Biopsychosocial approach

Your patient is not a machine!!!:

What does he think about his illness?-cause, effect on lifestyle, what does he want done?

What are the social issues that impact his condition? – work, compensation, family, sex life

What is wrong? – try to create a common understanding

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Patient Centeredness

Treat pt. as unique individual-not a case of….

Welcome him

Smile at him, exchange greetings, give him time to tell his story

Ask him questions – let him ask questions

Respect - his story, his body, his views/values

Discuss/explain - diagnosis, investigations, treatment plans (as appropriate)

Create rapport/friendship/a healing relationship

Low back pain

Very common condition – 49% to 70% life prevalence, 12% to 30% point prevalence

Health care costs – about $6,000 per year, per patient (2005)

Compromises- mobility, productivity, attendance at work

Can be excruciatingly painful

NB – pancreatitis, nephrolithiasis, pyelonephritis, aortic aneurysm, endocarditis, impotence, work compensation

85% of low back pain has no major underlying disease (body pathology) - non specific LBP

Rule out:
compression fracture – 4%
herniated disc (disc prolapse) – 4%

ankylosing spondylitis - 0.3-4%
symptomatic spinal stenosis – 3%

cancer – 0.7%
cauda equina syndrome – 0.04%

spinal infections – 0.01% (may be different in Africa)

Physical Examination to determine

A. Is there specific condition or pathology?

B. Is there neurological involvement; progressing, severe?

Based on findings:

i. Non specific LBP – manage

ii. Radiculopathy or spinal stenosis – refer

iii. Specific cause e.g. TB or compression fracture - manage or refer as appropriate

Non specific LBP

There is no significant underlying pathology

Most patients will get well

There is no need for investigations – X-rays, ultra sound, MRI, CT scans (drives unnecessary interventions and costs)

(Investigate only – severe/progressive nerve problems, suspected pathology)

Pharmacological treatment – non specific LBP

Most patients recover in 4 weeks – short course analgesics

No bed rest - encourage patient to remain active

Post 12 weeks and pain improvement minimal – reassess, give analgesics as required, multidisciplinary treatment programs, may refer for spine manipulation, consider psycho-social problems

Paracetamol, NSAIDs, Opioids, muscle relaxants, (anti depressants, topical medications, heat)

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Paracetamol

Analgesic, antipyretic, no anti inflammatory properties

Small or no effect as analgesic in non specific LBP

Less effective than NSAIDS but better SE profile

SE. Hepatotoxicity even at 4g/day (seems uncommon)
- chronic hepatitis in Botswana
- traditional medicine
-chronic headache

Pain is a social construct – is pain experienced similarly by Americans, Indians, Latinos, Africans???

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NSAIDS

Analgesic and anti inflammatory properties – block cyclo-oxygenase (Cox) 1 and 2 (non selective), 2 (selective)

Cox-1 protects stomach lining

Suggested 1st line treatment

Selective and non selective equally effective

In Bots consider costs: Cox 2 vs. non selective with proton pump inhibitor (ibuprofen +omeprazole)

NSAIDs SE profile

Hepatotoxicity

Gastric ulcers/ perforation

Myocardial infarction

CCF (elderly)

Complicate BP treatment

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Opioids

For pain not controlled with paracetamol or NSAIDs

Use for severe, disabling pain – who judges? How?

For patients with high risk for side effects of NSAIDs treatment

Starting patients on opioids should be considered carefully – abuse

Substance abuse – personal or family history of substance abuse

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Opioids

- Side effects
- Nausea
- Constipation
- Somnolence
- Myclonus
- Pruritis

Abuse is a problem

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Tramadol

Affinity for opioid α receptors

Not first line treatment

Has similar effects as NSAIDS

SE - potential for serotonin syndrome: agitation, confusion, fever, tachycardia, hypertension, rigidity, seizures, diarrhoea, sweating, shivering

Antidepressants

Tricyclic anti depressants (TCAs) commonly used for chronic nsLBP

Doubtful efficacy for pain relief

Side effects: dry mouth, dizziness, arrhythmias, QRS prolongation

Skeletal Muscle Relaxants

Have modest effect on pain relief

Use in acute cases

Combine with paracetamol or NSAIDs

SE – sedation, hepatotoxicity (some)

Other Medications

Anti-epileptics – insufficient evidence to recommend

Systemic Corticosteroids – not recommended

In Botswana – consider topical treatments; methyl salicylate, deep heat rub, and other skin preparations

Ref.

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