Medical Treatment Guidelines

Washington State Department of Labor and Industries

Guideline for hospitalization for low back pain

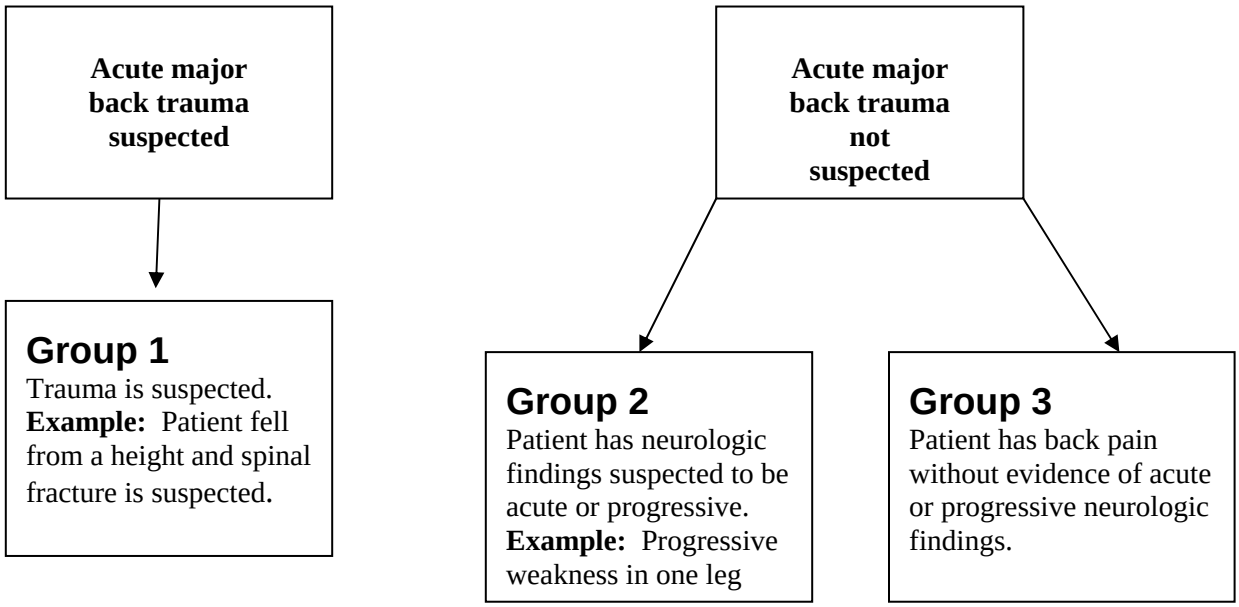
The following guideline replaces Criteria for Non-Surgical Hospital Admission for Acute and Chronic Low Back Pain.

Changes in Practice Patterns:
Several years ago it was fairly common for physicians to hospitalize patients for medical management of low back pain. Typically, hospitalized patients were treated with bed rest, traction, and medication.

The frequency with which low back pain patients are hospitalized for medical management has dropped dramatically during the past ten years. This trend applies to both the injured worker population and other patient groups. For example, in 1986 there were approximately 1500 hospitalizations for medical management of low back pain among L&I patients; in 1996, the corresponding number was about 70.

The present guidelines reflect the current consensus that hospitalization is rarely needed for patients with low back pain.

Classification of patients with low back pain



Guidelines for the management of these various groups or categories of medical problems are described on the following pages.

Date Introduced: June 1998.

Clinical features	Preadmission evaluation and treatment	Hospital admission criteria	Post-admission management
Group 1 **Acute major trauma suspected** A) Back injury occurred within the past 7 days. **AND** B) A major trauma was sustained (e.g. fall from a height, or back crushed by heavy object). **AND** C) Examining physician documents or suspects acute spinal fracture, spinal cord injury or nerve root injury.	Individualized	Individualized	Individualized.

