Low back pain scope stakeholder subgroup discussions Date: Thursday 3rd October 2013 (Time: 10am–1pm)			
Group 1	**Group 2**	**Group 3**	**Group 4**
Is the population appropriate for groups that will be covered?			
Age 16 to be more appropriate lower age limit? Danger of people being missed out between paediatrics and adult care. Overall consensus was that 16 was a more fitting lower threshold for the usual clinical population. Need for paediatric LBP expert though. Lots of armed forces literature. But red flag is age <18, so this would need to be amended. Licencing of drugs another issue against having 16 as threshold. Also issues of consent. LBP >6 weeks? Need for the guideline to look at people before this stage. <u>Preventative issues – can this be included?</u> 6 weeks coincides with point where people come back to their GP if problem continues. Also point at which pain is most severe. A bit late?? Need to get people early to prevent progression to chronic pain, especially for people with radiculopathy/motor deficits. Need for GPs to refer on such LBP	Struggle to find services for 16 years, adolescents also likely to have further problems. Desire to include under 18s. Behaviour patterns set in at that age. Would want to intervene at age 14/15. Cut off should align with current NHS services (e.g. paediatric up to age 16). Age 12 – 14 potential for developing back habits and potential to intervene. Is there targeted evidence for under 18s or would we need to extrapolate evidence from adults? There is variation in the cut off for adult in some trials and classification can depend on whether or not in education. Will be difficult below 18. May be helpful to co-opt a paediatric specialist to help. Most studies age range 18-65. Any issues over 65: Spinal stenosis, degenerative spine. People still work at age 65. May need to extrapolate for over 65 as many studies have 65 as the upper limit. Guideline shouldn't set an upper age limit but should exclude deformities e.g. degenerative scoliosis.	0-18 covered elsewhere? Would be good to have separate guidance in this age group. 18 good cut off – maturity of skeleton. Would be applied in practice by clinicians in 16-18 year olds so not a problem to use artificial cut off. Take out word "motor" and leave as "neurological deficit" Want to include all people with sensory symptoms. Simple/non-specific used in literature however manual therapists often find a cause once treating. Separate out those with underlying pathology. Difficult to tell true motor deficit – these patients probably on different pathway. 6 weeks? Lots of discussion on this. Odd to differ between this and 2 weeks for radicular pain in c). Attempt to separate acute and chronic LBP – assumption is acute LBP gets better – would be good to include the acute patients or least change to 2 weeks to match c).	People are unclear about what is non-specific back pain and we should ensure that the guideline has a clear definition for this. People need a good steer on what is meant by non-specific back pain – this is not just the presence or absence of a spondylolisthesis. This is particularly an issue within primary care. We need to have a clear guidance on who is escalated from primary to secondary care. The group discussed some alternative names for this – perhaps mechanical back pain would be more appropriate. However, the group did not feel that these are correct – we just need to ensure that we are clear from the outset what these terms mean. The guideline needs to divide patient groups by something more appropriate to the pathway that they are going to take – for example, we

patients earlier (no later than 2 weeks from ONSET). Overall, consensus was that guideline should start earlier for LBP but that 2 weeks for sciatica was about right. What about differentiating between true continuous chronic pain and episodic intermittent pain. Is this captured in the scope yet? Is 'persistent' a good word to use? 'Problematic' pain, 'high impact' or 'complex' pain?	Non-specific LBP 6 weeks: Patients referred to occupational physician after 4 weeks off work. 6 weeks off work is a long time. Suggest earlier time frame for employed people. Patients may not present until LBP is chronic, months / years of pain before presentation. 6 weeks is ok but need to consider length of time prior to presentation. Group of people with 'recurrent' back pain – acute episodic pain in the context of chronic long term back pain. Radicular pain: Happy with 2 weeks, unhappy with word 'sciatica' – state radicular / nerve root. Claudication – management is very different to acute disc prolapse (no bony narrowing). Claudication used for bone narrowing. State nerve root pain/ radicular pain in scope, not sciatica. Radicular pain could be a stand-alone guideline. Query whether both LBP and radicular pain can be covered in one guideline. Appropriate that they are both covered in the same guideline, but will need more clinical questions. Neurological deficit is key for definition of radicular pain	Would GPs be able to manage those people with acute LBP 2 weeks – feeling that acute pain often self-limiting. Unworkable, not pragmatic. Risk of overtreatment? Everyone happy with the addition of sciatica. Neck pain/upper back pain – not currently considered in guidelines – some patients have both this and LBP concurrently. Where do they fit? Sports medicine? May have better access to sports physiotherapist. Very active population / very sedentary people? Think all covered. Agreed with removal of 12 months limit.	can divide people by the intervention that they are most suited to, rather than grouping people into a single population group. We need to signpost the people who need to go to secondary care. People who are not signposted correctly are likely to continue to have pain and to take up a greater amount of resources. The group discussed the 16-18 year old group. Young people fall within two camps. The group felt that 16-18 years should potentially be considered although they acknowledged that there was a lack of data in this area. The group discussed the 6 week and 2 week cut off for non-specific and radicular pain. The group felt that we should consider people from 2 weeks (or potentially 3-4 weeks) for all populations, perhaps considering those who do not resolve at 6 weeks as a subgroup. The group felt that this was a significant amount of time for example, to not be at work and that the outcomes for people who

