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Usefulness of disability to sub-classify chronic low back pain and the crucial role of rehabilitation

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The recently published "Diagnostic therapeutic flow-charts (DTF) for low back pain (LBP) patients: the Italian clinical guidelines" [1] have been developed in a completely multidisciplinary way, but there are some characteristics that are of high importance for Physical and Rehabilitation Medicine (P&RM), such as: the classificatory value for chronic LBP given to disability (high *vs* low); the distinction between pain-killer treatment and rehabilitation; the importance given not only to the treatment *per se*, but also to the counselling and to the other activities of daily life (ADL) interventions; the approach to secondary LBP management.

Since the publication in 1980 of the World Health Organization "Classification of impairments, disabilities and handicaps",[2] and even more today with the "International classification of functioning",[3] the international medical community cannot avoid to face the impact of disability on health conditions. This is why disability is not of interest exclusively for P&RM (the medical branch primary dealing with it), but for all medical specialties.[3] The actual use of disability questionnaires outside the field of P&RM testifies the interest of many clinicians to these aspects of treatment, as well as the penetration of P&RM concepts in the clinical world. LBP is exactly in this situation. In fact, perhaps because of its widespread in the society, as it happened with clinical guidelines which had some pioneers efforts on this topic,[4] also disability questionnaires for LBP diagnosis and treatment were early developed,[5] widely applied, and are today considered cornerstones of clinical and research methodology.[6, 7] Being this the situation, it sounds strange that the today most used and accepted classification, that goes beyond the pathological process and derives from epidemiological data the tools for prognosis and ultimately for the understanding of LBP,[8] did not look until this DTF experience at disability as a means to distinguish different patients. In particular, it is widely recognized that chronic LBP is the most important category of the usual classification, because it accounts for only 5% of patients, but almost as much as 80% of the costs related to LBP.[9] Chronic LBP is also the clinical situation in which it is more useful the use of disability questionnaires;[5] on the other hand, the last ones have been used and recognized to be able to distinguish between different kinds of patients according to limits today well established:[5] from all these considerations, it appeared perfectly logical and useful to apply disability scales to sub-classify chronic LBP patients. The distinction between low- and high-disability appears a perfect tool to decide whether to apply or not highly complex and costly therapies, to address or not the patients to specialized P&RM team, and ultimately to distinguish in terms of cost/benefit the clinical choices.[1] Finally, this decision, while perfectly logical, seems to stress the fact that the specialty mostly dealing with disability, P&RM, should be that with the best therapeutic weapons to face such a disabling condition as chronic LBP.[8]

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In the field of pain treatment, the focus of patients, and consequently of treating physicians, is quite obviously toward pain-killer therapies. On the other hand, in chronic LBP treatment it has been shown since many years that the attention should be shifted from pain to function,[10-12] and consequently from pain-killer to more complex multidisciplinary P&RM treatments.[13, 14] The DTF has obviously accepted and made transparent this evolution, classifying correctly the most evidence based treatments of chronic LBP (*i.e.* exercises,[15] cognitive behavioural approaches,[13, 14] back school,[16] multidisciplinary treatments [17]), in the field of P&RM, even if actually exists different applications according to the disciplines using this kind of treatments. This decision, and the clear cut distinction between rehabilitation and pain-killer therapy, lead to avoid the classical definition of conservative therapy, born to distinguish what was surgical *versus* what it was not. In fact, today we have both the words and the medical specialty for this kind of treatments, so to allow a definition that comes from positive (being something - rehabilitation) instead of negative terms (not being something – conservative, *i.e.* not surgical treatment).

It is widely recognized that an approach to the person with LBP, based on counselling, is much more efficacious and efficient than the classical, pharmacological and medical approach to the disease LBP:[18, 19] nevertheless, all existing clinical guidelines, even the most modern,[9] seem not to be able to avoid a presentation according to the classical medical model, listing all possible therapies. In the DTF, to stress that the approach should be toward the person affected by LBP and not the pathology,[8] all therapeutic flow-charts includes as first steps counselling, work and ADL interventions, physical activity counselling, and only afterwards the classical pain-killer therapy and, where needed, rehabilitation. The medical specialties that usually rely on these weapons, looking at the entire person and not simply at the disease itself, include general medicine (today accepted as the most important for low back pain) and P&RM.

Another important point of the DTF include the presentation as a flow-chart, to give a practical guidance on what should be done in each single case, avoiding one typical criticism of classical guidelines on LBP.[20] This choice required a high effort by the Commission to cover all those "grey areas" (*i.e.* situations in which there are no clear cut evidences to follow) so common in the everyday clinical practice; but it also allowed to reach the decision of facing specific LBP, that is usually ignored by the existing clinical guidelines.[9, 21, 22] So, the DTF covers not only disc herniation (usually included in the sub-acute sciatica section of guidelines), but also adult painful scoliosis, spinal stenosis, spinal instability and spondylolisthesis, and arthropahties. In this case too, focus is not only on the surgical management, that has been described in the diagnostic process, clearly stating that the final decision arises from patient's choice as well as from clinical need and possibility: counselling, work and ADL interventions, physical activity counselling, pain-killer therapy, and rehabilitation are clearly stated for all clinical pictures. In particular, rehabilitation includes physical exercises, distinguished according to the pathology considered and the actual experts consensus, as well as orthosis.

In conclusion, these DTF represents a clear step-forward, at least from a P&RM's point of view, in the clinical management of LBP. Today LBP is considered the field of general practitioners (GPs), who should seldom refer to specialists according to specific needs; it is not yet stated in the DTF, but the next step forward should be the distinction between acute and most of low-disability chronic LBP (which should refer to GPs), *versus* sub-acute and high-disability chronic LBP, which are in the elective field of P&RM, that should ultimately address to surgeons all cases that they will not be able to solve through well-trained multidisciplinary teams. Given that physiatrists will be able to be rehabilitation specialists and not only simple conservative pain-killer physicians.[8]

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