Low back pain and sciatica

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments **5pm** on **5 May 2016** email: LBPUpdate@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on these questions: 1. Do any recommendations represent a substantial increase in costs, and do you consider that the reasons given in the guideline are sufficient to justify this? 2. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.			
Stakeholder organisation(s) (or your name if you are commenting as an individual):	**The Chartered Society of Physiotherapy**			
Name of commentator (leave blank if you are commenting as an individual):	**Carley King**			
Comment number	**Document** (**full** version1, full version 2 **short** version or the **appendices)**	**Page number** Or **'general'** for comments on the whole document	**Line number** Or **'general'** for comments on the whole document	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
1	Full (assessment and non-	General	General	The Chartered Society of Physiotherapy (CSP) welcome the opportunity to comment on this guideline. We recognise the enormous amount of work that has gone into preparing this document and the potential for improving the quality of life for people with non-specific low back pain (NSLBP) and sciatica if this guideline is implemented.

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	invasive treatments)			Whilst we welcome the guideline, aspects of it have highlighted tensions within the profession. Some recommendations are welcomed, but other recommendations are seen as very restrictive, with concerns about how the recommendations were reached. This may act as a barrier to implementation and we would urge NICE to consider this when developing an appropriate approach to implementation. Whilst we agree with the general movement towards a biopsychosocial approach (rather than biomedical) with inclusion of exercise and self-management, we do have some concerns about specific aspects of the guideline, and the consistency of the guideline development group (GDG) approach to the evidence presented. These specific concerns are addressed in more detail below.
2	Full (assessment and non-invasive treatments)	20	4-7	**Introduction** The use of the phrase “improve spontaneously without intervention” is not in line with the later recommendation about stratification of NSLBP. We would suggest altering the wording to “improve with initial primary care management, without the need for investigations or referral to specialist services”. This is more aligned with the recommendation later in the document, giving consistency in language throughout. This comment also applies to the short version of the guideline, page 11, line 10.
3	Full (assessment and non-invasive treatments)	22	3-5	**Development of the guideline** We welcome the focus on assessment and management from first presentation onwards, as opposed to having restrictions on the duration of low back pain as in the previous guideline. However, further information is needed on the rationale behind this move, as many clinicians are used to categorising patients as acute or chronic. This change may act as a barrier to implementation if guideline users do not understand the rationale and evidence base behind it, and why the use of “chronic” and “acute” are less prevalent.
4	Full (assessment and non-invasive treatments)	108	29	**Risk stratification** We welcome this recommendation, and how the wording emphasises that stratification tools should be used to support shared-decision making for further management. We note that the GDG highlighted the importance of the tool both in stratifying subgroups and informing appropriate management. The capability of the tool to inform management should be made more explicit throughout the guideline by linking/referring to the stratification tool in later recommendations e.g. psychological interventions, multidisciplinary biopsychosocial rehabilitation (MBR).
5	Full (assessment and non-invasive treatments)	147	23	**Clinical imaging** We welcome this recommendation which encourages sensible use of imaging rather than overuse.

