

ACUTE LOW BACK PAIN (ALBP)

Clinical Point-Of-Care Quick Reference



For adults with atraumatic ALBP lasting <6 weeks. Use evidence-based strategies to assess, support recovery, empower patients, inform shared decision-making, and tailor care. The full guideline may be found at: painmed.org/acute-low-back-pain-clinicians

1. IMAGING: DO NOT ROUTINELY IMAGE

Do not routinely obtain imaging for atraumatic ALBP <6 weeks unless signs, symptoms, or risk factors suggest serious spine pathology.

Why avoid routine imaging? In uncomplicated ALBP, imaging does not improve pain, function, or recovery; it can increase labeling/anxiety, costs, downstream testing or referrals, and radiation exposure with x-ray/CT. It is not useful for directing therapy.

EVALUATE FOR RED FLAGS, IMAGE IF:

- Cauda equina or spinal cord compression suspected: saddle anesthesia; bladder/bowel dysfunction; reduced anal tone; leg pain.
- Progressive motor weakness or weakness at multiple neurologic levels.
- Signs or risk factors for spinal infection / epidural abscess.
- Major risk factors for, or history of, cancer.
- Persistent or progressive symptoms that may indicate serious spine pathology.

MEDICATION / TREATMENT CAUTIONS

- NSAIDs: review kidney disease, cardiovascular disease, ulcers, anticoagulants, and other patient-specific risks.
- Skeletal muscle relaxants: CNS adverse effects are common and may increase fall risk; benzodiazepines are not included; carisoprodol is not recommended due to abuse potential.

AT EVERY VISIT: Reassess symptom trajectory and function; consider psychosocial “yellow flags” (fear-avoidance, coping, stress/distress, mood/anxiety) that may influence recovery; Tailor support and care accordingly

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2. START WITH SELF-MANAGEMENT

For ALBP without red flags:

- Explain the usual course of ALBP and when clinical evaluation is needed.
- Reassure: movement is safe and important to recovery. Continue usual low-impact activities; adjust activity based on pain.
- Consider superficial heat.
- Consider a short course of oral OTC NSAIDs at labeled doses/frequency, if safe.
- Resources for patients (painmed.org/acute-low-back-pain-patients)

Keep reinforcing: self-management can continue if additional care is added. Encourage active coping to mitigate patient fear-avoidance/catastrophizing.

4. RADICULOPATHY ONLY (Low certainty evidence)

In addition to Step 3 options, clinicians may consider:

- A short course of systemic steroids.
- Referral for consideration of epidural steroid injection (ESI).

Use only for radiculopathy. There is no evidence supporting these options for isolated nonradicular back pain. Benefits are limited and generally temporary; use shared decision-making.

- If systemic steroids are used: use a limited course / low-dose approach when appropriate.
- For ESI: obtain appropriate clinical consultation; avoid early use unless symptoms are significant.
- Severe or progressive weakness may require specialty referral.
- Continue activity, self-management, and physical therapy when possible.
- Do not use for: Non-specific ALBP due to muscular strain or ALBP without leg symptoms.

3. IF WORSE OR UNCHANGED AFTER 1–2 WEEKS

Offer one or more options — not listed in priority order:

- Optimize NSAID therapy, if safe.
- Skeletal muscle relaxant.
- Exercise-based physical therapy; consider psychologically informed PT (PIPT) for patients at risk for chronic LBP.
- Spinal manipulation and mobilization.
- Acupuncture.

Choose based on patient preference, health status/contraindications, prior response, availability, safety, access, and cost. Expected benefits are generally modest and short-term. Continue self-care as appropriate.

* **PIPT: low certainty evidence.** May be helpful in patients with psychosocial risk factors for chronicity.

5. OPIOIDS: NOT ROUTINE INITIAL TREATMENT

For most patients: Do not use opioids as first-line therapy; they usually are not indicated. Evidence shows little or no short-term benefit for pain/function, but they have important harms. (Low certainty evidence)

Most patients improve when self-management and other treatments are optimized

CONSIDER ONLY IN SELECTED / RARE CIRCUMSTANCES

- Persistent, severe pain despite optimized nonopioid and nonpharmacologic options, with major functional limitation.
- Benefits clearly outweigh risks; no major contraindications or high-risk features.
- If used: short-acting agent, low dose, shortest possible duration, time-limited supply, clear stop criteria, and reevaluation if still needed.
- Counsel on impairment, risks, safe storage/disposal; avoid alcohol or sedating drugs without close monitoring; consult CDC acute-pain guidance for additional prescribing considerations.

Do not use for mild/moderate pain when safer alternatives or in patients with high-risk conditions