

EDITORIAL

In this issue of Synovium we feature the 'headline-grabbing' new guidance on low back pain from NICE and more studies exploring whether patients are better served by steroids injected under image guidance (which most primary care clinicians will not be able to perform), or whether the steroids can still be safely and effectively injected 'blind', guided by surface anatomical features (as many GPs currently do).

And with a nod to the editor of *The Guardian* we launch an occasional feature, 'In praise of...'. We have in the past hinted that finding really useful articles on musculoskeletal topics to draw to colleagues' attention can be something of a challenge. Perhaps no longer. The *British Journal of Sports Medicine* has come to our aid magnificently.

Adrian Dunbar
Editor

NICE GUIDELINES FOR THE MANAGEMENT OF NON-SPECIFIC LOW BACK PAIN

The publication of NICE guidelines for the early management of persistent low back pain¹ made the national press recently. Unfortunately, as is often the case with material that makes a good story, the reporting was not always without some inaccuracy: 'Back pain patients to get acupuncture on the NHS'. However, we must not grumble. Some helpful and important messages were conveyed to newspaper readers. Synovium does not have sufficient space to list let alone discuss all the recommendations. Here we present some editor's highlights.



DO'S

1. Offer information about the nature of low back pain and advice to enable self-management of the problem.
2. Advise patients to take exercise and remain active.
3. Take into account the patient's expectations and preferences when formulating a management plan.

4. Consider offering:
 - (a) a structured programme of exercise, OR
 - (b) a course of manual therapy of up to 9 sessions, OR
 - (c) a course of acupuncture of up to 10 sessions.If there is no improvement consider offering one of the other options.
5. Consider referral for combined physical and psychological treatment of up to 100 hours, including a cognitive behavioural approach and exercise, in patients who have not benefited from a less intensive approach and/or who have high levels of disability and distress.
6. Consider referral for an opinion regarding spinal fusion in patients who have not benefited from all the above.
7. Treat psychological distress appropriately before surgical referral.



DON'TS

1. Do not order x-rays.
2. Do not order MRI scans unless fracture, infection, malignancy, inflammatory disease or cauda equina syndrome is suspected.
3. Do not offer electrotherapies, including interferential, laser, therapeutic ultrasound or transcutaneous nerve stimulation.
4. Do not offer injection treatments.
5. Do not offer traction or lumbar supports.

There is much more to read including advice about the prudent use of analgesics and anti-inflammatory drugs and some other interventions that are not considered appropriate.

Implementing these guidelines will require a significant increase in resources to provide the acupuncture, exercise programmes, manipulative therapy and cognitive behavioural therapy. Clearly these will not appear overnight, especially at a time when health service funding is under pressure from a harsh economic climate – so newspaper claims may be wide of the mark. However, resources will be saved by reduction in the use of imaging and the cessation of ineffective, expensive and invasive treatments, and it is to be hoped that these savings will be directed towards the provision of the treatments that are now recommended.

1. NICE Clinical Guideline 88. Low back pain: early management of persistent non-specific low back pain. 2009; May. www.nice.org.uk/CG88.

IMAGE-GUIDED STEROID INJECTIONS

In Synovium 26 we highlighted a study demonstrating that image-guided injection of corticosteroid into the subacromial bursa was no better than a depot intramuscular injection of steroid in relieving shoulder pain. Another study to disappoint the proponents of image-guided injections has appeared in *BMJ*.¹ This compared fluoroscopically guided steroid injections with blind injections to the trochanteric bursa in patients with trochanteric pain. There were no significant differences in positive outcomes between the two methods of injection 1 month and 3 months after the injection, suggesting that the five-fold increase in costs of image-guided injections was not justifiable.

Furthermore, in a study published in *Rheumatology*² blind intra-articular injections of 232 peripheral joints in patients with rheumatoid arthritis were found to be accurately placed, safe and effective. So perhaps those of us without access to imaging can carry on injecting as we have done for many years and not feel we are doing our patients a disservice.

1. Cohen SP, Strassels SA, Foster L et al. Comparison of fluoroscopically guided and blind corticosteroid injections for greater trochanteric pain syndrome: multicentre randomised controlled trial. *BMJ* 2009 Apr 14;338;b1088.
2. Lopes RV, Furtado RN, Parmigiani L, Rosenfeld A, Fernandes AR, Natour J. Accuracy of intra-articular injections in peripheral joints performed blindly in patients with rheumatoid arthritis. *Rheumatology (Oxford)* 2008 Dec;47(12):1792-4.

LATERAL HIP PAIN

Pain in the region of the greater trochanter of the hip is a common presentation in primary care. The term 'trochanteric bursitis' is often used to label the problem, frequently in the absence of any evidence of an inflammatory process in a bursa – of which there are several in the area. Unfortunately it is difficult to determine a precise diagnosis in patients with lateral hip pain. MRI scanning, as is often the case, discloses abnormalities (gluteal tendinopathy, complete and partial tendon tears) that are as common in asymptomatic individuals as in those with pain. This is another example of pain arising from where (or near to where) tendon meets bone, and despite increasingly sophisticated investigative techniques there is, as yet, no definitive understanding of what exactly is going on and what to do to relieve symptoms. In an editorial accompanying the *BMJ* injections study cited above, Bahr and Khan¹ suggest a pragmatic 5-step approach to manage lateral hip pain:

1. Eliminate the lumbar spine as a cause of the symptoms. L3–4 refers to the lateral hip. Resisted hip abduction should elicit the patient's pain.
2. Eliminate the lateral hip pain with a local anaesthetic injection to the trochanteric region.
3. Assume that the problem is a gluteal tendinopathy and prescribe (or refer to physiotherapy for) a programme of progressive eccentric loading exercises.
4. As the injection study demonstrated that 47% of patients had a positive outcome 3 months after blind injection of steroid, this could be offered.
5. In patients who fail to make progress, consider imaging and surgical referral for repair of any tendon tears identified.

In conjunction with this consider a Synovium editorial hobby horse:

'As with other tendinopathies there is likely to be little potential for benefit and much potential for harm in the prescription of non-steroidal anti-inflammatory drugs.'

1. Bahr R, Khan K. Management of lateral hip pain. *BMJ* 2009 Apr 21; 338:b713.

IN PRAISE OF... THE BRITISH JOURNAL OF SPORTS MEDICINE

The *British Journal of Sports Medicine* has been transformed in recent times. In place of papers largely concerned with exercise physiology and injury profiles in less-well-known sports we now find stacks of really useful and informative research and reviews on everyday musculoskeletal problems encountered by primary care clinicians.

The themed April issue¹ provides more insight on the nature and management of painful tendons, notably the rotator cuff, the lateral elbow and the Achilles. Eccentric exercise programmes (loading the tendon while it lengthens) are currently the cornerstone of the treatment of these problems, although it is not exactly clear how or why they work.

A new model of lateral elbow pain (tennis elbow) is proposed. Long disappeared is the notion that this is an inflammatory problem requiring anti-inflammatory treatments. It is suggested that the problem comprises a variable combination of three interlinked processes – degenerative tendon pathology and failed repair, changes in pain processing with hyperalgesia, and muscle dysfunction. Treatment, it is suggested, must address all three components to be effective.

There is also an interesting observation that patients with tendon pain have a higher body mass index and higher, though not abnormal, blood glucose levels. And there is more – but sadly Synovium does not have sufficient space so you will have to look this up yourselves.

1. *Br J Sports Med* 2009 April;43(4). Editor: Jill Cook.