed left leg pain.

Pain through leg to calf, severe, worse with coughing. No paraesthesia.

Bowel & bladder function unchanged

**O/E**

Slight build, moving carefully & protectively

Straight spine, = leg length,

Little unfolding of spine on flexion, good extension, decreased tilt to left but good tilt to right

No peripheral neurological abnormality

SLR – right 70<sup>0</sup>, left 40<sup>0</sup> with radiating pain

**DIAGNOSIS:**            **acute disc prolapse**

**INVESTIGATION:**    nil

**MANAGEMENT:**    Bed rest for a few days  
Regular paracetamol, NSAID  
Regular review

Post-acute phase:

Continue regular time-dependent analgesia

Encourage progressive increase in activity

Consider physiotherapy only when sciatic pain has settled

95% will settle with conservative care

**INDICATIONS FOR SURGERY**

- Cauda equina compromise (very rare)
- Progressive neurological deficit, particularly motor
- Pain failing to settle with appropriate conservative care

### Case Study 2:

50 year old housewife. 10 year history of intermittent back pain.

Worse recently – varying intensity. No real benefit with analgesics. No relationship to posture or movement.

Restricted activity. Sleep disturbed. Feeling of numbness left leg.

Reports previous MRI scan shows 2 severely affected discs.

O/E

Tearful, moves cautiously, slight limp

Straight spine, = leg length

Flexion – finger-tips to knee level, marked restriction of extension, approx 50% tilt

Reduced sensation light touch most of left leg & reduced pin-prick anterior thigh and lateral leg

Power normal. Reflexes brisk symmetrical

SLR : R = L (back pain limiting)

**INVESTIGATION:** X-rays show narrowing of both L5/S1 and L4/L5 disc with associated degenerative change – no real change compared to films 3 years earlier

**DIAGNOSIS:** **non-specific back pain**

**MANAGEMENT:** Reassurance – “not malignant, no fracture, no infection, no arthritis (inflammatory) x-rays about normal for age”

Encourage time-dependent analgesic

Discourage smoking – pain association

Encourage normal everyday activity

Follow-up 6 weeks

Review 6 weeks later:

Only slightly improved. Pain marginally better. Numbness leg not changed.

Lumbar spinal movement little better

Check diagnosis. Haematology

Repeat all advice of last consultation

Shift focus to activity level rather than pain

Consider physio referral for pool therapy

Consider amitriptyline at night

Follow-up 6 weeks

Review 6 weeks later:

Markedly improved. Pain now intermittent and less troubling. Numbness resolved

Able to complete all household chores except vacuuming

Moving easily – no limp. Flexion – fingertips to ankle level. Extension mildly restricted

Encourage further increase in activity - all home tasks, return to regular exercise

Weight control

Progressively discard analgesics

Advise self care for next episode

### REMINDER

- Majority of patients present with non-specific pain
- Pain cannot be seen by X-ray, CT or MRI
- General practitioners are better placed than specialists to provide the extended care and follow-up required in protracted cases