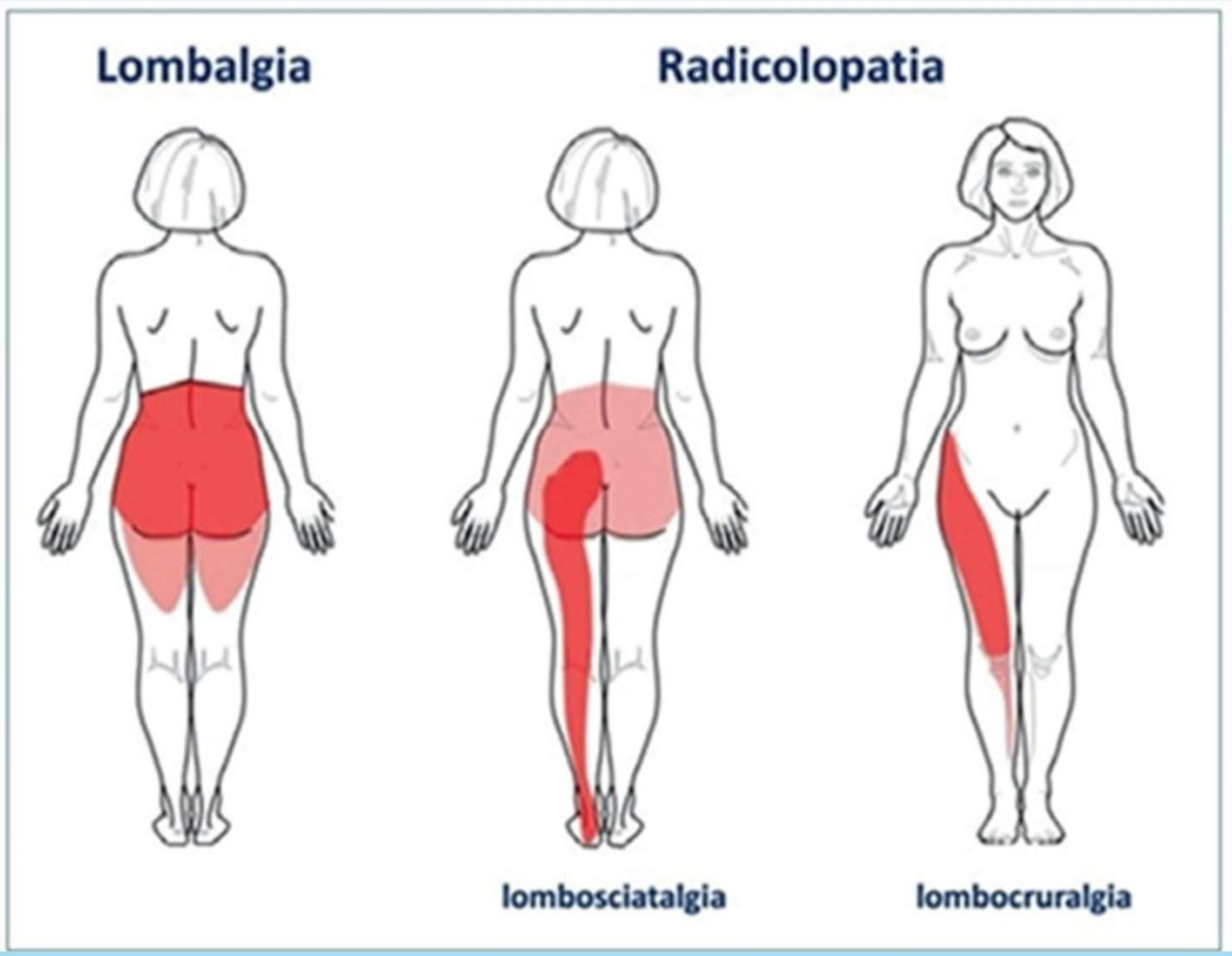
DOLORE LOMBARE: strategie terapeutiche

DOTT.SSA MATILDE PENAZZI
U.O. ANESTESIA E RIANIMAZIONE



LG SIOT 2016;42: 118-136

Definizione:

• **lombalgia non specifica** dolore compreso fra il margine inferiore dell'arcata costale e le pieghe glutee inferiori, con eventuale irradiazione posteriore alla coscia, ma non oltre il ginocchio.

• **radicolopatia** (lombosciatalgia e lombocruralgia):

- La sciatalgia è rappresentata da un dolore irradiato posteriormente al di sotto del ginocchio con o senza dolore lombare (in oltre il 90% dei casi di radicolopatia sono interessate le radici L5 o S1).

- La cruralgia è un dolore irradiato alla coscia anteriormente per interessamento delle radici di L2, L3 e L4.

L'importanza del problema MAL DI SCHIENA

La causa più frequente di assenza di lavoro;

Fino all' 84% della popolazione adulta presenta un episodio di dolore lombare nel corso della propria vita;

Nel 90% dei casi di patologie meccaniche la prognosi è buona;

ACUTO: il 50% dei pazienti stanno bene in 1 settimana;

CRONICO: meno del 5% dei pazienti.