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6	Full (assessment and non-invasive treatments)	147	23	**Question 2 response** Whilst we welcome this recommendation, we anticipate this could be a challenge to implement due to patient expectations. However, we also recognise that it is the clinician responsibility to educate patients about the purpose of imaging, fully explaining why they do not feel a referral for imaging is necessary. Whilst this guideline will be helpful in supporting clinicians when explaining imaging choices to patients, we anticipate that further resources may be required to gain patient buy-in when imaging isn't indicated.
7	Full (assessment and non-invasive treatments)	199	13	**Self-management** We welcome this recommendation. Promoting self-management is well-established as part of physiotherapy management of low back pain. We agree with the GDG conclusion that although the evidence for self-management in isolation is far from conclusive, it is important to provide advice to people about their condition. This also helps aid shared-decision making and gives the individual more control over their condition. Could further information be provided on what self-management should look like? For example, it requires a skilled assessment and intervention, as opposed to just the provision of information.
8	Full (assessment and non-invasive treatments)	303	7	**Exercise** Whilst we welcome a recommendation focused on exercise, this recommendation highlights some inconsistencies in how the GDG has approached the evidence. We are unsure as to why the recommendation is only a "consider" recommendation rather than an "offer" when the evidence suggests that supervised exercise is more effective than self-management and unsupervised exercise in reducing pain, improving function, and decreasing healthcare utilisation. This is inconsistent with the strength of recommendation given for self-management, and we would recommend that recommendations about exercise are "offer" instead of "consider".
9	Full (assessment and non-invasive treatments)	303	7	We are also unclear as to why there is a focus on group-based exercise interventions, when there is no evidence in the review to suggest that this is superior to individual exercise interventions. The impact of higher cost associated with individual exercise is used as a reason for this decision, yet this is not based on economic evidence or economic modelling. Physiotherapists also report concerns over group exercise with regards to DNA rates. In light of this, we would suggest altering the recommendation to "*offer* supervised exercise that incorporates individualisation and progression of exercises". This can be delivered in a group or individual basis, depending on the needs of the individual.
10	Full (assessment and non-invasive treatments)	15	Box A	As discussed above, our interpretation of the evidence is that this recommendation should be offered to all, and therefore should appear in Box A of the algorithm.

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10	Full (assessment and non-invasive treatments)	329	25	**Postural therapies** We understand and agree with the rationale behind making no recommendation with regards to postural therapies, namely the Alexander technique. However, we are less clear on why this is not included as a research recommendation. Throughout the text explaining the recommendation and link to evidence, it is clear that the Alexander technique could be clinically and cost effective. However, this conclusion is based on just one trial, and therefore further research is needed. The decision is then made not to include this as a research recommendation, because the existing trial is a feasibility trial. Whilst it is likely that this will be followed by a larger trial, unless this is registered, we are not sure how the research recommendation can be rejected on this assumption. If there are no larger trials registered, we would recommend that further research into postural therapies (namely Alexander technique) are included as a research recommendation.
11	Full (assessment and non-invasive treatments)	452	15	**Manual therapies** We welcome the focus on multi-modal treatment here. Physiotherapists report that the use of manual techniques can often open a "window of opportunity" to then enable the patient to participate in more active treatment such as exercise. This recommendation reflects the practice of a number of physiotherapists who use manual techniques as just one aspect of their treatment.
12	Full (assessment and non-invasive treatments)	493	7	**Acupuncture** This "do not use" recommendation is being contested by a number of physiotherapists who use acupuncture to help facilitate an active rehabilitation approach in treating low back pain. There are a number of different concerns about how this recommendation was reached. The first concern is the approach taken in reviewing the evidence. We recognise that the approach taken is the same as the approach to the evidence for acupuncture use in osteoarthritis (CG 177), i.e. the evidence needs to show superiority of acupuncture over sham. However, we believe this rationale is flawed and at odds with the review question. "Developing NICE guidelines: the manual" clearly states that "NICE prefers data from head-to-head RCTs to compare the *effectiveness* of interventions" (page 109). Sham controlled trials demonstrate the efficacy of an intervention, rather than the effectiveness. Therefore, to answer the review question "What is the clinical and cost-effectiveness of acupuncture in the management of non-specific low back pain and sciatica?" it seems appropriate for trials comparing acupuncture to usual care to be the basis of the recommendation.
13	Full (assessment and non-	493	7	The approach taken to favour the sham-controlled evidence is not only at odds with the review question, it is also inconsistent with the approach taken for other modalities. Other modalities have been recommended despite not having evidence to show they are superior to sham interventions (e.g. psychology therapies, exercise). The approach either needs to be consistent or the inconsistencies fully explained.

