LOW BACK PAIN WITH OR WITHOUT SCIATICA CRITERIA BASED ACCESS (CBA) & EVIDENCE BASED INTERVENTIONS (EBI) POLICY

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Application Form	EBI Generic application form if appropriate to apply

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VERSION CONTROL

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DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments**
1718.v2 July	August 2017	Correction of spelling Update with NICE cg173 on page 6
1718.v2b	February 2019	House styling updated, Background data removed, wording from NHSE EBI statutory policy, inclusion of wording ‘with and without sciatica’
1920.v3	January 2020	Inclusion of guidance documents & Radiofrequency Denervation commissioned, OASIS review
1920.v3b	September 2020	Amend RFD wording to include’ is commissioned for LBP +/- without sciatica with a positive response to MBB
1920.v3c	October 2020	Inclusion of pharmacological management of sciatica, updated General Guidance CBA & EBIP process
2021.v4	January 2021	Inclusion of repeat injections and MSK urgent clinical circumstance
2021.v5	May 2021	Update of ARMA link and wording to Appendix 2 CES second paragraph
2021.v5	July 2022	Amendment from SCCG to NHS Somerset ICB. New PALS email address
2223.v5a	March 2023	Wording change on 8.6

Equality Impact Assessment (EIA) Form OR EIA Screening Form completed. Date:	January 2019
Quality Impact Assessment QIA. Date:	March 2021
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1 GENERAL PRINCIPLES

1.1 Treatment should only be given in line with these general principles. Where patients are unable to meet these principles, in addition to the specific treatment criteria set out in this policy, funding approval may be sought from the ICB Evidence Based Interventions Service (EBI) by submission of an EBI application form

1.2 Clinicians should assess their patients against the criteria within this policy prior to a referral and/or treatment

1.3 Treatment should only be undertaken where the criteria have been met and there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where the patient has previously been provided with the treatment with limited or diminishing benefit, it is unlikely that they will qualify for further treatment

1.4 Referring patients to secondary care without them meeting the criteria or funding approval not secured not only incurs significant costs in out-patient appointments for patients that may not qualify for surgery, but inappropriately raises the patient's expectation of treatment

1.5 On limited occasions, the ICB may approve funding for an assessment only in order to confirm or obtain evidence demonstrating whether a patient meets the criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with surgery and surgery will only be provided where it can be demonstrated that the patient meets the criteria to access treatment in this policy

1.6 Patients should be advised being referred does not confirm that they will receive treatment or surgery for a condition as a consent discussion will need to be undertaken with a clinician prior to treatment

1.7 The policy does not apply to patients with suspected malignancy who should continue to be referred under 2 week wait pathway rules for assessment and testing as appropriate

1.8 Patients with an elevated BMI of 30 or more may experience more post-surgical complications including post-surgical wound infection so should be encouraged to lose weight further prior to seeking surgery. https://www.sciencedirect.com/science/article/pii/S1198743X15007193 (Thelwall, 2015)

1.9 Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing

2 BACK FACTS

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3.1 **MSK Conditions requiring onward referral**
http://arma.uk.net/wp-content/uploads/2021/01/Urgent-emergency-MSK-conditions-requiring-onward-referral-2.pdf

3.2 Patients who have previously exhausted pain management therapies or have been unwilling to follow the recommendations do not qualify for treatment under this policy

3.3 An Epidural Injection or Nerve Root Block will be commissioned for patients with acute and severe sciatica who meet the criteria below;

- a patient is unable to participate effectively in conservative pain management **OR**

- a Specialist Pain or Trauma & Orthopaedic clinician judges that an injection is necessary and appropriate to enable participation by the patient in a Conservative Pain Management Programme

3.4 Injections for the same episode of radicular pain are only repeated where there is evidence of at least six months of significant pain relief and functional improvement has been achieved (Spinal Services GIRFT Programme National Specialty Report Jan 2019)

