# Rotherham Low Back Pain Pathway

**Patient presents with low back pain** (i.e. pain below the costal margin and above the inferior gluteal folds) with or without leg pain

**Secondary Care**

**Primary Care**

## Please refer the following directly to Secondary Care

Symptoms suggestive of cauda equina compression e.g. altered bladder/bowel function, saddle anaesthesia etc. -**Immediate referral to A&E required**

History of, or suspected malignance, investigate and refer as appropriate. Consider red flags of unexplained weight loss, night pain and high inflammatory markers.

Suspected fracture, dislocation, or infection, refer to A&E.

Suspected inflammatory condition, investigate and refer to Rheumatology

Patients presenting with low back pain and leg symptoms due to vascular compromise, investigate and refer as appropriate.

## Acute Low Back Pain

**Clinical presentation**
Patient presents with low back pain with/without pain in their upper thighs. Restricted lumbar spine R.O.M. and normal peripheral neurology

**Investigations/ management**
X-ray and MRI are not indicated.

Provide reassurance and advice including remaining as active as possible.

Consider conservative management and analgesia. If symptoms not eased by simple analgesia consider NSAID's and/or weak opioids.

**Referral**
If no improvement by following 6 weeks of conservative management, refer to physiotherapy

www.nhs.uk/conditions/back-pain

www.sheffieldbackpain.com

## Low Back Pain with referred leg pain

**Clinical Presentation**
Patient presents with predominantly leg pain with or without low back pain. Restricted SLR and altered peripheral neurology.

**Investigations/ management**
X-ray and MRI are not indicated.

Provide reassurance and advice including remaining as active as possible.

Consider analgesia, NSAID's and/or weak opioids

**Referral**
Refer immediately to MSK CATS.

www.nhs.uk/conditions/back-pain

www.sheffieldbackpain.com

## Persistent Non specific Low Back Pain

**Clinical Presentation**
Patient presents with predominantly low back pain with/without pain in their upper thighs. Restricted lumbar spine R.O.M. and normal peripheral neurology

**Investigations/ management**
X-ray and MRI are not indicated

Provide reassurance and advice including remaining as active as possible

Consider conservative management, analgesia. If symptoms not eased by simple analgesia, consider NSAIDs and/or weak opioids

**Referral**
If no improvement following 6 weeks of conservative management, refer to physiotherapy.
If unresponsive to a previous course of physiotherapy, refer to MSK CATS.

**Draft Rotherham Low Back Pain Pathway**

**Supporting Information**

| | |
|---|---|
| **Sciatica** | Usually gradual onset low back pain which refers down the posterior or posterolateral aspect of one or both legs positive SLR.<br><br>Neurological examination normal. |
| **Stenosis** | Usually gradual onset of one or bilateral leg pain. Symptoms usually aggravated by weight bearing activities and eased with lumbar spine flexion.<br><br>NB: Check peripheral pulses. |
| **Low Back Pain** | Gradual or sudden onset.<br><br>Pain localised to lumbar spine may refer to buttocks, upper thighs but no sciatica or neurological signs.<br><br>Movement and daily activities usually influence symptoms. |
| **Lumbar spondylosis** | Gradual onset pain may be localised or referring down leg e.g. sciatica. May have neurological involvement.<br><br>Pain usually altered by position/movement but underlying ache usually remains. |
| **Lumbar Prolapsed IV disc** | Onset usually following trauma/injury but can be gradual.<br><br>May be local lumbar spine pain, but can be pain free.<br><br>Referral of pain down one or both legs often more severe peripherally.<br><br>Usually neurological signs and symptoms |