Chiropractic Guidelines: Care for Low-Back Pain

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Most acute pain, typically the result of injury, responds well to a short course of conservative treatment (see table below). If effectively treated at this stage, patients often recover with full resolution of pain and function, although recurrences are not uncommon.

Delayed or inadequate early clinical management may result in increased risk of chronicity and disability. Furthermore, those responding poorly in the acute stage and those with increased risk factors for chronicity must also be identified as early as possible.

The following table is from an article in the Journal of Manipulative and Physiological Therapeutics (JMPT), the official scientific journal of the American Chiropractic Association (ACA), and pieced together by Nicole Racadag (2016).

### Frequency and Duration for Chiropractic Treatment of Low Back Pain (LBP)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Freq. of Care</th>
<th>Reevaluation</th>
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<tbody>
<tr>
<td>a. Acute and subacute</td>
<td>2-3× weekly, 2-4 wks.</td>
<td>2-4 wks.</td>
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<tr>
<td>Recurrent/flare-up</td>
<td>1-3× weekly, 1-2 wks.</td>
<td>1-2 wks.</td>
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<tr>
<td>b. Chronic</td>
<td>1-3× weekly, 2-4 wks.</td>
<td>2-4 wks.</td>
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<tr>
<td>b. Exacerbation (mild) of chronic</td>
<td>1-6 visits per episode</td>
<td>At beginning of each episode of care</td>
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<tr>
<td>b. Exacerbation (moderate or severe) of chronic</td>
<td>2-3× weekly for 2-4 wks.</td>
<td>Every 2-4 wks. following acute care guidelines</td>
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<tr>
<td>b. Scheduled ongoing care for management of chronic pain</td>
<td>1-4 visits per month</td>
<td>At minimum every 6 visits, or as necessary to document condition changes.</td>
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</table>

a. For acute and subacute stages; up to 12 visits are warranted. If additional care is indicated, supporting documentation should be available for review, including, but not necessarily limited to, documentation of complicating factors and/or comorbidities coupled with evidence of functional gains. Efforts toward self-care recommendations should be documented.

b. For chronic presentations, exacerbations, and scheduled ongoing care for management of chronic pain, additional care must be supported with evidence of either functional improvement. Such presentations may include: (1) substantial symptom recurrences following treatment withdrawal, (2) minimization/control of pain, (3) maintenance of function and ability to perform common activities of daily living (ADLs), (4) minimization of dependence on therapeutic interventions with greater risk(s) of adverse events, and (5) care which maintains or improves capacity to perform work. Efforts toward self-care recommendations should be documented.
Examination Procedures

Thorough history and evidence-informed examination procedures are critical components of chiropractic clinical management. These procedures provide the clinical rationale for appropriate diagnosis and subsequent treatment planning.

Assessment should include, but is not limited to, the following:

- Health history
- Specific causes of LBP
- Examination
- Diagnostic testing (indications) for red flags

Routine imaging or other diagnostic tests are not an absolute requirement for patients with nonspecific LBP. Imaging and other diagnostic tests are indicated if there is suspicion of a serious underlying pathology.

Patients with persistent LBP accompanied by signs or symptoms of radiculopathy or spinal stenosis should be evaluated, preferably with MRI or CT scan.

Imaging studies should be considered when patients fail to improve following a reasonable course of conservative care or when there is suspicion of an underlying anatomical anomaly.

Severity and Duration of Conditions

Conditions of illness and injury are typically classified by severity and/or duration. Common descriptions of the stages of illness and injuries are acute, subacute, chronic, and recurrent, and further subdivided into mild, moderate, and severe.

- Acute—symptomatic for less than 6 weeks.
- Subacute—symptomatic between 6 and 12 weeks.
- Chronic—symptomatic for at least 12 weeks in duration.
- Recurrent/flare-up—return of symptoms perceived to be similar to those of the original injury as a result of exacerbating factors.

Initial Course of Treatments for Low Back Disorders

To be consistent with an evidence-based approach, DCs should use clinical methods that generally reflect the best available evidence, combined with clinical judgment, experience, and patient preference. Therefore, in the absence of contraindications, these methods are generally recommended.