3.5 If one injection for radicular pain **did not** achieve at least six months of significant pain relief and functional improvement, then further injections for the same pain **are not routinely commissioned**, unless there is a lack of suitable alternative treatments e.g.:
- Patient unfit for surgery
- Patient unable to tolerate neuropathic pain medications – especially elderly
- Patient wish to avoid surgery (Informed consent)

To apply for funding please refer to item 8
EVIDENCE BASED INTERVENTIONS APPLICATION PROCESS

3.6 Radicular pain affecting the contralateral side or a different nerve root is treated as a new and different episode for the purpose of this policy

3.7 Radio Frequency Denervation – refer to item 5

3.8 Pharmacological management of sciatica
https://www.nice.org.uk/guidance/ng59

- Do not offer gabapentinoids, other antiepileptic's, oral corticosteroids or benzodiazepines for managing sciatica as there is no overall evidence of benefit and there is evidence of harm
- Do not offer opioids for managing chronic sciatica
- If a person is already taking opioids, gabapentinoids or benzodiazepines for sciatica, explain the risks of continuing these medicines

- As part of shared decision making about whether to stop opioids, gabapentinoids or benzodiazepines for sciatica, discuss the problems associated with withdrawal with the person
- Be aware of the risk of harms and limited evidence of benefit from the use of non-steroidal anti-inflammatory drugs (NSAIDs) in sciatica

3.8.1 If prescribing NSAIDs for sciatica:

- take into account potential differences in gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age
- think about appropriate clinical assessment, ongoing monitoring of risk factors, and the use of gastro protective treatment
- use the lowest effective dose for the shortest possible period of time

4 CRITERIA - LOW BACK PAIN without SCIATICA

4.1 Spinal injections for nonspecific low back pain **is not commissioned** by the ICB

4.2 For other medication treatment options see the Somerset CCG Formulary https://somersetccg.nhs.uk/about-us/how-we-do-things/prescribing-and-medicines-management/prescribing/

4.3 Radio Frequency Denervation – refer to item 5

5 Radio Frequency Denervation

Is a commissioned procedure and can be offered according to NICE guideline (NG59)

5.1 Radiofrequency facet joint denervation **is only recommended** as an adjunct in the management of chronic lower back pain;

- to both those with LBP +/- sciatica where there is a positive response to Medial Branch Block (MBB)
- where non-surgical and alternative treatments have been tried and has not worked **AND**
- the main source of pain is thought to come from structures supplied by the medial branch nerve **AND**
- they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral **when**
- non-operative treatment has failed **AND**
- the main source of pain is thought to arise from one or more degenerate facet joints

5.2 Risks of facet joint injections include bleeding and infection, or rarely nerve or spinal cord damage.

5.3 No repeat radiofrequency denervation should be considered if the benefit is for less than 16 months

5.4 Physiotherapy, with appropriate psychological therapies where necessary, should be considered as an early intervention to support the individual

6 Person with Low Back Pain with/without leg pain Flow Chart
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7 Treatments, interventions and devices listed below **are not routinely funded** for the treatment of Low Back Pain with or without sciatica

- Facet joint injections
- Trigger Point Injections with any agent, including botulinum toxin
- Intradiscal therapy
- Prolotherapy
- Interferential Therapy
- Percutaneous Electrical Nerve Simulation (PENS)
- Transcutaneous Electrical Nerve Simulation (TENS)
- Anticonvulsants
- Traction
- Acupuncture
- Ultrasound
- Spinal Fusion
- Disc Replacement
- Belts or Corsets
- Epidural injections for neurogenic claudication in people who have central spinal canal stenosis
- Rocker Sole Shoes

7.1 **IMAGING**

Explain to people with low back pain with or without sciatica that if they are being referred to specialist opinion, they may not need imaging. The musculoskeletal service will decide on the clinical need or not for imaging

