Spine Related Pain

Spinal manipulative therapy (SMT) for low back pain (LBP)

In 2010 and 2014, evidence was found for the effectiveness of SMT for acute, subacute, and chronic low back pain in adults.1,2

Adherence to clinical practice guidelines – management of acute and subacute low back pain

A 2014, best evidence synthesis of the literature found that “quality papers in this area of research are very limited.” All three professions, physiotherapy, chiropractic and medical practitioners failed to attain satisfactorily high guideline adherence for evidence-based practice. Chiropractors have “the highest levels of guideline adherence, and chiropractors and physiotherapists are both significantly more guideline concordant than medical practitioners with respect to management of acute and subacute low back pain.”3

Spinal manipulative therapy (SMT) for chronic low back pain (LBP) in adults

A 2011 Cochrane review finds no clinically important differences between SMT and other treatments for pain and functional improvement for chronic LBP.4

Expert consensus recommends the following dosages for chronic spine-related pain:

- 2-3 visits/week for 2-4 weeks.
- Mild exacerbation: 1-6 visits; scheduled ongoing care 1-4 visits/month.5,6

A 2014 review of Physiotherapist-delivered group education and exercise interventions and self-management for people with osteoarthritis (OA) and chronic low back pain (CLBP), found group-based physiotherapy-led self-management interventions (GPSMI) for people with OA or CLBP is no more beneficial than individual physiotherapy or usual general practitioner care/medical management – both are equally comparable in clinical effectiveness.7

Report of the National Institutes of Health (NIH) Task Force on research standards for chronic low back pain

In 2014, the research task force (RTF) concluded that “at the current state of scientific evidence on chronic low back pain (cLBP), it is not realistic to create operationally defined research diagnostic criteria for subsets of cLBP.” This is due to the multifactorial nature of cLBP.8 This article proposes a recommended definition of cLBP and encourages classification in terms of its impact and any presumed pathoanatomic diagnosis.8 The RTF recommends a “uniform minimal data set, with recommendations for medical history, physical examination, diagnostic tests and self-report measures of physical function, depression, and sleep disturbance, in addition to pain intensity and interference.”8

Continued on next page.
Spinal manipulative therapy (SMT) for neck pain in adults

A 2014 evidence-based guideline made strong recommendations for manipulation, manual therapy, and exercise combined with other modalities for chronic neck pain. It made moderate recommendations for manipulation and mobilization combined with other modalities for acute neck pain. Recommendations were weak for exercise alone for acute neck pain and manipulation alone for chronic neck pain. Thoracic manipulation and trigger point therapy were not recommended for acute neck pain. Transcutaneous nerve stimulation, thoracic manipulation, laser, and traction were not recommended for chronic neck pain.\(^9\)

A 2013 evidence-based guideline from the Italian Society of Physical and Rehabilitation Medicine recommended, for non-specific acute neck pain, NSAIDs, manipulation, massage, physical therapy, acupuncture or anesthetic blocks. For persistent non-specific neck pain it recommended exercises (especially strengthening and stabilizing), manipulation and mobilization. Ultrasound, TENS, laser and acupuncture may be combined to optimize pain relief.\(^10\)

Concerning whiplash-associated disorders (WAD): a 2014 systematic review suggests:

- “There is a role for multimodal care in the management of patients with NAD and WAD.

- Multimodal program may include manual therapy, education, and exercise

  Relationship of intensity of multimodal care to outcomes:

  Pts with recent WAD and NAD - >6 visits per 8 weeks do not report better outcomes than those who receive fewer treatments.

  “Association between type and intensity of care was strongest during the first 6 months postcollision”.\(^11\)

According to a 2014 systematic review of the literature, “most patients with symptomatic cervical spine disc herniation with radiculopathy recover.” The course of symptomatic cervical disc herniation with radiculopathy is comparable with neck pain the general population (recurrent, and may be persistent and/or progressive).\(^12\) “Quality of the literature regarding prognostic factors of symptomatic cervical disc herniations with radiculopathy is poor.”\(^12\)

Interventions to improve walking ability in neurogenic claudication with lumbar spinal stenosis

A 2014 systematic review, found that no firm conclusions could be drawn due to current evidence of low and very low quality in regard to the effectiveness of surgical or non-surgical treatments to improve walking ability in patients with neurogenic claudication.\(^13\) It was also noted that physical therapy has not been shown to be clinically effective in the current evidence. “Supervised exercise improved walking ability but was found to be no better than no treatment or other combined treatments.\(^13\)

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Spine Related Pain continued

References