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14	Full (assessment and non-invasive treatments)	493	7	The recommendation for "do not use" is particularly strong, considering evidence from 2 large trials showed a clinically important benefit of using acupuncture vs sham in the physical component of SF-36 in the short term and long term (on page 491). To state that any benefit in the acupuncture vs usual care trials was "probably the result of non-specific contextual effects" is quite vague without explicit explanation to justify a "do not use" recommendation.
15	Full (assessment and non-invasive treatments)	494	N/A	The GDG state that the benefits of acupuncture vs usual care for pain were not sustained longer than 4 months. However, the forest plot in Appendix K (page 159) shows superiority of acupuncture versus usual care. This is a further example of inconsistency in the GDG analysis of the evidence. In light of this, and the preceding comments, we would recommend the GDG revisit how they have used the evidence to reach a recommendation on acupuncture.
16	Full (assessment and non-invasive treatments)	500		**Electrotherapies** We recognise that much of the literature around the use of TENS is conflicting. However, this is not uncommon for other modalities covered in this guideline. The evidence review suggests that TENS is effective at improving quality of life and decreasing pain in the short term in patients with low back pain only, when compared to sham (page 560, lines 25-27). Whilst the evidence is conflicting around the effect of TENS on function when compared to sham, this is unsurprising given research cross-matching patient-reported functional benefits of TENS against the RMDQ, which found RMDG has limited capacity to capture patient-reported benefits (Gladwell, 2013). *Gladwell PW. Focusing outcome measurement for transcutaneous electrical nerve stimulation evaluation: incorporating the experiences of TENS users with chronic musculoskeletal pain [PhD Thesis]. Bristol, UK: University of the West of England; 2013*.
17	Full (assessment and non-invasive treatments)	17	N/A	**Psychological interventions** Recommendation 18 is missing from the list on page 17 – please add the recommendation here.
18	Full (assessment and non-	601	6	The reference to the cost of a band 5 nurse seems irrelevant in the unit cost table. Why have band 5 costings been used for nursing staff, whereas band 7/8a costings are used for psychologists and physiotherapists? This may reflect

	invasive treatments)			the range of expertise in delivering psychological approaches, but this is not made clear. Perhaps further clarity could be provided on the need for different levels of expertise/input depending on the complexity of the patient.
19	Full (assessment and non-invasive treatments)	666	34	**Pharmacological interventions** Physiotherapists have raised concerns about the lack of options with regards to pain relief that these recommendations offer. Given the lack of good quality evidence available, would a more nuanced approach to this be more helpful in aiding decision making by prescribers? This could include clearer guidance about trialling analgesics in individual patients, including guidance on how/when to stop them in the absence of effectiveness, and suggest specialist assessment for those with complex pain needs.
20	Full (assessment and non-invasive treatments)	671	N/A	The GDG highlights the need to also use NICE clinical guideline 173 for the pharmacological treatment of sciatica – could this be made clearer in the recommendations, as there is potential for confusion with regards to recommendations 26 and 27.
21	Full (assessment and non-invasive treatments)	673	25	**Multidisciplinary biopsychosocial rehabilitation (MBR)** Would it be more accurate to focus on the improvement in quality of life as the primary aim of MBR, rather than decreasing disability and improving function?
22	Full (assessment and non-invasive treatments)	736	1	Whilst we welcome this recommendation, we are unclear as to why there is a preference for a group programme. The evidence does not suggest that group treatment is superior to individual, and there is no economic model demonstrating cost-effectiveness. We would suggest re-wording to “either group or individual sessions, depending on individual’s needs”.
23	Full (assessment and non-invasive treatments)	764	5	**Return to work** We welcome this recommendation. Return to work is a key area where physiotherapy can impact, and we are supporting our members to consider how they can facilitate people to return to work, including people with low back pain.
24	Short version	1	6	It could be beneficial to also include what the guideline does *not* cover here, rather than towards the end of the document where this information currently sits (page 11, lines 21-29) i.e. that it does not include progressive neurological deficit or cauda equine syndrome.

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25	Short version	6	8	In the full version of the guideline, reference is made to NICE guidelines on neuropathic pain (CG173) for guidance on the pharmacological management for sciatica. Could this guideline be referenced here too? Or further clarity that the recommendations are for NSLBP alone?

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Include page and line number (not section number) of the text each comment is about.
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- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
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