Consider imaging in specialist settings of care (for example, a musculoskeletal interface clinic or hospital) for people with low back pain with or without sciatica **only if the result is likely to change management**

8 EVIDENCE BASED INTERVENTIONS APPLICATION PROCESS

8.1 Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or Consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy

8.2 Completion of a **Generic EBI Application Form** by a patient's GP or Consultant is required

8.3 Applications cannot be considered from patients personally

8.4 Only electronically completed EBI applications will be accepted to the EBI Service

8.5 It is expected that clinicians will have ensured that the patient, on behalf of who they are forwarding the application for, is appropriately informed about the existing policies prior to an application to the EBI service. This will reassure the service that the patient has a reasonable expectation of the outcome of the application and its context

8.6 EBI applications are reviewed and considered against clinical exceptionality

For further information on 'clinical exceptionality' please refer to the NHS Somerset ICB website and input into the 'Search this website' box clinical exceptionality. Click on the link to access the full NHS description of clinical exceptionality

Social, Emotional and Environmental factors *i.e. income, housing, environmental pollution, access to services, family, friends, ethnicity, life experiences etc.* CANNOT be considered with an application

8.7 Where appropriate photographic supporting evidence can be forwarded with the application form

8.8 An application put forward for consideration must demonstrated some unusual or unique clinical factor about the patient that suggests they are exceptional as defined below:

- Significantly different to the general population of patients with the condition in question
- Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition

9 ACCESS TO POLICY

9.1 If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Patient Advice and Liaison Service on Telephone number: 08000 851067

9.2 **Or write to us**: NHS Somerset ICB, Freepost RRKL-XKSC-ACSG, Yeovil, Somerset, BA22 8HR or **Email** us: somicb.pals@nhs.net

10 REFERENCES

The following sources have been considered when drafting this policy:

10.1 https://www.nice.org.uk/guidance/ng59
10.2 Thelwall, S. P. (2015). Impact of obesity on the risk of wound infection following surgery: results from a nationwide prospective multicentre cohort study in England. Clinical microbiology and infection : the official publication of the European Society of Clinical Microbiology and Infectious Diseases, , vol. 21, no. 11, p. 1008.e1
10.3 https://www.nice.org.uk/guidance/cg173
10.4 United Kingdom Spine Societies Board: https://www.ukssb.com/improving- spinal-care-project

10.5 Benyamin RM, Manchikanti L, Parr AT, Diwan S, Singh V, Falco FJ, et al. The effectiveness of lumbar interlaminar epidural injections in managing chronic low back and lower extremity pain. Pain Physician. 2012 Jul- Aug;15(4):E363-404

10.6 Choi HJ, Hahn S, Kim CH, Jang BH, Park S, Lee SM, et al. Epidural steroid injection therapy for low back pain: a meta-analysis. Int J Technol Assess Health Care. 2013 Jul;29(3):244-53

10.7 Cohen SP, Bicket MC, Jamison D, Wilkinson I, Rathmell JP. Epidural steroids: a comprehensive, evidence-based review. Reg Anesth Pain Med. 2013 May- Jun;38(3):175-200

10.8 Neuropathic pain in adults: pharmacological management in non-specialist settings (2013 updated 2017) NICE guideline CG173

10.10 Pharmacological management of sciatica https://www.nice.org.uk/guidance/ng59

10.11 NICE NG59 https://www.nice.org.uk/guidance/ng59

10.12 NHS England EBI Evidence-based interventions - Academy of Medical Royal Colleges (aomrc.org.uk)

Evidence-Based Interventions - List 2 Guidance - Academy of Medical Royal Colleges (aomrc.org.uk)

Appendix 1

1. Persistent back pain can be scary, but it's rarely dangerous

Persistent back pain can be distressing and disabling, but it's rarely life-threatening and you are very unlikely to end up in a wheelchair

2. Getting older is not a cause of back pain

Although it is a widespread belief and concern that getting older causes or worsens back pain, research does not support this, and evidence-based treatments can help at any age.

