

## Concord Sport & Spine Newsletter



### “Non-specific Low Back Pain”

As far as I can determine, the expression *non-specific low back pain* (NSLBP), was first used by Deyo and Phillips in 1996. It has come to be accepted terminology by low back pain researchers around the world. A definition of the term was provided by the National Institute for Health and Clinical Excellence in 2009 with their Low Back Pain Guidelines. They stated “Non-specific low back pain is tension, soreness and/or stiffness in the lower back region for which it is not possible to identify a specific cause of the pain. Several structures in the back, including the joints, discs, and connective tissues, may contribute to symptoms” It has been said that “The most common form of low back pain is non-specific low back pain.” (Maher et al 2017). It is widely reported that up to 90% of all low back pain (LBP) seen in primary healthcare falls under this “diagnosis”.

However, NSLBP it is not a diagnosis. It is a nonspecific and unclear term. And often, it is one that confuses and fails to reassure patients. It is an admission by its proponents that they don’t have a clue as to what is happening with 90% of painful backs. And what does this admission say to patients? Depending on their beliefs and perceptions, it could invoke one of several responses. For instance: “does this person know what they are doing?”. Worse still: “they don’t believe me” or “are they’re saying it’s in my head”. Or: “if you don’t know the cause, how can you tell me it’s not serious?” How about “if you don’t know, I insist on getting an MRI because I need to know!”

Patients presenting with acute or severe low back pain are often distressed, particularly if their

symptoms are unfamiliar. In seeking treatment, a primary requirement for their wellbeing is reassurance. According to the literature “patients main concerns are the need to seek **diagnosis**, treatment, cure...reassurance of the absence of pathological abnormality...and **wanting to be believed...**” (Froud et al 2014, cited in Maher et al 2017). Yet the back pain academics suggest we tell our patients that a diagnosis is impossible to provide. And when the patient has to tell friends or family that no one knows the cause of their pain, wouldn’t they be concerned that they are not going to be believed?

Researchers go so far as to say “by definition, NSLBP does not have a known pathoanatomical cause. There are therefore **no specific treatments that can be provided for non-specific low back pain**...management focuses on reducing pain and its consequences...” If this is the case, as a clinician who provides effective specific treatments, could it be that, by some peculiarity, my patients do have a specific cause? Because our imaging techniques are not sensitive enough to trace the source of pain, should we deny our patients important knowledge if our experience, thinking or methods aren’t advanced enough to provide irrefutable proof of the exact area of injury or disease?

When you know the correct questions to ask, and what examination procedures are most relevant, back pain presentations become very familiar. And when you have a specific diagnosis and knowledge of how injured tissues behave, predicting how that condition will respond to treatment becomes quite reliable. To the experienced clinician, unfamiliar

presentations are rare.

Once red flag conditions are excluded, the patient needs to be empowered with knowledge to reassure them that their condition is not serious, and that they will get better. They need an informed and knowledgeable explanation. I educate my patients about their condition, and provide them with a structural diagnosis. The diagnosis is based on sound pathophysiological and anatomical knowledge. Once provided, this makes perfect sense to the patient, because it explains the reasons for the things that have happened to them since their pain began. The patient then 'buys in' to both the explanation and proposed remedy. This is essential, because the patient's role in management is crucial.

There are two areas of science that are very closely drawn upon in the practice of physiotherapy – anatomy and biomechanics. The anatomy is appreciated early in one's career. However, the mechanics of how the moving parts of the body behave in injury and health is a life-long learning experience. Those with significant experience appreciate that LBP is a mechanical condition. Specific forces applied, particularly over extended periods, will result in a predictable response. And once you have seen a particular (or substitute the word 'specific') presentation thousands of times, it becomes routine to identify the patterns that make this condition recognizable. When understanding the mechanical forces at play, therein lies the key to both the causes and the effective treatments for LBP.

Unfortunately, there is a large disconnect between experienced clinicians who treat back pain every day, and non-clinical researchers who look at the available evidence. Those researchers know as much about clinical practice as I do about methodology and statistics (which is very little). Hopefully this will change in the future. Just as the experienced clinician knows the right questions to ask in the clinic, the right research questions need to be asked so as to be relevant to all those poor 'non-specific' sufferers out there.

#### References:

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4. Maher, C et al (2017). Non-specific low back pain. *The Lancet*, **389**, 736-747.

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