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Perspective

Self-Management of Non-Specific Low Back Pain

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DESCRIPTION

Low back pain (LBP) is the number one cause of years lived with disability globally. The specific pathoanatomical causes are unclear for 85% of all cases of LBP and these cases are classified as non-specific. The most consistently recommended treatments for non-specific LBP in clinical guidelines (e.g., supervised exercise therapy and cognitive behavioural therapy) have at best moderate effects on patients' clinical outcomes (85% of treatments had point estimates of ≤ 20 points on 100-point scale). A major problem for currently recommended treatments is that people with incomplete recovery of Low back pain (LBP) or with recurrent episodes often seek further treatment, initiating a process of dependence on health care services, and increasing the economic burden of the condition. 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 Low back pain Low back pain (LBP). 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. 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. Furthermore, self-management has been advocated for Low back pain (LBP). There is a growing awareness that Low back pain (LBP) is a long term condition and self-management could decrease dependence and the burden of this condition.

Self-management has been described as a model of care whereby patients retain a primary role in management. However, the current self-management programs do not appear to include the patient in the decision-making process appropriately and actively. For instance, pre-designed educational material does not include patients' opinion and preferences in the decision-making process. 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. 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.

CONCLUSION

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. 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 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.

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