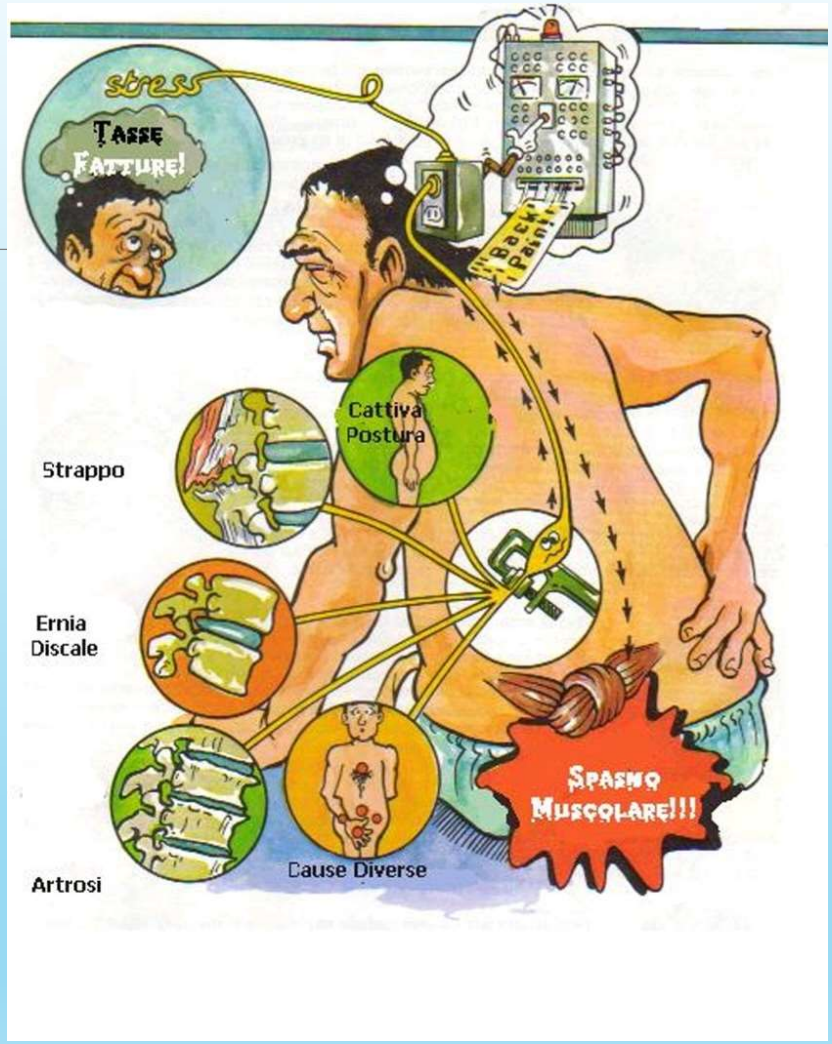
TABELLA III.
Definizione di mal di schiena nelle diverse LG.

	LGE	PDT	LGA	LGI	LGNZ	LGC
	Dolore e un disagio, tra il margine costale e la linea glutea inferiore, con o senza dolore alla gamba	Dolore dal limite inferiore delle costole al limite inferiore della linea glutea con possibili irradiazioni alla coscia, ma non oltre il ginocchio	Dolore che si verifica in primo luogo nella schiena, in assenza di segni di gravi patologie	Tensione e rigidità nella parte inferiore della schiena, tra il margine inferiore della gabbia toracica e le creste iliache, comprende la parte superiore delle gambe. Non è possibile identificare una causa specifica	Dolore episodico e comune, generalmente aspecifico, se si irradia lungo la gamba può essere causato da un'ernia del disco	Dolore, una tensione muscolare o rigidità, tra la gabbia toracia e la linea glutea inferiore, con o senza dolore alla gamba, in assenza di cause identificabili
	LGE	**PDT**	**LGA**	**LGI**	**LGNZ**	**LGC**
Acuta	< 6 settimane	< 4 settimane	< 4 settimane	< 6 settimane	< 3 mesi	< 12 settimane
Sub Acuta	6-12 settimane	4-12 settimane	4-12 settimane	6-12 settimane		
Cronica	> 12 settimane	> 12 settimane	> 12 settimane	> 12 settimane	> 3 mesi	> 12 settimane

LG SIOT Giugno2011;37:113-130

Eziologia:

- Oltre 95% dei casi sono lombalgie aspecifiche, ad eziologia sconosciuta;
- Nell'1% dei casi, sono riconoscibili cause gravi come fratture o tumori;
- In un altro 2% sono individuate cause viscerali- sistemiche come l'aneurisma dell'aorta e malattie gastrointestinali.



Valutazione del DOLORE LOMBARE

- ANAMNESI

RED FLAGS:

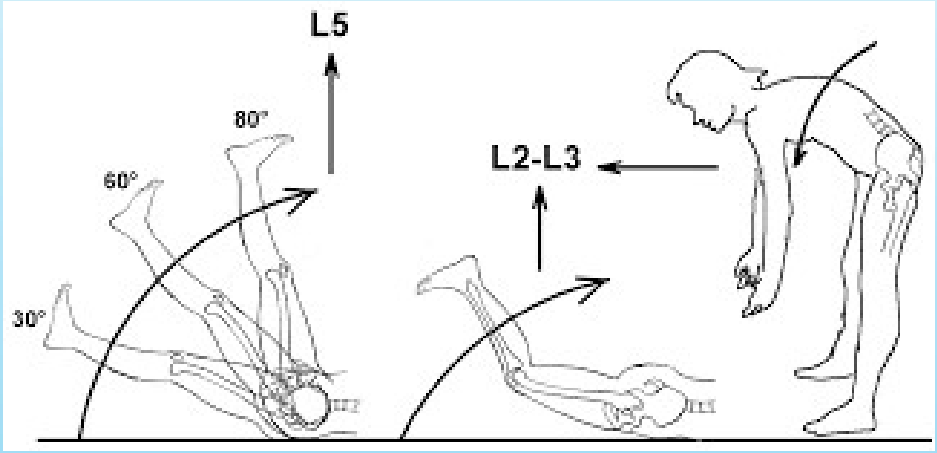
Quadro clinico	Possibile patologia associata
Ritenzione urinaria, anestesia a sella	Sindrome della Cauda Equina
Febbre di ndd, tossicodipendenza, immunosoppressione	Infezione
Uso prolungato di steroidi	Frattura, infezione
Trauma a bassa energia in età superiore ai 55 anni	Frattura o tumore
Anamnesi + per neoplasia, perdita di peso non giustificata	Neoplasia
Deficit neurologico progressivo	Tutte le cause sopracitate

