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Low back pain: state of art

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Abstract

Diagnosis of low back pain (LBP) is made by exclusion of secondary spinal diseases, identifiable in the first month of pain (acute LBP – ALBP) through the so-called "reds flags", and only if pain persists over 4 weeks (sub-acute LBP – SALBP) using diagnostic exams. LBP classification is actually based on the localization (LBP and sciatica) and duration of pain: ALBP, SALBP, and chronic (CLBP) when it lasts over 6 months. ALBP prognosis is very good because it is auto-resolving in most of the cases; on the contrary, CLBP has a bad prognosis (very low rate of resolution even with treatment). The stage of most interest is SALBP, in which it is possible to identify risk factors ("yellow flags") of chronicity and to avoid the development of a series of vicious cycles that, according to a bio-psycho-social model of illness, can lead the patient to CLBP. In CLBP it's mandatory to make the patient able to manage his problem, so to increase his quality of life and decrease disability and pain. Treatment approach to ALBP consist of reassuring the patient and providing accurate preventive information, recommendations to remain as active as possible, to avoid bed rest. In SALBP and CLBP, a multidisciplinary team rehabilitation approach is the most important one, combining educational, cognitive-behavioural and physical exercise treatments according to the individual needs. Pain killer therapies can be proposed, but bearing in mind their short-term effects.

Keywords: Low back pain; Rehabilitation; Chronic pain

1. Introduction

Low back pain (LBP) is defined as pain or discomfort in the lumbar region, on one or both sides of the back, eventually irradiating to the buttocks. LBP is actually classified as secondary (less than 10% of cases) and primary, or idiopathic, or simply LBP (Balague et al., 2007). In fact, according to the actual knowledge, the term LBP is a diagnosis instead of being merely a symptom. Today the most up-to-date classification is based on the duration of pain (Arnau et al., 2005; Autio, 2004; Balague et al., 2007; Koes et al., 2007):

- Acute LBP (ALBP): up to four weeks;
- Sub-acute LBP (SALBP): from two to six months;
- Chronic LBP (CLBP): over six months.

A recent study has shown in 14 days the presumable transition between ALBP and SALBP (Kovacs et al., 2005), while others propose 90 days as the starting point of CLBP (Negrini et al., 2006).

Even if this classification seems to have only an epidemiological meaning, it constitutes today the starting point for everyday clinical decisions; in fact, as we will see, the three groups are clinically different and their pathological background is totally distinguishable.

The incidence, prevalence and costs of LBP are incredibly high (Bressler et al., 1999; Hansson et al., 2004; Krismer et al., 2007). ALBP life prevalence is more than 80% of the population, year prevalence counts up to 30%, and costs in term of absenteeism rank second for importance, following only cold and flu; however, over 90% of ALBP resolve in less than 30 days. On the other side, CLBP is an everyday experience for 4% to 7% of the population; it consumes 75% to 80% of the entire enormous costs of LBP, and less than 5% of patients achieve a complete resolution of pain. SALBP has scarcely been studied and today we have no reliable epidemiological data, even if this stage of pathology should deserve the highest attention.

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