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Group 2 **Acute major back trauma not suspected; patient has neurologic findings suspected to be active or progressive** A) No history of recent major injury. **AND** B) Patient complains of symptoms suggesting acute or progressive neurologic deficit. Typically these include: 1) Progressive weakness or numbness in one leg (and occasionally both legs). **OR** 2) Loss of control of bowel or bladder function. **OR** 3) Progressive numbness in the perineal region. **AND** C) The examining physician indicates that the patient has (or probably has) an acute or progressive neurologic deficit.	A) Outpatient setting: Evaluation and treatment is individualized. B) Emergency Department Setting: 1) Advanced diagnostic imaging may be indicated when a patient in Group 2 comes to the Emergency Department. 2) An attempt to reach the patient's attending physician should always be made before an emergency department MD decides to order advanced imaging studies. (The attending physician is in the best position to evaluate the patient's clinical presentation and judge the usefulness of imaging studies). 3) If an imaging study is done and does NOT demonstrate an acute, lesion, for which surgery is indicated, the patient should be managed like a patient in Group 3. The patient should be discharged unless he/she is unable to perform ADLs at home.	A) If a patient has a new or progressive neurologic deficit, he/she may be hospitalized in order to facilitate surgical decision-making, to provide close observation of further progression or to help the patient compensate for neurological deficits (e.g. to determine whether the patient needs to learn intermittent catheterization). B) If a patient does NOT have a new or progressive neurologic deficit, he/she should be treated like a patient in Group 3. The only valid reason for hospitalization is that he/she cannot manage basic ADLs at home. C) If a patient is admitted through an emergency department, the decision to admit should be made with the concurrence of the attending physician, unless the attending physician cannot be reached.	A) *Duration of hospitalization should be brief*. The great majority of Group 2 patients who are admitted to a hospital can be discharged in 1-3 days (if spine surgery is not performed). B) Treatment Plan Goals 1) General Strategy – It is crucial to assess the patients' ability to perform ADLs and to identify environmental barriers to return home. a) An assessment of these factors should begin immediately upon admission. A list of barriers to discharge should be noted in the patient record. b) The ability of the patient to perform ADLs should be measured serially, e.g., can the patient ambulate to the bathroom? c) Discharge planning should begin immediately, for example: the patient's significant other should be contacted and problem solving should be undertaken regarding practical problems such as the ability to get food and ambulate to the bathroom in the home. 2) Pain Management – Review potential to benefit from nonsteroidals, antidepressants, opiates. **NOTE:** The Department of Labor and Industries does not cover epidural or intrathecal administration of opiates except in the peri-operative period. 3) Management of Neurological Deficits – a patient may need help with bladder catheterization or may need a brace for his/her leg. C) Diagnostic Imaging, Physician Consultants and Surgical Planning – Individualized. D) **NOTE:** Prolonged bed rest usually does more harm than good in a patient with low back pain. Admission for the purpose of bed rest is not acceptable.

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Clinical features	Preadmission evaluation and treatment	Hospital admission criteria	Post-admission management
Group 3 **Acute major back trauma not suspected; patient has back pain without evidence of acute or progressive neurologic findings** A) No history of recent major trauma. **AND** B) Patient complains of back pain with or without symptoms in the legs. Occasionally patients will complain mainly of symptoms in the legs but the evaluating physician concludes that symptoms are not caused by lumbar radiculopathy. **AND** C) No evidence of acute or progressive neurologic deficit.	A) When the attending physician initiates hospitalization from an outpatient setting: 1) The attending physician must document that he/she has given the patient an adequate trial of oral medication to control pain and that the patient has made a genuine attempt to manage ADLs at home. B) When hospitalization is initiated from an emergency room: **NOTE:** most admissions for back pain start with an injured worker going to the emergency department. 1) Advanced imaging is RARELY indicated. Advanced imaging should be ordered ONLY with the concurrence or the patient's attending physician.	A) The only valid reason for hospitalizing a patient is that he/she cannot manage basic ADLs at home. Example, the patient lives alone and is unable to get to the bathroom. B) If a patient is admitted through the emergency department, the decision to admit should be made with the concurrence of the attending physician, unless the attending physician cannot be reached.	A) *Duration of hospitalization should be brief.* The great majority of Group 3 patients who are admitted to a hospital can be discharged in less than 24 hours. B) *Treatment Plan Goals.* 1) General Strategy – It is crucial to assess the patient's ability to perform ADLs and to identify environmental barriers to return to the home. a) An assessment of these factors should begin immediately upon admission. A list of barriers to discharge should be noted in the patient record. b) The ability of the patient to perform ADLs should be measured serially – e.g., can the patient ambulate to the bathroom? c) Discharge planning should begin immediately, for example: the patient's significant other should be contacted and problem solving should be undertaken regarding practical problems such as the ability to get food and ambulate to the bathroom in the home. 2) Pain Management – Review potential to benefit from nonsteroidals, antidepressants, opiates. **NOTE:** The Department of Labor and Industries does not cover epidural or intrathecal administration of opiates except in the peri-operative period). Physical Activity – The patient should receive aggressive physical therapy at least twice per day. 3) Diagnostic Imaging and Physician Consultants. a) These rarely need to be done while a patient is in the hospital. b) The patient's hospital stay should not be prolonged simply to facilitate imaging or consultation while he/she is still in the hospital. The patient should be discharged as soon as he/she is able to manage basic ADLs. Imaging and consultation can be done as an outpatient. C) **NOTE:** Admission for the purpose of bed rest or traction alone is not acceptable. D) A patient should not be admitted to a hospital that does not have the capacity to assess ADLs, develop a treatment plan, & provide physical therapy within the first 24 hours.