3. Persistent back pain is rarely associated with serious tissue damage

Backs are strong. If you have had an injury, tissue healing occurs within three months, so if pain persists past this time, it usually means there are other contributing factors. A lot of back pain begins with no injury or with simple, everyday movement. These occasions may relate to stress, tension, fatigue, inactivity or unaccustomed activity which make the back sensitive to movement and loading.

4. Scans rarely show the cause of back pain

Scans are only helpful in a minority of people. Lots of scary-sounding things can be reported on scans such as disc bulges, degeneration, protrusions, arthritis, etc. Unfortunately, the reports don't say that these findings are very common in people without back pain and that they don't predict how much pain you feel or how disabled you are. Scans can also change, and most disc prolapses shrink over time.

5. Pain with exercise and movement doesn't mean you are doing harm

When pain persists, it is common that the spine and surrounding muscles become really sensitive to touch and movement. The pain you feel during movement and activities reflects how sensitive your structures are – not how damaged you are. So it's safe and normal to feel some pain when you start to move and exercise. This usually settles down with time as you get more active. In fact, exercise and movement are one of the most effective ways to help treat back pain.

6. Back pain is not caused by poor posture

How we sit, stand and bend does not cause back pain even though these activities may be painful. A variety of postures are healthy for the back. It is safe to relax during everyday tasks such as sitting, bending and lifting with a round back – in fact, it's more efficient!

7. Back pain is not caused by a 'weak core'

Weak 'core' muscles do not cause back pain, in fact people with back pain often tense their 'core' muscles as a protective response. This is like clenching your fist after you've sprained your wrist. Being strong is important when you need the muscles to switch on, but being tense all the time isn't helpful. Learning to relax the 'core' muscles during everyday tasks can be helpful.

8. Backs do not wear out with everyday loading and bending

The same way lifting weights makes muscles stronger, moving and loading make the back stronger and healthier. So activities, like running, twisting, bending and lifting, are safe if you start gradually and practice regularly.

9. Pain flare-ups don't mean you are damaging yourself

While pain flare-ups can be very painful and scary, they are not usually related to tissue damage. The common triggers are things like poor sleep, stress, tension, worries, low mood, inactivity or unaccustomed activity. Controlling these factors can help prevent exacerbations, and if you have a pain flare-up, instead of treating it like an injury, try to stay calm, relax and keep moving!

