



A summary of prescribing recommendations from NICE guidance

Low back pain and sciatica in over 16's

NICE NG59; 2016

This guideline covers the assessment and management of low back pain with or without sciatica in people aged ≥16 years.

Definition of terms

SSRI	selective serotonin reuptake inhibitor
SNRI	serotonin–norepinephrine reuptake inhibitor
TCA	tricyclic antidepressant
PENS	percutaneous electrical nerve stimulation
TENS	transcutaneous electrical nerve stimulation
NSAID	non-steroidal anti-inflammatory

Sciatica

- ◆ Sciatica in this guideline describes leg pain secondary to lumbosacral nerve root pathology.
- ◆ This guideline does not cover the evaluation or care of people with sciatica with progressive neurological deficit or cauda equine syndrome. Clinicians should be aware of these potential neurological emergencies and know when to refer to an appropriate specialist.

Assessment

- ◆ Think about alternative diagnoses when examining or reviewing people with low back pain, particularly if they develop new or changed symptoms.
- ◆ Exclude specific causes of low back pain e.g. cancer, infection, trauma or inflammatory disease such as spondyloarthritis. If serious underlying pathology is suspected see [NICE pathway: metastatic spinal cord compression, trauma \(spinal injury\), suspected cancer recognition and referral \(pain section\)](#).
- ◆ Consider using risk stratification (e.g. [STarT Back](#) risk assessment tool) at first point of contact with a healthcare professional for each new episode of low back pain with or without sciatica to inform shared decision-making about management.
- ◆ Based on risk stratification consider:
 - simpler and less intensive support for people likely to improve quickly and have a good outcome e.g. reassurance, advice to keep active and guidance on self-management,
 - more complex and intensive support for people at higher risk of a poor outcome e.g. exercise programmes with or without manual therapy or using a psychological approach.

Imaging

- ◆ **Do NOT** routinely offer imaging in a non-specialist setting.
- ◆ Explain to people that if they are being referred for specialist opinion, they may not need imaging.
- ◆ Consider imaging in specialist settings of care (e.g. a musculoskeletal interface clinic or hospital) only if the result is likely to change management.

Treatment and management

Self-management

- ◆ Provide people with advice and information, tailored to their needs and capabilities, to help them self-manage their pain, at all steps of the treatment pathway. Include:
 - information on the nature of low back pain and sciatica,
 - encouragement to continue with normal activities.

- ◆ Promote and facilitate return to work or normal activities of daily living: see [NICE pathway: managing long-term sickness and incapacity for work](#).

Exercise

- ◆ Consider a group exercise programme (biomechanical, aerobic, mind–body or a combination of approaches) within the NHS for people with a specific episode or flare-up of low back pain with or without sciatica. Take people's specific needs, preferences and capabilities into account when choosing the type of exercise.

Manual therapies

- ◆ Manual therapies include spinal manipulation, mobilisation or soft tissue techniques e.g. massage.
- ◆ Consider manual therapy but only as part of a treatment package including exercise, with or without psychological therapy.

Psychological therapy

- ◆ Consider psychological therapies using a cognitive behavioural approach but only as part of a treatment package including exercise, with or without manual therapy.

Combined physical and psychological programmes

- ◆ Consider a combined physical and psychological programme, incorporating a cognitive behavioural approach (preferably in a group context that takes into account a person's specific needs and capabilities), for people with **persistent** low back pain or sciatica:
 - when they have significant psychosocial obstacles to recovery e.g. avoiding normal activities based on inappropriate beliefs about their condition, **OR**
 - when previous treatments have not been effective.

Do NOT offer:

- ◆ acupuncture
- ◆ ultrasound.
- ◆ PENS
- ◆ TENS
- ◆ interferential therapy
- ◆ traction
- ◆ belts or corsets
- ◆ foot orthotics or rocker sole shoes
- ◆ spinal injections for low back pain
- ◆ disc replacement in people with low back pain
- ◆ spinal fusion for people with low back pain unless as part of a randomised controlled trial.

Radiofrequency denervation

- ◆ Consider referral for assessment for radiofrequency denervation for people with chronic low back pain when:
 - non-surgical treatment has not worked, **AND**
 - the main source of pain is thought to come from structures supplied by the medial branch nerve, **AND**
 - they have moderate or severe levels of localised back pain (rated as ≥5 on a visual analogue scale, or equivalent) at the time of referral.

