Spinal surgery for chronic low back pain: review of clinical evidence and guidelines

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Record Status
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Citation

Authors' objectives
The objective of this rapid systematic review is to facilitate the appropriate referral of patients with CLBP to surgical specialists in acute hospitals by summarising the evidence base regarding thresholds of pathology for surgical specialist referral, evaluating the comparative clinical effectiveness of surgery versus alternative treatments and identifying the non-surgical therapies available in Victoria for patients with CLBP according to the following research questions. 1. Does the evidence show a clinical threshold of pathology for CLBP below which referral for surgical opinion is not required? 2. Is there evidence on the clinical effectiveness of alternative treatments compared with surgery for CLBP? 3. Are effective alternative therapies for CLBP accessible throughout Victoria?

Authors' conclusions
While there is evidence to suggest that surgery provides benefit for a select subset of patients with CLBP, there remains a significant demand for specialist assessment for back pain in Victoria. Inappropriate surgical referrals in Victoria were attributed to both patient and GP factors. GPs may need further information regarding the pathophysiology of back and radicular pain, along with information about the facilities and treatments available in Victoria, as there is a tendency for some GPs to refer patients with refractory pain who have not explored all conservative treatment options. Patients often hold inappropriate expectations about surgical outcomes and many GPs may be unaware of which types of back pain are amenable to surgical treatment. Access to physiotherapy in the private system is limited by cost to the patient, and there is a long wait to access publicly funded pain management programmes and physiotherapy-led clinics in Victoria. Consequently, patients may experience a long wait to receive only short periods of treatment. However, anecdotal evidence suggested that physiotherapy-led clinics are reducing over-referral and improving patient outcomes in Victoria by enabling patients to be treated sooner. Once a GP has ruled out a pathological cause for persistent low back pain, a patient can be managed in primary care indefinitely. Often patients with apparently refractory pain can benefit from continued treatment in the primary care setting after careful reevaluation of their treatment plan and degree of compliance by an appropriately trained primary care practitioner. Conservative care involves active, long-term management by GPs and significant buy-in from patients to self-manage their condition. A universal guideline or algorithm for the management of patients with CLBP in primary care may support GPs in this role, but there are other barriers to primary care treatment of CLBP including a lack of knowledge among GPs about the range of facilities and non-surgical treatments available and the types of back pain that are amenable to surgery, as well as limited access to physiotherapy-led clinics and multidisciplinary care programmes. Compliance with guidelines has been relatively poor worldwide; however, there are successful efforts to bridge the guideline implementation gap using structured referral forms, involvement of consultants in educational activities, specialised clinics and financial incentives. A programme in Canada reduced variations in practice patterns by developing a systematic care pathway for the management of low back pain that involved spine surgeons, physicians and chiropractic, physiotherapy and pain clinics. The spinal care pathways significantly reduced the number of unnecessary surgical referrals, with potential cost savings and improved patient care. However, for any CPG or care pathway to be successful, it must have the buy-in of all stakeholders affected by its guidance and be actively supported with appropriate educational initiatives.

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