LG SIOT 2016;42: 118-136

- ESAME OBIETTIVO

La valutazione neurologica si basa sul rilevamento dei segni d'interessamento radicolare:

- L3: Wasserman positivo, ROT patellare ridotto/assente, riduzione forza estensione ginocchio;
- L4: Wasserman/Lasègue positivi, ROT patellare ridotto/assente, riduzione forza estensione ginocchio, alterazione sensibilità piede (interno);
- L5: Lasègue positivo, ROT patellare e achilleo presenti, riduzione forza flessione dorsale alluce e dita, alterazione sensibilità piede (dorso);
- S1: Lasègue positivo, ROT patellare presente, ROT achilleo ridotto/assente, riduzione forza flessione plantare piede/alluce, alterazione sensibilità piede (esterno).



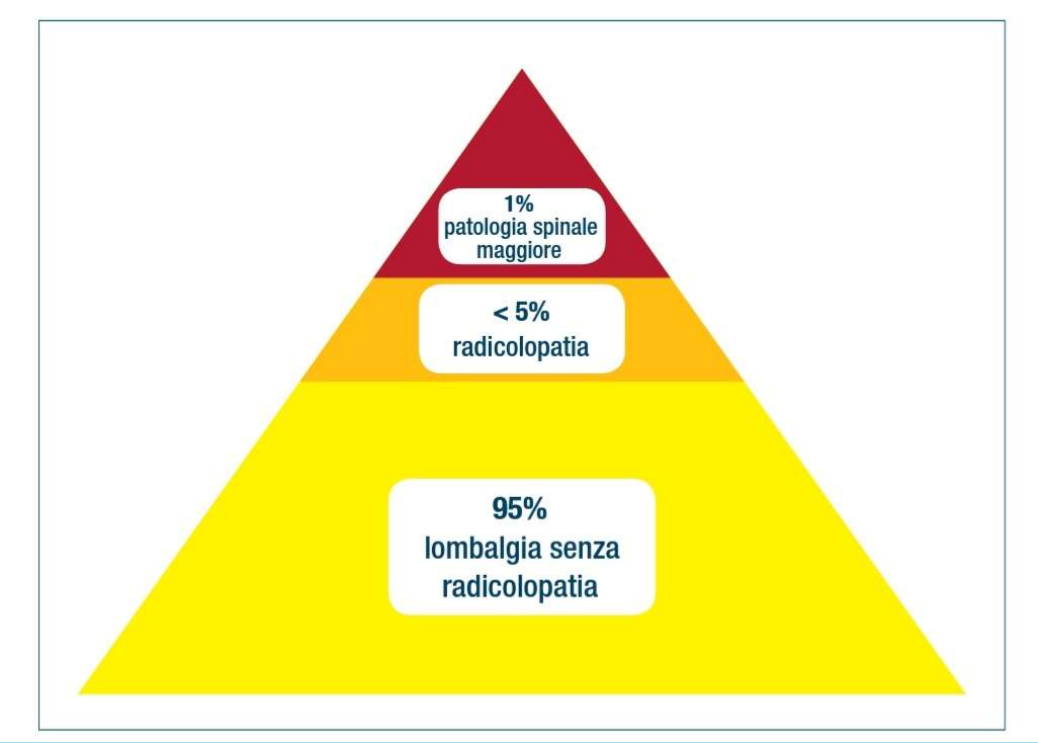
- ESAMI STRUMENTALI

-Sospetto di Red Flags;

-Deficit neurologico acuto/progressivo;

-Dolore cronico non responsivo alle terapie;

Che tipo di dolore lombare presentano i pazienti???



LG SIOT 2016;42: 118-136

Prevenzione e Trattamento del Dolore Lombare

Lancet 2018; 391: 2368–83

Low back pain 2

Prevention and treatment of low back pain: evidence, challenges, and promising directions

*Nadine E Foster, Johannes R Anema, Dan Cherkin, Roger Chou, Steven P Cohen, Douglas P Gross, Paulo H Ferreira, Julie M Fritz, Bart W Koes, Wilco Peul, Judith A Turner, Chris G Maher, on behalf of the Lancet Low Back Pain Series Working Group**

	Effect in adults[4]	Effect in children[5]
Exercise and education	Effective (moderate quality)	No trials available
Exercise	Effective (low quality)	No trials available
Education	Ineffective (moderate quality)	Ineffective (moderate quality)
Back belt	Ineffective (very low quality)	No trials available
Shoe insoles	Ineffective (low quality)	No trials available
Ergonomic interventions at workplace	Ineffective (moderate quality)	No trials available
Ergonomic school furniture	NA	Effective (very low quality)

NA=not applicable.

Table 1: **Evidence of prevention strategies for low back pain: conclusions on effectiveness (and GRADE strength of evidence ratings) from systematic reviews**