	Is it 2 weeks from onset of symptoms? This may be unrealistic. State 2 weeks from onset of treatment / presentation. Difficulty getting patients assessed/ diagnosed in 2 weeks. Some patients may initially be managed by GP with painkillers for 2 weeks before referred for specialist assessment. Some patients cope with pain for a long time before presenting. Group asked to send pathways to the NCGC. NHS England currently working on national pathfinder project for commissioning. Early referral for surgical opinion for radicular pain is important. Need to clearly define the 3 groups: 1. LBP only 2. Radicular pain only 3. Both LBP and radicular pain. People can move between the three groups.		present for 2 weeks are better than those who present later. The group felt that potentially the standard definition of what constitutes acute and chronic does not fit the practicality of the situation. Pleased with the removal of the cut off of 12 months.
Groups that will not be covered			
Spondylolisthesis is often incidental so shouldn't be an exclusion unless it is clearly the sole cause of the pain. But how would we know? Same arguments for scoliosis. <u>Definitions of exclusions need to be clearer.</u>	Spondylolisthesis group- early management of low grade spondylolisthesis should be included. Suggest high grade spondylolisthesis is excluded (grade 2 plus). Degenerative scoliosis with radicular	Difficulties identifying people with e.g. spondylolisthesis without imaging – worth taking this out of the bullet point. These patients would benefit from of the interventions e.g. conservative management/exercise. Pelvic ring pain patients could benefit also. Not sure	Should consider referencing red or yellow flags.

Cancer – should such a red flag be an exclusion criterion, or just a warning to instil caution? Again, is the pain DUE to the cancer or is it co-incidental? This needs to be clearer in scope.	pain, ankylosing spondylitis: initial management is similar to LBP - management diverges when symptoms change. Cancer, fractures and sepsis should definitely be excluded. Agreed that cauda equina syndrome should be excluded.	about pelvic ring pain. Suggest exclude red flags then look at all other patients? Will guideline cover diagnosis in any more detail – present with LBP need to go through red flags first to exclude some of these conditions, trauma, etc. Once these excluded what is left to cover? LBP poorly defined?	
Are there any specific subgroups that have not been mentioned?			
Very elderly? Their drug treatments may be different.	Patients with high psychosocial comorbidities (e.g. anxiety, depression, poor coping mechanisms). Occupational risk: e.g. NHS workers, emergency services, post workers		Groups of patients with high psychological distress could be considered as a patient subgroup – these people react differently to interventions and need input very early. This would also be a reason for including people from an earlier stage and having an assessment as early as possible. These are people who have a 'yellow' flag. Could people with recurrent back pain be considered here? There is limited evidence specifically in this population but they may require different recommendations and management strategies.
Have we covered all the key clinical issues?			
The assessment process should be	Include CPPP (combined physical and	Good to include these different areas	Systematic assessment should

