Pharmacological management of Lower Back Pain

These guidelines are based on the current NICE Clinical Guideline 88: Low Back Pain which is due for review in Nov 2016.

Step 1: Initial management with regular Paracetamol 1g QDS

When paracetamol alone provides insufficient pain relief, offer:

Step 2: Non-steroidal anti-inflammatory drugs (NSAIDs) – Either **Ibuprofen** or **Naproxen** as per NHS Rotherham CCG NSAIDs: A risk reduction strategy (here)

and/or

Weak opioids – Either **Codeine** or **Dihydrocodeine**. Tramadol can be used however clinicians should be vigilant for psychiatric reactions (both on initiation and withdrawal of treatment), due to its effects on the seretonergic and adrenergic pathways.

Step 3: Consider offering tricyclic antidepressants e.g. **Amitriptyline**. Start at a low dosage (10mg at night) and increase up to 75mg daily (higher doses under specialist supervision) until therapeutic effect is achieved or unacceptable side effects prevent further increase.

Step 4: Consider stopping any weaker opioids and offering strong opioids such as **morphine** (e.g. Zomorph), **oxycodone** (e.g. Shortec / Longtec) or buprenorphine for short-term use to people in severe pain.

An up to date dose conversion chart from weak to strong opiates can be found in the palliative care section of the BNF (here).

A **stimulant laxative** (e.g. Bisacodyl 2 at night) should be offered to patients taking regular strong opioids as per NHS Rotherham CCG Laxative guidelines (here).

Consider referral for specialist assessment for people who may require prolonged use of strong opioids.