	Acute low back pain (<6 weeks)	Persistent low back pain (>12 weeks)
Education and self-care		
Advice to remain active	First-line treatment, consider for routine use	First-line treatment, consider for routine use
Education	First-line treatment, consider for routine use	First-line treatment, consider for routine use
Superficial heat	Second-line or adjunctive treatment option	Insufficient evidence
Non-pharmacological therapy		
Exercise therapy	Limited use in selected patients	First-line treatment, consider for routine use
Cognitive behavioural therapy	Limited use in selected patients	First-line treatment, consider for routine use
Spinal manipulation	Second-line or adjunctive treatment option	Second-line or adjunctive treatment option
Massage	Second-line or adjunctive treatment option	Second-line or adjunctive treatment option
Acupuncture	Second-line or adjunctive treatment option	Second-line or adjunctive treatment option
Yoga	Insufficient evidence	Second-line or adjunctive treatment option
Mindfulness-based stress reduction	Insufficient evidence	Second-line or adjunctive treatment option
Interdisciplinary rehabilitation	Insufficient evidence	Second-line or adjunctive treatment option
Pharmacological therapy		
Paracetamol	Not recommended	Not recommended
Non-steroidal anti-inflammatory drugs	Second-line or adjunctive treatment option	Second-line or adjunctive treatment option
Skeletal muscle relaxants	Limited use in selected patients	Insufficient evidence
Selective norepinephrine reuptake inhibitors	Insufficient evidence	Second-line or adjunctive treatment option
Antiseizure medications	Insufficient evidence	Role uncertain
Opioids	Limited use in selected patients, use with caution	Limited use in selected patients, use with caution
Systemic glucocorticoids	Not recommended	Not recommended
Interventional therapies		
Epidural glucocorticoid injection (for herniated disc with radiculopathy)	Not recommended	Limited use in selected patients
Surgery		
Discectomy (for herniated disc with radiculopathy)	Insufficient evidence	Second-line or adjunctive treatment option
Laminectomy (for symptomatic spinal stenosis)	Insufficient evidence	Second-line or adjunctive treatment option
Spinal fusion (for non-radicular low back pain with degenerative disc findings)	Insufficient evidence	Role uncertain

Subacute low back pain is a transition period between acute and chronic low back pain; evidence on optimal therapies for subacute low back pain is scarce but a reasonable approach is to shift towards therapies recommended for chronic low back pain.

Table 2: **Overview of interventions endorsed for non-specific low back pain in evidence-based clinical practice guidelines (Danish,[6] US,[7] and UK[8] guidelines)**

- Rimanere attivi / Formazione per un corretto stile di vita (1° linea dolore acuto e cronico)
- Esercizio fisico e CBT (1° linea dolore cronico)
- FANS tp di 2° linea (dolore cronico e acuto)
- Antidepressivi tp di 2° linea nel dolore cronico
- Oppioidi uso limitato in pz selezionati
- Glucocorticoidi ad uso epidurale (radicolopatia da conflitto DR) uso limitato in pz selezionati nel dolore cronico
- Chirurgia tp di 2° linea in pz selezionati

Low back pain 2

Lancet 2018; 391: 2368–83

Prevention and treatment of low back pain: evidence, challenges, and promising directions

*Nadine E Foster, Johannes R Anema, Dan Cherkin, Roger Chou, Steven P Cohen, Douglas P Gross, Paulo H Ferreira, Julie M Fritz, Bart W Koes, Wilco Peul, Judith A Turner, Chris G Maher, on behalf of the Lancet Low Back Pain Series Working Group**

KEY MESSAGES

- Low back pain should be managed in primary care
- Provide education and advice
- Remain active and stay at work
- Imaging should only occur if the clinician suspects a specific condition that would require different management to non-specific low back pain
- First choice of therapy should be non-pharmacological
- Most guidelines advise against electrical physical modalities (eg, short-wave diathermy, traction)
- Due to unclear evidence of efficacy and concerns of harm, the use of opioid analgesic medicines is now discouraged
- Interventional procedures and surgery have a very limited role, if any, in the management of low back pain
- Exercise is recommended for chronic low back pain
- A biopsychosocial framework should guide management of low back pain

REVIEW ARTICLE

EJP

Evidence-based treatment recommendations for neck and low back pain across Europe: A systematic review of guidelines

Nadia Corp[1] | Gemma Mansell[1,2] | Siobhán Stynes[1,3] | Gwenllian Wynne-Jones[1] | Lars Morso[4] | Jonathan C. Hill[5] | Danielle A. van der Windt[1]

2021

Intervention	Low Back Pain		Neck Pain	
	No. guidelines (countries)	Overall strength of recommendation	No. guidelines (countries)	Overall strength of recommendation
Reassurance (advice)	4(4)	Weak FOR	3(3)	Weak FOR
Advice and Education (advice)	10(8)	Strong FOR	5(5)	Weak FOR
Remain active (advice)	9(6)	Strong FOR	2(2)	Weak FOR
Encourage physical exercise (advice)	7(6)	Weak FOR	3(3)	Weak FOR
Continue/return to work (advice)	2(2)	Weak FOR	1(1)	(For)
Bed rest (advice)	6(4)	Strong AGAINST WITH EXCEPTIONS	1(1)	(Against)
Analgesics incl. for neuropathic pain	1(1)	(For)	2(2)	Weak FOR
Paracetamol	8(6)	Moderate AGAINST	2(2)	Weak FOR
NSAIDs	9(7)	Inconsistent	4(3)	Weak FOR
Opioids (including tramadol) +/- paracetamol (or NSAIDs)	8(6)	Inconsistent	2(1)	Weak FOR
Antidepressants	6(5)	Strong AGAINST WITH EXCEPTIONS		
Anticonvulsants/Antiepileptics	5(5)	Strong AGAINST		
Muscle relaxants	5(4)	Strong AGAINST WITH EXCEPTIONS		
Topical medications incl. NSAIDS	3(3)	Inconclusive	2(2)	Moderate FOR
Spinal injections [for non-specific LBP]	6(5)	Strong AGAINST		
Spinal epidural steroid injection	5(5)	Inconsistent	1(1)	(For)
Other injections	2(2)	Inconclusive		