10. Injections, surgery and strong drugs usually aren't a cure

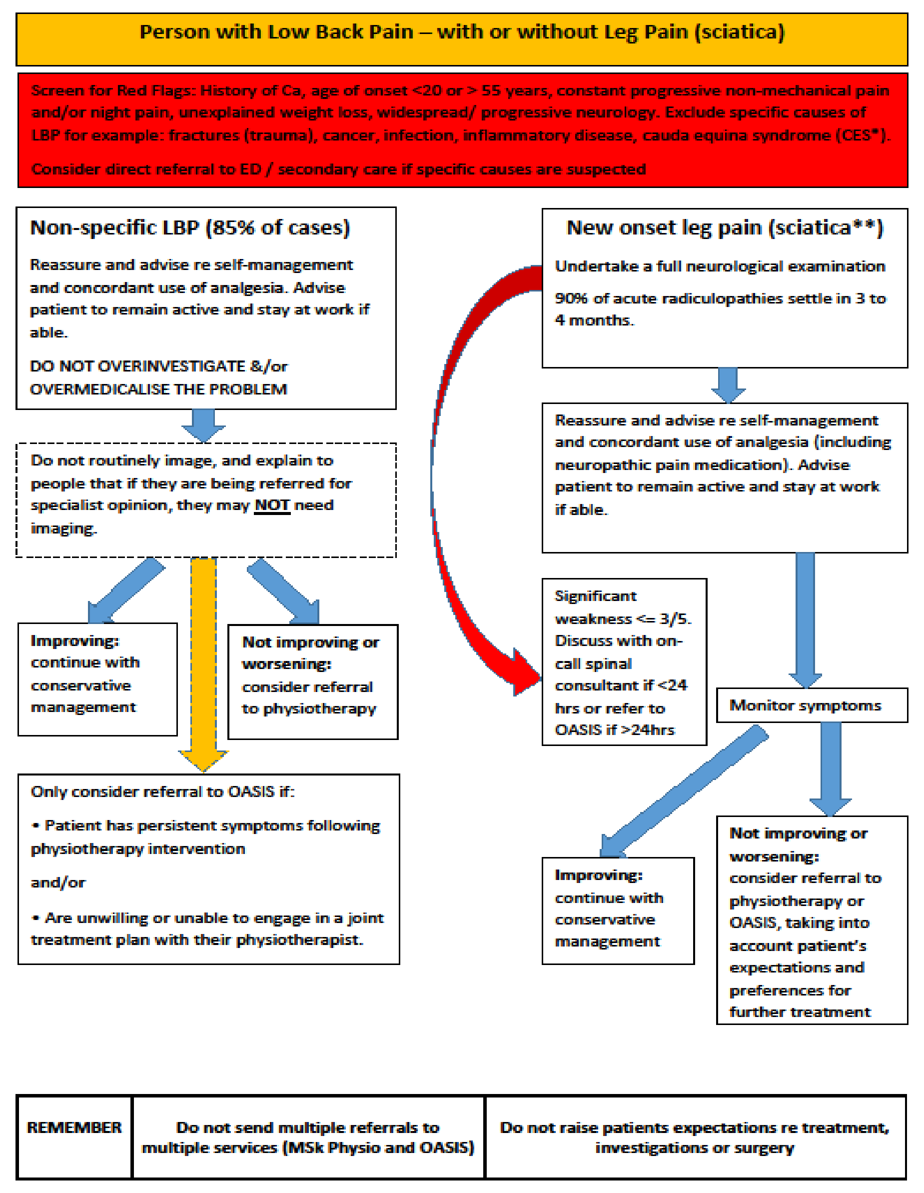
Spine injections, surgery and strong drugs like opioids aren't very effective for persistent back pain in the long term. They come with risks and can have unhelpful side effects. Finding low-risk ways to put you in control of your pain is the key.

Infographic by: @KWernliPhysio in collaboration with authors

This infographic is a summary only. Please consult the full text for clarification and supporting references.

O'Sullivan P, Caneiro JP, O'Sullivan K, Lin I, Bunzli S, Wernli K, O'Keeffe M. Back to Basics: 10 facts about low back pain. BJSM. 2019

Appendix 2



*Cauda Equina Syndrome (CES) - British Association of Spinal Surgeons (BASS) have issued a statement regarding the management of suspected CES (December 2018) which states:

"Cauda Equina Syndrome (CES) is a relatively rare but disabling condition which can result in motor and sensory deficits, incontinence of urine and faeces, and loss of sexual function.

Any patient with a possible diagnosis of threatened /partial/complete CES requires urgent investigation.

A patient presenting with back pain and/or sciatic pain with any disturbance of their bladder or bowel function and/or saddle or genital sensory disturbance or bilateral leg pain should be suspected of having a threatened or actual CES."

Given the above statement any patient presenting with the above pattern of symptoms should be referred to the Emergency Department or discussed with the on-call Spinal Team or Orthopaedic registrar on call (bleep 7005).

**Sciatica (Radiculopathy) - irritation of or injury to a nerve root that typically causes pain, numbness, or weakness in the part of the body which is supplied by the root/roots involved. Symptoms of P&N/numbness in the absence of any radicular pain or abnormal neurological signs, such as weakness, does not require active treatment or further investigation (reassure and monitor patient)