

# From the EDITOR



**Dr. Wulf H. Utian** has served as Editor-in-Chief of *Menopause Management* since its inception in 1988. Arthur H. Bill Professor Emeritus of Reproductive Biology and Obstetrics and Gynecology at Case Western Reserve University, he is President of Rapid Medical Research, headquartered in Cleveland, and is Consultant in Women's Health to the Cleveland Clinic Foundation. He is a Fellow of both the Royal and American Colleges of Obstetricians and Gynecologists, a Fellow of the International College of Surgeons, and a board-certified reproductive endocrinologist.

A pioneer in menopause research, Dr. Utian founded the world's first menopause clinic in Cape Town, **South Africa in 1966**, and established the Cleveland Menopause Clinic in 1983.

Recipient of many research grants and awards, he is the author of more than 150 scientific publications and five books. He is the Honorary Past-President of the International Menopause Society and Honorary Founding President and Executive Director of The North American Menopause Society (NAMS).

## Low Back Pain: Management Dilemmas

Low back pain, both acute and chronic, is a frequent complaint in the general patient population, and it is no less so in women through menopause and beyond. The problem is always a clinical challenge, and in this population the added issue of osteoporotic vertebral fracture has to be addressed as well.

From a psychosocial and an economic perspective, the cost of low back pain is enormous. The good news is that much of acute low back pain is self-limiting. Almost half of patients will recover within a week, and be back to full activity or at work within 20-30 days after onset of an acute episode.<sup>1</sup> But about 10% will continue to have low back pain and will convert to chronic low back pain.

Risk factors for low back pain unrelated to osteoporosis include occupation and cigarette smoking (which seems to be an adverse factor for virtually every major problem!). But psychosocial factors also seem to play a role, including adverse work conditions, job dissatisfaction and stress.

### Evaluation

Evaluation of low back pain follows the traditional clinical approach of eliciting a comprehensive history, including risk factors as outlined above, as well as history of trauma, cancer, leg pain or symptoms, bladder or bowel problems, or known osteoporosis. Evaluation also involves a thorough physical examination, including a pelvic and rectal examination. Attention should be focused on determining the complex interplay between pain and the woman's psychological makeup, while attempting to elucidate the degree of suffering and disability demonstrated.

Given the high rate of rapid resolution, there is little need for special diagnostic studies

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in those women with typical presentations. If, however, the presentation is atypical, special studies obviously need to be utilized earlier than in a typical presentations.

Special tests include radiographs, magnetic resonance imaging and computed tomography. There is a high incidence of abnormal findings with these procedures, even in asymptomatic women. For this reason, the results should always be closely correlated with the clinical presentation.

## Treatment

Treatment of low back pain remains controversial, with the pendulum generally swinging strongly toward the side of conservatism. Indeed, periods of bed rest of less than 2 days' duration seem to be as effective as longer durations, with prolonged bed rest actually seeming to slow recovery.

A short course of analgesics is appropriate, and non-steroidal anti-inflammatory drugs may also offer some benefit. Local injection of corticosteroids does not appear to be effective.

The debate becomes a little more heated as to whether brief pain-management programs are more effective than various hands-on physical therapy treatments. In a very well-conducted trial of high internal validity, a brief pain-management program of non-manual physiotherapy instruction was compared with a program of physiotherapy that included manual spinal management techniques. The former was delivered in fewer treatment sessions, and the outcomes for both groups were essentially the same.<sup>2</sup> Indeed, the authors' conclusions were featured on the front cover of that issue of *The Lancet*: "Most cases of back pain resolve regardless of the course of therapy, and some do not get better no matter what is done." Therein lies the problem for practitioners, patients and policymakers. The dilemma could not have been expressed better!

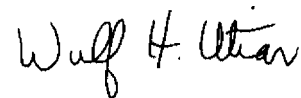
Two systematic reviews within the Cochrane Collaboration Back Pain Review Group have also addressed the problem. One concluded that "back schools" have better

*"Most cases of back pain resolve regardless of the course of therapy."*

short and intermediate effects on pain and functional status than other treatments for patients with recurrent and chronic low back pain.<sup>3</sup> The other, evaluating randomized controlled trials of exercise therapy, concluded that exercise therapy appears to be slightly effective at decreasing pain and improving function in adults with chronic low back pain. In subacute low back pain there was some evidence that a graded activity program has some benefit. However, in acute low back pain, exercise therapy is as effective as either no treatment or other conservative treatments.<sup>4</sup>

## Give Patients Information

So, there you have it. Low back pain is a major clinical problem that presents a dilemma for management. Current practice would, therefore, suggest a process of comprehensive evaluation, counseling, bed rest for a short period of time with short-term analgesic use, and special tests for nonresponders or atypical presentations. Above all, patients with low back pain must be given adequate information about their symptoms. Allaying a patient's fears may reduce the utilization of medical resources and encourage adherence with treatment.<sup>1</sup>



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