Intervention	Low Back Pain		Neck Pain	
	No. guidelines (countries)	Overall strength of recommendation	No. guidelines (countries)	Overall strength of recommendation
Thermotherapy	5(4)	Inconsistent	2(2)	Inconclusive
Manual therapy	8(6)	Inconsistent	5(4)	Inconsistent
Manual therapy combined with other treatment	4(3)	Moderate FOR	3(3)	Moderate FOR
Exercise programs/therapy	9(6)	Strong FOR	5(5)	Moderate FOR
Exercise therapy combined with other treatment			2(2)	Moderate FOR
Group exercise programmes/back schools	3(3)	Moderate FOR		
Postural therapies	3(3)	Inconclusive		
Traction	6(6)	Strong AGAINST	3(3)	Inconclusive
Electrotherapy	6(6)	Strong AGAINST	4(4)	Inconclusive
Orthoses	6(6)	Strong AGAINST	4(4)	Inconclusive
Acupuncture	5(4)	Inconsistent	4(3)	Inconsistent
Psychological therapies	4(3)	Strong FOR SPECIFIC SUBGROUPS	3(3)	Weak FOR SPECIFIC SUBGROUPS
Psychological therapies combined with other treatment	2(2)	Moderate FOR		
Multidisciplinary treatment	7(5)	Strong FOR SPECIFIC SUBGROUPS	2(2)	Weak FOR SPECIFIC SUBGROUPS

Intervention	Low Back Pain		Neck Pain	
	No. guidelines (countries)	Overall strength of recommendation	No. guidelines (countries)	Overall strength of recommendation
Work-based interventions	3(3)	Moderate FOR		
Return to work programmes	3(3)	Strong FOR		
Imaging	9(6)	Strong AGAINST WITH EXCEPTIONS	2(2)	Inconclusive
To surgeon/surgery	8(6)	Strong FOR SPECIFIC SUBGROUPS		Appendix S1 Appendix S2 Appendix S3 Appendix S4 Appendix S5 Appendix S6 Appendix S7

What does best practice care for musculoskeletal pain look like? Eleven consistent recommendations from high-quality clinical practice guidelines: systematic review

Ivan Lin ,[1] Louise Wiles,[2] Rob Waller,[3] Roger Goucke,[4] Yusuf Nagree,[5,6] Michael Gibberd,[7] Leon Straker ,[8] Chris G Maher,[9] Peter P B O'Sullivan[10]

Box 2 Consistent recommendations across musculoskeletal (MSK) pain conditions

1. Care should be patient centred. This includes care that responds to the individual context of the patient, employs effective communication and uses shared decision-making processes.
2. Screen patients to identify those with a higher likelihood of serious pathology/red flag conditions.
3. Assess psychosocial factors.
4. Radiological imaging is discouraged unless:
   i. Serious pathology is suspected.
   ii. There has been an unsatisfactory response to conservative care or unexplained progression of signs and symptoms.
   iii. It is likely to change management.
5. Undertake a physical examination, which could include neurological screening tests, assessment of mobility and/or muscle strength.
6. Patient progress should be evaluated including the use of outcome measures.
7. Provide patients with education/information about their condition and management options.
8. Provide management addressing physical activity and/or exercise.
9. Apply manual therapy only as an adjunct to other evidence-based treatments.
10. Unless specifically indicated (e.g. red flag condition), offer evidence-informed non-surgical care prior to surgery.
11. Facilitate continuation or resumption of work.

Box 3 Consistent recommendations within single musculoskeletal (MSK) pain conditions

Osteoarthritis (OA)
- Offer self-management programmes.
- Provide interventions targeting weight loss to people with OA who are overweight or obese.
- Do not use glucosamine or chondroitin for disease modification.
- Do not undertake knee arthroscopic lavage and debridement unless there is a rationale (such as mechanical knee locking).

Low back pain
- Do not offer paracetamol as a single medication.
- Do not offer opioids for chronic LBP.
- Do not offer selective serotonin reuptake inhibitors, serotonin–norepinephrine reuptake inhibitors, tricyclic antidepressants or anticonvulsants for LBP.
- Do not offer rocker shoes or foot orthotics.
- Do not offer disc replacement.
- Only offer spinal fusion if part of a randomised controlled trial.
- Spinal injections (eg. facet joint injections, medical branch blocks, intradiscal injections, prolotherapy and trigger point injections) should not be used for LBP.