applied to a timeline. Duration from onset, and episodic/chronic is an important part of assessment – could be a useful prognostic factor. <u>Diagnosis</u> is an important area to be covered – needs to be clearer in scope that it is. Need for early differentiation between mechanical and no mechanical pain Antibiotics: A big area – thus important. Controversial so needs to go in the scope. Other drugs? Topicals need to be included too. Maybe should be very clear about the distinction between topicals and orals. Overall, agreed that the list covers all the important areas comprehensively. Surgery: A GP stated that the primary care pathway is the most important thing. Felt to be relevant to radicular problems, but not simple LBP. Need to just have questions on referral or actual questions about different surgery types? No orthopaedic surgeon present so group reticent to decide. 'Spinal manipulation' might be better	psychological program) was not implemented from previous guideline. There are high and low intensity versions of CPPP. Back schools outdated – remove. Separate workplace interventions as a separate bullet point. Move acupuncture to point c). Manual therapy includes massage, mobilisation and manipulation. Revise this sentence in the scope. Postural therapy is exercise-based (using muscles). Move postural therapy into exercise therapies. Patient choice is an important theme. There needs to be a managed process of care (a healthcare professional to oversee an individual's care). Cost effectiveness of guideline-driven care vs. individual clinician choice of care. Issues with RCTs for LBP– not possible to	of assessment. Good to assess at 2-4 weeks to guide patients to relevant treatment. Referring from primary care already if talking about imaging? Analgesics – includes everything: opioids, NSAIDs, paracetamol, etc. Antibiotics: danger that guideline accused of being out of date before it starts. Perhaps worth including to say more research required. Experience of patients with LBP caused by constipation which is relieved by antibiotics/laxatives. May be useful. Mixed feelings as to whether it should be included. Would be odd not to include as leaves a grey area where there may be question marks. Diet? Weight loss? – Would this be under self-management/patient education & advice. Current guidance says A or B or C which doesn't allow a multimodal approach (NHS trust won't fund it). Could we include evidence to support multimodal therapies? Could we include a separate point on	potentially be renamed to diagnosis. We need to identify different patients at an early stage so we can identify the best possible intervention for these individuals. This should include imaging. Antibiotics – we should definitely consider this as we need to consider the evidence and identify whether practice is appropriate or not. The research on this area is quite early. There are a group of patients who have a virus which leads to chronic back pain and there are implications in terms of resistance etc. These antibiotics are licensed for this indication. There should be a clear indication for how these people are identified and how we prove the presence of an infection. These are a difficult patient group to identify. We could deprioritise muscle relaxants if necessary. Antidepressants and antiepileptics could be grouped together as

than 'manipulative' – maybe we need to make it clearer that manipulation is a chiropractic/osteopathic technique. But also stated that interventions are the important aspect, and the professions providing them are secondary considerations. Need to avoid focussing on 'physiotherapy' which can exclude the other manual therapists. Self-management should be prioritised. Not just about lifestyle – about proactive management. Very important is accurate education – i.e. not just advising bed-rest! Health trainers – query on their efficacy? Psychological should also be prioritised – maybe after self-management. Issues about whether we should look at issues around training manual therapists to provide behavioural therapies as part of their scope of practice. Advice for employers may also be needed – i.e. lighter duties rather than home rest. Invasive therapies – belongs in tertiary guidance, which should be separate? But others said it should be part of primary care. Overall, though, agreement that the guideline should cover all NHS settings.	blind. Observational and cohort studies will be used where appropriate. Timing of therapy is important. At what stage to give treatment? Lifestyle interventions e.g. smoking and weight loss. We will cross-refer to relevant NICE guidance. Link between smoking and disc degeneration. Affects surgical decision-making. Self-management strategies could be expanded (information provision, education). Use of antibiotics: Group felt important to include. Currently little evidence but this may change during the duration of the guideline. Caution needed re: antibiotics (e.g., GPs prescribing more antibiotics would have a big impact in terms of harmful effects). Could lead to a research recommendation. GP view that place of antibiotics is in secondary care. 'Startback' stratification tool to quantify	combination/multimodal/packaged care. Recommendations need to be written in order that combinations can be made. Alexander Technique = postural & movement re-education/education strategy. Electrotherapeutic modalities – include TENS (excluded from previous guideline). Orthotics & appliances – could mention podiatry here as overlaps. Add diet/weight loss to self-management. Back schools/groups – group therapy. Posture etc. Surgery – should be a referral for specialist opinion e.g. pain mgmt. specialist - which surgery is one option. This might include further testing for specific pathology. If evidence for surgery is not strong then could refer to someone other than a surgeon for an opinion of where next.	neuroactives. Exercise therapies are important to consider. The group discussed yoga which would be considered as both an exercise therapy or psychological therapy. The group felt that this could be considered in a group called combination therapy (this could include electroacupuncture, acupuncture and yoga). Acupuncture should be considered to be a non-pharmacological therapy rather than an invasive procedure. Difficult to identify which categories we use and which therapies are put into each group. Electrotherapeutic modalities should include TENS, acuTENs etc. as these are non-invasive. Psychological interventions do not need to be led by psychologist. There is for example, psychological physiotherapy – we should consider psychological techniques which can be delivered by a range of healthcare

