

Surgical Threshold Policy

Surgery and Other Invasive Interventions for Low Back Pain

Definition and Scope

Low back pain (LBP) is defined as pain, muscle tension or stiffness localised between the costal margin and above the inferior gluteal folds, with or without leg pain (sciatica).

This policy does not include acute back pain due to fracture, dislocation, tumours, infection, inflammatory disorders or progressive neurological deficit.

Patients with suspected cancer or cauda equina compression (CES) should be referred directly to secondary care according to the acuity of their presentation. ([CES pathway Getting It Right First Time \(GIRFT\)](#))

This policy links to the [Radiofrequency Denervation Policy](#) for chronic back pain.

Policy

Referral for treatment should be through the MSK service/pathway.

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid the clinical audit process and provide evidence of compliance with the policy. For patients not meeting the policy criteria, clinicians can apply for funding to the Exceptional Cases Panel by completing the exceptional funding section of the [referral proforma](#).

Management before referral

For all patients comprehensive conservative management should be tried including advice to continue to remain active, pain relieving medication, exercise and referral for physiotherapy. Psychological therapies can be considered using a cognitive behavioural approach for managing low back pain with or without sciatica but only as part of a treatment package including exercise, with or without manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage).

Imaging

Imaging often does not change management, hence referral for MRI or CT scans should only be made by secondary care consultants or specialists working in NHS C&P (ICB) commissioned MSK services.

Referral for Diagnostic Testing and Surgery

- Spinal fusion is not funded for chronic low back pain unless any of the criteria below are met.
 - Patients with a symptomatic spinal deformity e.g. scoliosis
 - Instability e.g. spondylolisthesis; trauma

- As an adjunct during spinal decompression surgery, where a more extensive exposure of the affected neurological structures is required and would otherwise render the spine unstable.
- Disc replacement is not funded for chronic low back pain.

Corticosteroids and Local Anaesthetics Injections

- Epidural injections (combination of local anaesthetic and steroid) will be funded for patients with severe radicular pain. Epidural injections **will not be funded** for non-specific low back pain with no associated radicular pain.
- In patients with severe pain, as defined above, due to proven lumbar pathology (on MRI or CT), up to 3 epidural injections, 6 months apart, will be funded when there is evidenced improvement following each treatment.
- Medial branch blocks will be funded to assess suitability for radiofrequency denervation or prior to surgery. Diagnostic injections for other indications are not funded.

Other Diagnostic Tests and Interventions that will not be Funded

- Injections for non-radicular low back pain (Facet joint/Epidural injections)
- Intradiscal electrothermal therapy (IDET)
- Transcutaneous electrical nerve stimulation (TENS)
- Therapeutic ultrasound, laser therapy and interferential therapy
- Traction
- Injection of other therapeutic substances (e.g. prolotherapy)
- Acupuncture

Smoking

Patients who smoke should be advised to attempt to stop smoking – see [stop smoking policy](#).

Weight Management

Patients who are overweight or obese should be advised about the benefits of weight loss and offered referral to the appropriate weight management service.

Rationale and Evidence

Patients Without Symptoms of Nerve Root Compromise

Overall, trials of spinal fusion surgery (see references 2) show no advantage of surgery over intensive rehabilitation and it has been suggested that it is not cost effective compared to intensive rehabilitation (see reference 3). NICE guidance does not recommend the use of spinal fusion surgery (see reference 4). It has been recommended that, in patients without radicular pain, where conservative treatment fails, intensive rehabilitation with cognitive behavioural therapy is given (see reference 5).

Patients with Symptoms of Nerve Root Compromise

In patients with radicular pain, surgery can improve pain, function and quality of life compared to conservative therapy (see references 6), but it is recommended that conservative therapy with exercise is attempted before surgery (see reference 7).

For spinal fusion surgery, trials do not show an advantage of spinal fusion with decompression compared with decompression alone (see references 9 to 11) and NICE guidance (see reference 4 and 8) does not recommend spinal fusion in these patients.

Referral for Diagnostic Tests

NICE recommend (see reference 4) against the routine use of imaging in a non-specialist setting for low back pain with or without sciatica. They recommend the use of imaging in specialist settings only where results are likely to change management.

Corticosteroid Injections

For patients with non-specific back pain, NICE does not recommend (see reference 4) the use of therapeutic injections. Although there appears to be short-term pain relief, trials do not show evidence of longer-term benefit on pain and function in patients with non-specific LBP (see reference 12 to 13), spinal stenosis (see references 14 to 16) or radicular LBP (see references 17 to 19). However, epidural steroid injections may bring short-term relief and are recommended as an option in patients with persistent acute and severe sciatica (see reference 4).

Other Diagnostic Tests and Interventions that Will Not Be Funded

NICE recommend (see reference 4) against the use of disc replacement, traction, acupuncture, ultrasound, PENS, TENS, interferential therapy and spinal injections for people with back pain with or without sciatica.

Estimated Number of People Affected

Low back pain is a common disorder, affecting around one-third of the UK adult population each year. Around 20% of people with low back pain will consult their GP about it. In patients experiencing lower back pain, symptoms usually improve within weeks. However, about 10% remain off work and about 20% have persistent symptoms at 1 year (see reference 20).

Glossary

Cauda equina compression:	Rare syndrome that can be extremely serious and should be treated as an emergency. It can lead to paralysis of the lower body and significantly impair or even cause the loss of all sensation to the bowel and bladder.
Discectomy:	Surgical removal of the soft part of the disc that is out of place.
Discogenic back pain:	Pain that emanates from the intervertebral discs.
Disc prolapse:	Protrusion of the intervertebral disc.
PENS:	Peripheral Electrical Nerve Stimulator.
Prolotherapy:	Injection of an otherwise non-pharmacological and non-active irritant solution into the body, generally in the region of tendons or ligaments, for the purpose of strengthening weakened connective tissue and alleviating musculoskeletal pain.
Sciatica:	Pain that radiates from the back into the buttock or leg and is most commonly caused by prolapse of an intervertebral disk, the term may also be used to describe pain anywhere along the course of the sciatic nerve.
Spinal fusion:	The placement of a bone graft between the vertebrae.
Spinal stenosis:	Narrowing of the spinal canal that results in nerve compression.

References

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The Keele STarT Back Screening Tool

This tool assesses the barriers to recovery (such as disproportionate fears and concerns) and, if not addressed, increase the 'risk' that the patient will develop long-term back pain.

Patient Name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1 My back pain has spread down my leg(s) at some time in the last 2 weeks	☐	☐
2 I have had pain in the shoulder or neck at some time in the last 2 weeks	☐	☐
3 I have only walked short distances because of my back pain	☐	☐
4 In the last 2 weeks, I have dressed more slowly than usual because of back pain	☐	☐
5 It's not really safe for a person with a condition like mine to be physically active	☐	☐
6 Worrying thoughts have been going through my mind a lot of the time	☐	☐
7 I feel that my back pain is terrible and it's never going to get any better	☐	☐
8 In general I have not enjoyed all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ Sub Score (Q5-9): _____

The STarT Back Tool Scoring System