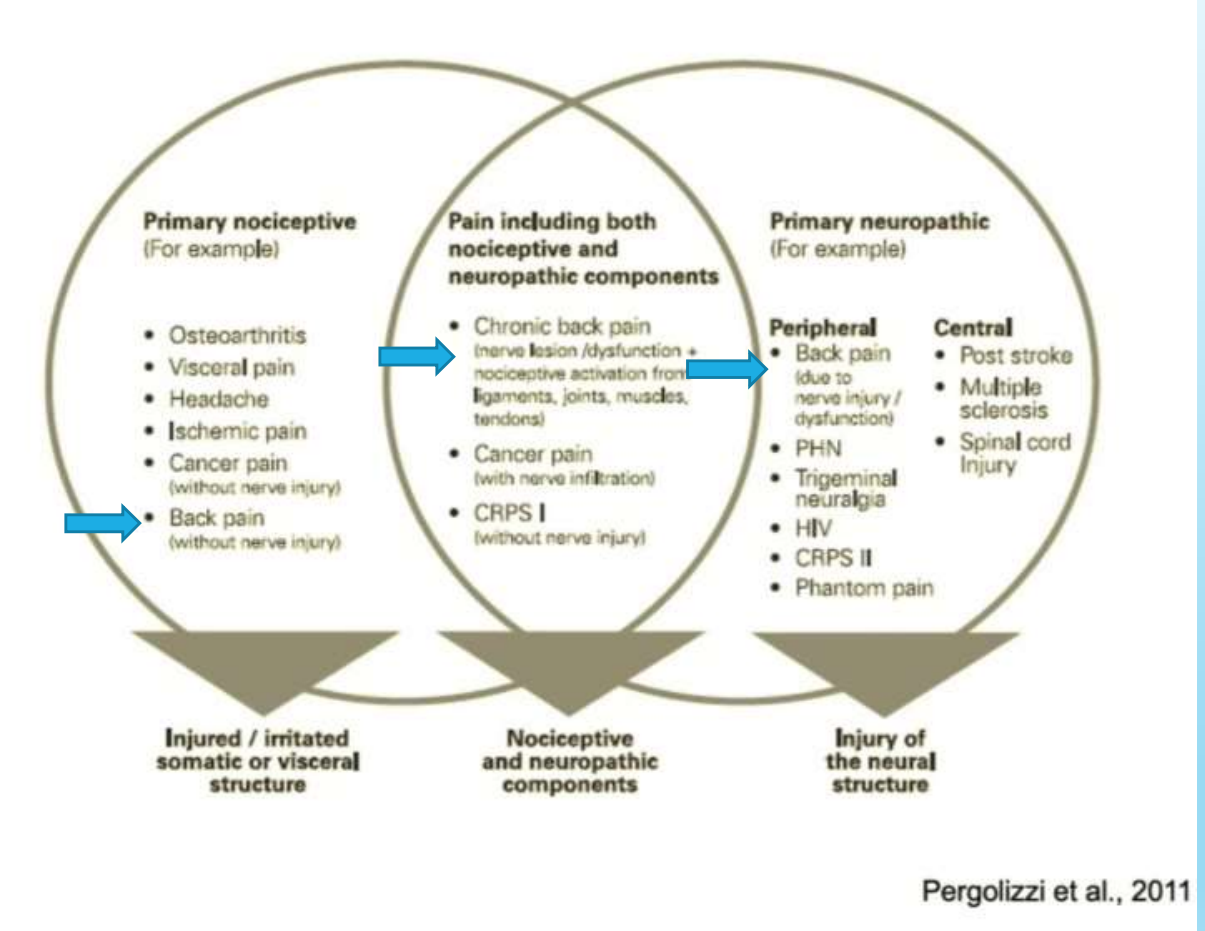
Neck pain
- Neck pain disorders should be classified as grades I–IV.

Lin I, *et al*. *Br J Sports Med* 2020;**54**:79–86. doi:10.1136/bjsports-2018-099878

Queste le considerazioni della British Pain Society (BPS):

- ✓ un enorme potenziale impatto negativo e conseguenti implicazioni negative per i pazienti che soffrono di dolore cronico e che trarrebbero un significativo beneficio individuale dai trattamenti farmacologici
- ✓ La BPS riconosce l'importanza di adottare notevole cautela e attenzione con tutti i farmaci che possono potenzialmente dare tolleranza, dipendenza e pericolo di abuso.