Re-evaluation and Re-examination

After an initial course of treatment has been concluded, a detailed or focused re-evaluation should be performed. The purpose of this reevaluation is to determine whether the patient has made clinically meaningful improvement. A determination of the necessity for additional treatment should be based on the response to the initial trial of care and the likelihood that additional gains can be achieved.
As patients begin to plateau in their response to treatment, further care should be tapered or discontinued depending on the presentation. A reevaluation is recommended to confirm that the condition has reached a clinical plateau or has resolved (maximum therapeutic benefit, MTB). The DC should perform a final examination, typically following a trial of therapeutic withdrawal, to verify that MTB has been achieved.

**Continuing Course of Treatment**

If the criteria to support continuing chiropractic care has been achieved, a follow-up course of treatment may be indicated. However, one of the goals of any treatment plan should be to reduce the frequency of treatments to the point where MTB continues to be achieved while encouraging more active self-therapy. Patients also need to be encouraged to return to usual activity levels as well as to avoid catastrophizing and overdependence on physicians, including DCs. The frequency of continued treatment generally depends on the severity and duration of the condition.

**Potential Outcome Measurements**

1. Pain scales such as the visual analog scale and the numeric rating scale.
2. Pain diagrams that allow the patient to demonstrate the location and character of their symptoms.
3. Validated ADL measures, such as the Revised Oswesty Back Disability Index, Roland Morris Back Disability Index, RAND 36, and Bournemouth Disability Questionnaire.
4. Increases in home and leisure activities, in addition to increases in exercise capacity.
5. Increases in work capacity or decreases in prior work restrictions.
6. Improvement in validated functional capacity testing, such as lifting capacity, strength, flexibility, and endurance.

**Spinal Range of Motion Assessment**

Range of motion testing may be used as a part of the physical examination to assess for regional mobility, although evidence does not support its reliability in determining functional status.

**Management of Chronic LBP**

Definition of chronic pain patients. Note: MTB is defined as the point at which a patient's condition has plateaued and is unlikely to improve further. Chronic pain patients are those for whom ongoing supervised treatment/care has demonstrated clinically meaningful improvement with a course of management and who have reached MTB. The management for chronic pain patients ranges from home-directed self-care to episodic care to scheduled ongoing care.

**Chronic Care Goals**

- Minimize lost time on the job
- Support patient's current level of function/ADL
- Pain control/relief to tolerance
- Minimize further disability
- Minimize exacerbation frequency and severity
- Maximize patient satisfaction
- Reduce and/or minimize reliance on medication
Factors Affecting the Necessity for Chronic Pain Management of LBP

Prognostic factors that may provide a partial basis for the necessity for chronic pain management of LBP after MTB has been achieved include the following:

- Older age (pain and disability)
- History of prior episodes (pain, activity limitation, disability)
- Duration of current episode >1 month (activity limitation, disability)
- Leg pain (for patients having LBP) (pain, activity limitation, disability)
- Psychosocial factors (depression [pain]; high fear-avoidance beliefs, poor coping skills [activity limitation]; expectations of recovery)
- High pain intensity (activity limitation; disability)
- Occupational factors (higher job physical or psychological demands [disability])

Each of the following factors may complicate the patient's condition, extend recovery time, and result in the necessity of ongoing care:

- Nature of employment/work activities or ergonomics
- Impairment/disability
- Medical history: Concurrent condition(s) and/or use of certain medications may affect outcomes.
- Lifestyle habits
- Psychological factors

Diagnosis of Chronic LBP

The diagnosis should never be used exclusively to determine need for care (or lack thereof). The diagnosis must be considered with the remainder of case documentation to assist the physician or reviewer in developing a comprehensive clinical picture of the condition/patient under treatment.

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References


Council on Chiropractic Education. Accreditation standards, principles, processes & requirements for accreditation. ; 2013 (Scottsdale, AZ).

Christensen, M, Kollasch, M, Hyland, JK. Practice analysis of chiropractic. NBCE, Greeley, CO; 2010.


The AGREE Next Steps Consortium. Appraisal of guidelines for research and evaluation II. : 2013 ([Ontario, Canada]).


Russell, R. The rationale for primary spine care employing biopsychosocial, stratified and diagnosis-based care-pathways at a chiropractic college public clinic: a literature review. Chiropr Man Ther. 2013;21 ([Online access only 11 p.]).


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