Low Back Pain

Red flags, imaging stewardship & stepped care

CLINICAL PATHWAY

drregu.com.au

Around 90% of low back pain resolves within 6 weeks. Image only if a red flag is present or conservative treatment fails beyond 6 weeks — degenerative changes and disc bulges are common incidental findings even in people without pain. Encourage normal activity: bed rest worsens outcomes.

RED FLAGS — ASK IN EVERY CONSULT

- Cancer: age >50 with new pain, history of cancer, unexplained weight loss, night pain, no relief with rest
- Infection: fever, immunosuppression, IV drug use, or recent spinal surgery/procedure
- Fracture: significant trauma, or minor trauma with osteoporosis, long-term steroid use, or age >70
- Cauda equina (emergency): saddle anaesthesia, bilateral leg symptoms, new bladder or bowel dysfunction
- Inflammatory: age <40, morning stiffness >30 minutes, improves with exercise, alternating buttock pain
- Progressive neurology: worsening or severe leg weakness, or bilateral neurological signs

CLASSIFY THE PAIN (RED FLAGS EXCLUDED)

- Non-specific (~90%): no red flags or neurological signs; axial pain ± thigh referral — reassure and keep moving
- Radicular/sciatica: dermatomal leg pain often worse than back pain; positive straight-leg raise; motor, sensory or reflex change
- Claudication: bilateral leg symptoms worse on standing/walking, eased by flexion — suggests spinal stenosis
- Yellow flags: fear-avoidance, catastrophising, a compensation claim — predicts chronicity, address early

IMAGING STEWARDSHIP

- X-ray: suspected fracture or inflammatory change at the SI joints; not for routine non-specific LBP
- MRI: persistent radicular pain beyond 6 weeks, a red flag, or surgical planning; not first-line for non-specific LBP
- CT: bony detail when MRI is contraindicated, or fracture assessment; not for routine screening
- Bone scan: suspected metastases, osteomyelitis or an occult fracture; not for non-specific LBP

STEPPED CARE — MOST RECOVER AT 1–2

- 1. Education & reassurance: most LBP is benign, movement is safe, typical recovery 4–6 weeks
- 2. Movement & exercise: stay active, graded exercise, physiotherapy where available
- 3. Simple analgesics (if persisting beyond ~6 weeks): short-course oral NSAID if no contraindication, paracetamol PRN
- 4. Referral & imaging (if persisting): physiotherapy review, MRI if radicular, pain clinic

ALLIED HEALTH & MBS PLANNING

Up to 5 Medicare-subsidised allied health visits per calendar year are available under a GP Chronic Condition Management Plan (replacing the former EPC arrangements). Confirm current item numbers and eligibility at mbsonline.gov.au.

■ SAFETY

- Ask the red-flag questions at every LBP consultation, not only at first presentation
- Don't image routine non-specific LBP — degenerative changes and disc bulges are common incidental findings and rarely change management
- Avoid bed rest and avoid opioids for LBP — marginal benefit, real harm; encourage normal activity instead

■ RED FLAGS / REFER

- Cauda equina syndrome, a progressive neurological deficit, or suspected fracture/spinal infection/malignancy → emergency department, same day
- Radicular pain with a neurological deficit, or failed conservative treatment beyond 6–12 weeks with imaging confirming a surgical target → spinal surgery
- Chronic LBP beyond 3 months, multiple failed interventions, or a significant psychosocial component → pain clinic