Importanza del FENOTIPO



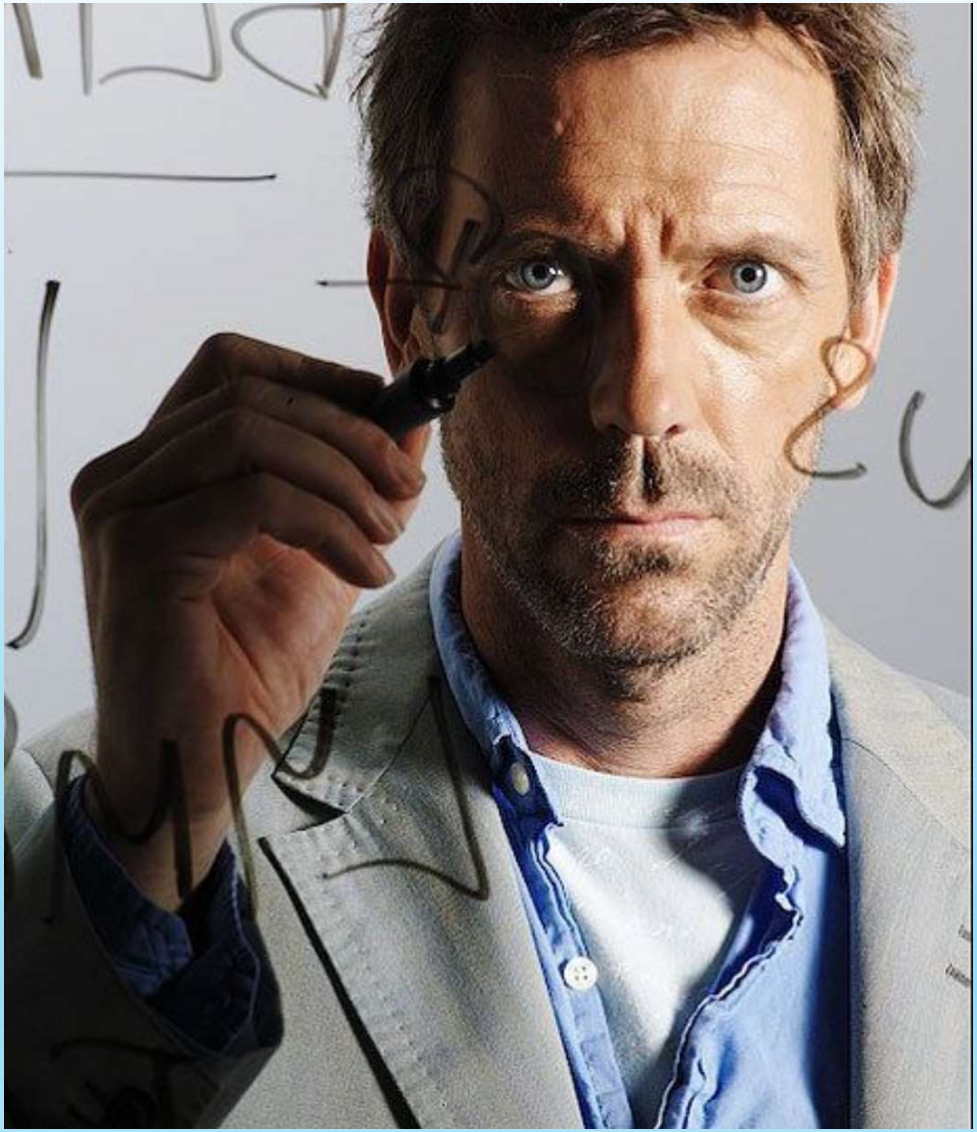
Pergolizzi et al., 2011

Oggi sappiamo che il dolore cronico cambia le sue caratteristiche nel tempo

- Inizialmente è di tipo nocicettivo periferico
- Poi si va incontro ad una neuroinfiammazione periferica
- Successivamente si presenta con le caratteristiche di sensibilizzazione centrale
- …. e di neuroinfiammazione centrale
- Infine assume caratteristiche di dolore neuropatico

→ **Dolore NOCIPLASTICO**

Ma cosa ci dice la letteratura sull’efficacia dei diversi trattamenti nel dolore refrattario???



PARACETAMOLO???

2016

AUTHORS' CONCLUSIONS

Implications for practice

The results argue against the use of paracetamol in the management of acute LBP. It is not possible to make recommendations for or against the use of paracetamol for subacute or chronic LBP as we did not locate any trials.

FANS???

Authors' conclusions:

This updated systematic review including 10 trials evaluating the efficacy of NSAIDs versus placebo or other drugs in people with sciatica reports low- to very low-level evidence using the GRADE criteria. The efficacy of NSAIDs for pain reduction was not significant. NSAIDs showed a better global improvement compared to placebo. These findings must be interpreted with caution, as the level of evidence according to the GRADE classification was very low for the outcome pain reduction and low for global improvement due to small study samples, inconsistent results, imprecision, and a high risk of bias in the included trials. While the trials included in the analysis were not powered to detect potential rare side effects, we found an increased risk for side effects in the short-term NSAIDs use. As NSAIDs are frequently prescribed, the risk-benefit ratio of prescribing the drug needs to be considered.

ANTICONVULSIVANTI???

RESEARCH

Anticonvulsants in the treatment of low back pain and lumbar radicular pain: a systematic review and meta-analysis

Oliver Enke MBBS MSc, Heather A. New MBBS MPH, Charles H. New MBBS, Stephanie Mathieson PhD, Andrew J. McLachlan PhD, Jane Latimer PhD, Christopher G. Maher PhD, C.-W. Christine Lin PhD

Cite as: *CMAJ* 2018 July 3;190:E786-93. doi: 10.1503/cmaj.171333

ABSTRACT

BACKGROUND: The use of anticonvulsants (e.g., gabapentin, pregabalin) to treat low back pain has increased substantially in recent years despite limited supporting evidence. We aimed to determine the efficacy and tolerability of anticonvulsants in the treatment of low back pain and lumbar radicular pain compared with placebo.

METHODS: A search was conducted in 5 databases for studies comparing an anticonvulsant to placebo in patients with nonspecific low back pain, sciatica or neurogenic claudication of any duration. The outcomes were self-reported pain, disability and adverse events. Risk of bias was assessed using the Physiotherapy Evidence Database (PEDro) scale, and quality of evidence was assessed using Grading of Recommendations Assessment, Development and Evaluation (GRADE). Data were pooled and treatment effects were quantified using mean differences for continuous and risk ratios for dichotomous outcomes.

RESULTS: Nine trials compared topiramate, gabapentin or pregabalin to placebo in 859 unique participants. Fourteen of 15 comparisons found anticonvulsants were not effective to reduce pain or disability in low back pain or lumbar radicular pain; for example, there was high-quality evidence of no effect of gabapentinoids versus placebo on chronic low back pain in the short term (pooled mean difference [MD] −0.0, 95% confidence interval [CI] −0.8 to 0.7) or for lumbar radicular pain in the immediate term (pooled MD −0.1, 95% CI −0.7 to 0.5). The lack of efficacy is accompanied by increased risk of adverse events from use of gabapentinoids, for which the level of evidence is high.

INTERPRETATION: There is moderate- to high-quality evidence that anticonvulsants are ineffective for treatment of low back pain or lumbar radicular pain. There is high-quality evidence that gabapentinoids have a higher risk for adverse events. **Protocol registration:** PROSPERO-CRD42016046363

Pharmacotherapy for neuropathic pain in adults: systematic review, meta-analysis and updated NeuPSIG recommendations

Nanna B Finnerup, MD [*],[a], Nadine Attal, MD [*],[b,c,1], Simon Haroutounian, PhD[d], Ewan McNicol, MS[e], Ralf Baron, MD[f], Robert H Dworkin, PhD[g], Ian Gilron, MD[h], Maija Haanpaa, MD[i], Per Hansson, MD[j], Troels S Jensen, MD[a,k], Peter R Kamerman, PhD[l], Karen Lund, MD[a], Andrew Moore, DSc[m], Srinivasa N Raja, MD[n], Andrew SC Rice, MD[o], Michael Rowbotham, MD[p], Emily Sena, PhD[q], Philip Siddall, MD[r], Blair H Smith, MD[s], and Mark Wallace, MD[t]