	risk based on distress. Surgery: Suggestion it should be indications for surgical referral (e.g. consultation) rather than indications for surgery. Surgical interventions - For radicular pain e.g. spinal cord stimulation, microdiscectomy, discectomy, lumbar decompressions (e.g. laminectomy, NB there were other types of surgery for decompression that I didn't capture) disc replacement, spinal fusion. - For LBP: Fusion, total disc replacement, flexible stabilisation Questions are effectiveness, cost effectiveness, complications and long-term outcomes.	Indication for referral to pain management specialist? As important. Should also be included prior to surgery.	professionals. Overlap with the section on lifestyle interventions. These bullet points could be merged or replaced by psychosocial interventions. Lifestyle therapies – complementary therapists would say that lifestyle interventions are part of their treatments. Some of these may be specific to the therapy for example, acupuncture would include lifestyle interventions for example, massage and therapeutic intervention. This should be considered when we are looking at acupuncture and other therapies. We need to consider the duration of some of these therapies – we can't have people coming back. This could be a potential area for health economics. These recommendations also need to be implementable. Communication and information for patients – we need to develop a common, non-threatening language for patients who have back pain. There is a large variation in the

			language used by the large range of healthcare professionals involved in the care of these people. For example, the use of degenerative etc. may be non-patient friendly language. This would help to make the recommendations more implementable. For example, the term non-specific is a good example of this – patients do not like the term non-specific. This needs to be standardised. This is something that there would be evidence on. The group felt that the indications for surgery should be broadened to indications for referral to secondary care as well.
Have we captured the relevant outcomes?			
Maybe not pain at top. Bournemouth Questionnaire also good for functional measures. Also SIGN chronic pain. Startback used as an outcome too? Mobility suggested as a VAS scale. How useful would it be to measure pain frequency as well as severity, if so how? Number of days of pain per week / month? Felt to have potential to over complicate things. Severity could capture this if we	Patient-reported condition-specific outcomes e.g. Bournemouth questionnaire, validated for LBP but not sciatica. Used by multidisciplinary health professionals. Workability index – measure of function in the workplace. Return to work. Need caution re: using	Adverse events should include overtreatment. Useful from patients' point of view to measure pain frequency as well as severity. A good study would have range of different pain measures. Frequency should be included. Median number of days/4 week period. Not aware of validation studies. Also a fortnightly measure which better for	Concerns about using the VAS for initial assessment. This would be appropriate for pain relief rather than pain intensity. Numerical scales are a more appropriate measure. Absence from work and return to work are difficult to capture. Return to normal functioning.

ask patients about severity over a time period.	'work' as this could be discriminatory.	patients as don't have to remember 4 week period. Many studies don't include frequency. Feeling that patients include frequency when they report quality of life. Work on PROMs ongoing. Most people want a 50% reduction in pain. **What are the main ways that pain will be measured? VAS / NRS?:** NRS is more common now. Brief pain inventory. Separate measure reported recently = patient satisfaction. Additional to all these outcomes in scope.	Pain frequency is important as well as pain severity – these can be measured using pain diaries. Some queries about how useful these measures would be – this might need a bit more thought. This frequency could be interlinked with the functional and quality of life related measures. Need to define the follow up times – a minimum of 6 months, 12 months. Need to consider how we can look at people who have recurrent back pain separately. We need to think about how we can measure return to work and whether there is any way to do this. We need to make sure that people who have a new event which has caused the pain are excluded. We could consider specifying this within the scope. This could be considered when we are looking at the quality of the evidence. We should make Roland Morris and Oswestry examples of function scales.

			A&E attendances – this is an important outcome to consider.
• **Will the social aspects of 'Disability' (e.g. days of work absenteeism, reduced activities in daily living) be captured within health related quality of life measures? If not, how could it adequately be captured?**			
The group felt it would be adequately captured by EQ-5D and SF-36.		Working has many issues associated – graduated return to work possible in some areas. Return to work may depend more on HR department/occupational health than the person with LBP. Recording fit for work not helpful. Captured in public health guidance? Don't want to miss disability scores other than Roland & Morris/Oswestry. Need to think about how they're validated (which setting, use in primary/secondary care etc.). Studies sometimes group scoring systems – can be dangerous to include these measures. All validated tools should be included.	Work is not covered by all of the disability scores.
• **Are you aware of any established minimal important differences (MID) for these outcomes to help us determine clinical importance?**			
Nicholas has done work on this. 2cm on a 10cm scale is felt to be a good MID for VAS. 30% global response also felt to be a clinically important value.		50% reduction in pain. Or one third difference in score. Each outcome will have its own MID differs according to individuals/population.	Publications using thousands of patients on MIDs. Take a median of 30%. International consensus of change in Roland and Morris.

