Self-Management of Non-Specific Low Back Pain

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Low back pain (LBP) is the number one cause of years lived with disability globally [1]. The specific pathoanatomical causes are unclear for 85% of all cases of LBP and these cases are classified as non-specific [2]. The most consistently recommended treatments for non-specific LBP in clinical guidelines (e.g., supervised exercise therapy and cognitive behavioural therapy) [3] have at best moderate effects on patients’ clinical outcomes (85% of treatments had point estimates of ≤ 20 points on 100-point scale) [4]. A major problem for currently recommended treatments is that people with incomplete recovery of LBP or with recurrent episodes often seek further treatment [5], initiating a process of dependence on health care services, and increasing the economic burden of the condition [6]. A potential solution for the process of dependence on health care services is to shift from traditional models of care where the patient is a passive recipient of treatment, to models where patients are actively involved in the management of their LBP [7]. Self-management has been described as a model of care where patients use strategies to manage and monitor their own health, retaining a primary role in management, and where they learn skills to be used in the daily management of their health condition [7]. Written information, discussion sessions and audiovisual resources (audiotape, videotape and web site) have been used as self-management strategies for LBP, and the amount of support given by health care providers varies from one to thirteen sessions [8]. Furthermore, self-management has been advocated for LBP [7,9]. There is a growing awareness that LBP is a long term condition and self-management could decrease dependence and the burden of this condition [7,9].

Self-management of LBP has been recommended to avoid dependence on health care services and to decrease the costs of this condition; however, the estimated effect size of self-management of LBP found in a recent systematic review was only small (<5 points on 100-point scale for pain and disability), unlikely to be clinically important [8]. This suggested that the recommendations of self-management in guidelines for management of LBP [9] are probably too optimistic. To potentially reduce global costs of LBP, self-management needs to be optimised. A major challenge for clinicians and researchers is how to optimise the self-management of LBP.

Self-management has been described as a model of care whereby patients retain a primary role in management [7]. However, the current self-management programs do not appear to include the patient in the decision-making process appropriately and actively [8]. For instance, pre-designed educational material does not include patients’ opinion and preferences in the decision-making process [8]. A further problem is the lack of agreement concerning the amount of intervention by a health care provider that is consistent with self-management. Currently, the format for provision of self-management programs varies from one to thirteen single or group sessions with or without support of health care providers and with short- or long-term follow-ups [8]. To optimise self-management programs, further research should attempt to reach consensus among clinicians and researchers on the definition of self-management and also on the content of programs. For instance, consensus should be found for whether the intervention involves no interaction with a health care provider or could involve advice and education about an exercise program.

Another potential way to optimise self-management of LBP is screening specific features of patients’ prognosis from the health domains of pain, activity limitation and psychosocial factors using, for instance, tools such as the STarT [10] and subgrouping patients into risk of poor prognosis to assist decisions about appropriate treatment (i.e., self-management strategies or other supervised therapies). Subgroup of patients with low risk of poor prognosis treated with self-management may have greater improvements on clinical outcomes than subgroup of patients with high risk of poor prognosis [10].

References

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