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- ◆ Only perform radiofrequency denervation in people with chronic low back pain after a positive response to a diagnostic medial branch block.
- ◆ **Do NOT** offer imaging for people with low back pain with specific facet joint pain as a prerequisite for radiofrequency denervation.

Surgical procedures – see [NICE pathway](#)

Also see:

[NICE interventional procedures guidance with special arrangements for clinical governance, consent and audit or research.](#)

Sciatica - additional treatments**Pharmacological treatment** – see **Box 1**

- ◆ For recommendations on pharmacological management of sciatica see [NICE pathway: Neuropathic pain in adults](#)

Epidural injections

- ◆ Consider epidural injections of local anaesthetic and steroid in people with acute and severe sciatica.
- ◆ **Do NOT** use epidural injections for neurogenic claudication in people who have central spinal canal stenosis.

Spinal decompression

- ◆ Consider spinal decompression for people with sciatica when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms.

Referral

- ◆ **Do NOT** allow a person's BMI, smoking status or psychological distress to influence the decision to refer them for a surgical opinion for sciatica.

Additional resources**Infographic: Managing low back pain and sciatica**

<http://www.bmj.com/content/bmj/suppl/2017/01/06/bmj.i6748.DC1/beri151216.w1.pdf>

STarT Back risk assessment tool:

<https://www.keele.ac.uk/sbst/>

NICE: Key Therapeutic Topic (KTT13): NSAIDs

<https://www.nice.org.uk/advice/ktt13>

Find NICE Bites at:

www.sps.nhs.uk

Type **NICE Bites** into the search box to access all editions of this bulletin.

Recommendations – wording used such as 'offer' and 'consider' denote the [strength of the recommendation](#).

Drug recommendations – the guideline assumes that prescribers will use a drug's [Summary of Product Characteristics \(SPC\)](#) to inform treatment decisions.

Box 1**Pharmacological treatment****Low back pain**

- ◆ Consider oral NSAIDs for managing low back pain.
- ◆ Take into account potential differences in gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age.**
- ◆ When prescribing oral NSAIDs, think about appropriate:
 - > clinical assessment,
 - > ongoing monitoring of risk factors,
 - > use of gastroprotective treatment.
- ◆ Prescribe oral NSAIDs at the lowest effective dose for the shortest possible period of time.
- ◆ Consider weak opioids (with or without paracetamol) for managing acute low back pain **only** if an NSAID is contraindicated, not tolerated or has been ineffective.
- ◆ **Do NOT** offer paracetamol alone.
- ◆ **Do NOT** routinely offer opioids for managing **acute** low back pain.
- ◆ **Do NOT** offer opioids for managing **chronic** low back pain.
- ◆ **Do NOT** offer SSRIs, SNRIs or tricyclic antidepressants.
- ◆ **Do NOT** offer anticonvulsants.

Sciatica

- ◆ See [NICE pathway: Neuropathic pain in adults](#):
- ◆ Offer a choice of amitriptyline^U, duloxetine^a, gabapentin^b or pregabalin as initial treatment for neuropathic pain.
- ◆ If initial treatment is not effective or not tolerated, offer one of the remaining three drugs. Consider switching again if the second and third drugs tried are also not effective or not tolerated.
- ◆ Consider tramadol only if acute rescue therapy is needed (i.e. short term use only).
- ◆ Consider capsaicin cream^c for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments.
- ◆ **Do NOT** start treatment with any of the following for neuropathic pain in non-specialist settings, unless advised by a specialist to do so:
 - > cannabis sativa extract,
 - > capsaicin patch,
 - > lacosamide,
 - > lamotrigine,
 - > levetiracetam,
 - > morphine,
 - > oxcarbazepine,
 - > topiramate,
 - > tramadol (long-term use),
 - > venlafaxine.

** See CKS guidance: NSAIDs – prescribing issues:

<https://cks.nice.org.uk/nsaids-prescribing-issues#!scenario>

U Unlicensed indication. Obtain and document informed consent.
a duloxetine is licensed for diabetic peripheral neuropathic pain only.

b gabapentin is licensed for peripheral neuropathic pain only.

c capsaicin cream is licensed for post-herpetic neuralgia and painful diabetic peripheral polyneuropathy.