Further Questions:			
Are there any critical clinical issues that have been missed from the Scope that will make a difference to patient care?			
		Referral to specialist opinion Effects of intervention delay – how much difference does not having treatment in certain time make.	
Are there any areas currently in the Scope that are irrelevant and should be deleted?			
Are there areas of diverse or unsafe practice or uncertainty that need to be addressed that aren't currently covered?			
			Adverse events from the misuse and overuse of opioids. BPS are looking at upper limits and long term advantages of opioids, as well as increasing the awareness amongst GPs on the different types of opioids. RCGP are currently developing relevant guidance on this area and this might be something that we can cross refer to.
Which practices have the most marked/biggest cost implications for the NHS? (ensure the group understand we look at cost effectiveness as well as clinical effectiveness)			
		Surgery. Overtreatment – primary to secondary care – cost effectiveness needs to be broken down so costs can be addressed. Number of appointments in general practice.	Duration of lifestyle therapies. Imaging and early and accurate diagnosis. Stratified care – if we could prevent everyone who is high risk from having no more than one consultation, this would be potentially cost saving. Indications for surgery – it is important that we have the most appropriate patients for surgery.

			Selection procedures are generally more appropriate in the UK than in the US. Some of the spinal surgeries would challenge this QALY threshold. Lots of interventional procedure (IP) guidance in this area but these rarely cover standard treatments. We need to identify the patients who are appropriate for surgery as early as possible in the pathway. Some pharmacological interventions may have costly implications.
5. Are there any new practices that might save the NHS money whilst improving care for patients compared to existing practice?			
			Utilising conservative treatments. CG88 – problems in the incidence.
6. If you had to delete (or de prioritise) two areas from the Scope what would they be?			
		Antibiotics?	
7. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be?			
		Primary care. Stratified care – targeting treatments to the right people (bias) Referral patterns / capacity of e.g. physios to handle workload.	Could consider using community based triage clinics. Muscle relaxants. Physiological electrotherapies may be less important. Orthotics and appliances.
Any comments on GDG membership?			
Felt to be good. Spinal surgeon could include orthopods with interest in spinal surgery. CBT expert? Behavioural therapists and pain management experts maybe co-opted? Take physiotherapist out of the main list? Sports	Representative from Department of Work and Pensions (links to benefits, employment etc.). Occupational health physician (in addition to occupational therapist).	Commissioning manager – could be useful to translate complex area (maybe as co-optee). Rheumatologist could go (or co-optee? deliver these services in some areas).	Physiotherapist could be the person with spinal manipulation. A bit medical heavy. Epidemiologist – the group were unsure of who would be involved –

medicine expert. Sports therapist? Pharmacist on the main list? Felt pharmacists would be vital as drug treatment is a big issue. Add care of elderly expert for co-optees. Occupational health expert too. Self-management specialists? One member felt that osteopaths/chiropractors have an interest greater than just manipulation. Public health expert/epidemiologist too?	Specify back pain specialist (not just pain). Representatives from individual manual therapy groups, not one person to represent all types of therapy. Discussion whether both spinal surgeon and neurosurgeon needed. Spinal surgeon could be neurosurgeon or orthopaedic. Ideally want neurosurgeon and orthopaedic expertise. Radiologist should be a full member of GDG rather than co-opted (diagnostics and intervention).	Not sure if two surgeons necessary – could cover with one (neurosurgeon) – co-optee is necessary for other. Occupational health physician as extra Health ergonomist as co-optee.	could be an expert adviser. 1 general practitioner (they could be interested in acupuncture). Could potentially have one surgeon – widen this to all surgeons to see who we could get. Commissioner (potentially a co-optee). Acupuncturist as part of the full guideline – but could also be someone else on the group or combination therapist – we might be able to find someone who could be interested in. Should ensure that we have a broad range of primary care and secondary care practitioners – we should recruit broadly and then consider the individual specialists. Could consider co-opting a radiographer and a radiologist.
Other issues raised during subgroup discussion for noting:			
Guideline should focus on areas where we can add value (areas not in previous guideline / where new evidence is available). • Suggested barriers to implementation / commissioning barriers as a clinical question. • Prevention of LBP. • Change title to cover radicular pain. • Co-ordination through pathways of care. • Early assessment – getting the right person to the right treatment			

• Standardisation of language and communication.		
10. Any specific equalities issues relevant to low back pain that have not already been discussed?		
• Uptake of interventions based on ethnicity (for example, CBT). • Non-English speakers may have no access to psychological therapies e.g., CBT. • This would also apply to people who have learning difficulties.		