Lancet Neurol 2015

GRADE classification	Drugs	Daily dosages and dose regime	Recommendations
STRONG FOR	Gapabentin	1200–3600 mg TID	First-line
	Gabapentin ER/enacarbil	1200–3600 mg BID	First-line
	Pregabalin	300–600 mg BID	First-line
	SNRIs duloxetine/venlafaxine	60–120 mg QD (duloxetine);150–225 mg QD (venlafaxine ER)	First-line
	TCAs	25–150 mg qd or BID	First-line [1]
WEAK FOR	Capsaicin 8% patches	1–4 patches to the painful area for 30–60 min every 3 months	Second-line (PNP) [2]
	Lidocaine patches	1–3 patches to the painful area for up to 12 hours	Second-line (PNP)
	Tramadol	200–400 mg BID (tramadol ER) or TID	Second-line
	BTX- A (SC)	50–200 units to the painful area every 3 months	Third-line ; specialist use (PNP)
	Strong opioids	Individual titration	Third line[3]
INCONCLUSIVE	Combination therapy		
	Capsaicin cream		
	Carbamazepine		
	Clonidine topical		
	Lacosamide		
	Lamotrigine		
	NMDA antagonists Oxcarbazepine		
	SSRI antidepressants Tapentadol		
	Topiramate		
	Zonisamide		
WEAK AGAINST	Cannabinoids		
	Valproate		
STRONG AGAINST	Levetiracetam		
	Mexiletine		

OPPIOIDI???

- Nel dolore neuropatico 3° o 4° scelta
- Preferire formulazioni per via orale a lento rilascio
- Formulazioni per via transdermica sono la seconda scelta
- Formulazioni rapide (es ROO) da riservare a riacutizzazioni di dolore in pazienti che già usano oppioidi
- Considerare il profilo di efficacia
- Tollerabilità nel trattamento a lungo termine
- Rotazione degli oppiodi
- Sospensione delle tp inefficaci


Cochrane

Cochrane Library

Coronavirus (COVID-19) resources

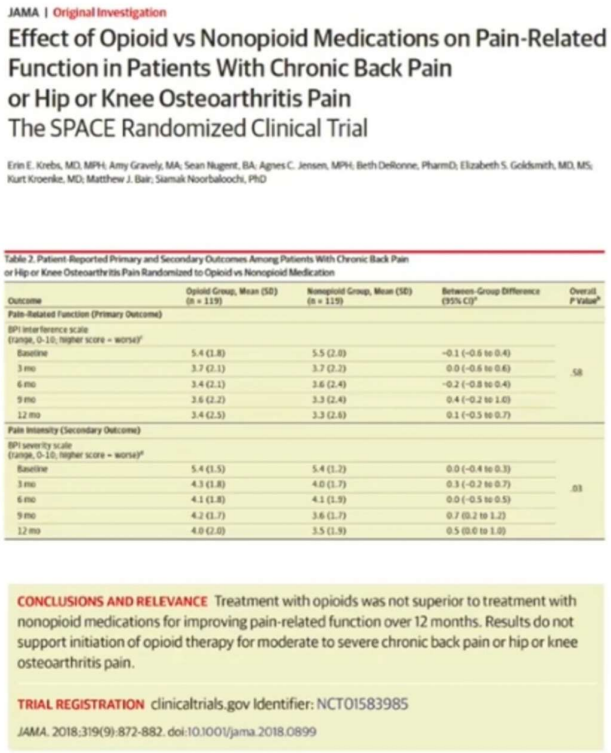
Opioids for the treatment of chronic low-back pain

Published:
27 August 2013

Authors:
Chaparro L, Furlan AD, Deshpande A, Mailis-Gagnon A, Atlas S, Turk DC

Authors' conclusions:

There is some evidence (*very low to moderate quality*) for short-term efficacy (for both pain and function) of opioids to treat CLBP compared to placebo. The very few trials that compared opioids to non-steroidal anti-inflammatory drugs (NSAIDs) or antidepressants did not show any differences regarding pain and function. The initiation of a trial of opioids for long-term management should be done with extreme caution, especially after a comprehensive assessment of potential risks. There are no placebo-RCTs supporting the effectiveness and safety of long-term opioid therapy for treatment of CLBP.


JAMA | Original Investigation

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain
The SPACE Randomized Clinical Trial

Erin E. Krebs, MD, MPH; Amy Gravely, MA; Sean Nugent, BA; Agnes C. Jensen, MPH; Beth DeRonne, PharmD; Elizabeth S. Goldsmith, MD, MS; Kurt Kroenke, MD; Matthew J. Bair; Siamak Noorbaloochi, PhD

Table 2. Patient-Reported Primary and Secondary Outcomes Among Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain Randomized to Opioid vs Nonopioid Medication

Outcome	Opioid Group, Mean (SD) (n = 119)	Nonopioid Group, Mean (SD) (n = 119)	Between-Group Difference (95% CI)[a]	Overall P Value[b]
Pain-Related Function (Primary Outcome)				
BPI interference scale (range, 0-10; higher score = worse)[c]				
Baseline	5.4 (1.8)	5.5 (2.0)	−0.1 (−0.6 to 0.4)	.58
3 mo	3.7 (2.1)	3.7 (2.2)	0.0 (−0.6 to 0.6)	
6 mo	3.4 (2.1)	3.6 (2.4)	−0.2 (−0.8 to 0.4)	
9 mo	3.6 (2.2)	3.3 (2.4)	0.4 (−0.2 to 1.0)	
12 mo	3.4 (2.5)	3.3 (2.6)	0.1 (−0.5 to 0.7)	
Pain Intensity (Secondary Outcome)				
BPI severity scale (range, 0-10; higher score = worse)[d]				
Baseline	5.4 (1.5)	5.4 (1.2)	0.0 (−0.4 to 0.3)	.03
3 mo	4.3 (1.8)	4.0 (1.7)	0.3 (−0.2 to 0.7)	
6 mo	4.1 (1.8)	4.1 (1.9)	0.0 (−0.5 to 0.5)	
9 mo	4.2 (1.7)	3.6 (1.7)	0.7 (0.2 to 1.2)	
12 mo	4.0 (2.0)	3.5 (1.9)	0.5 (0.0 to 1.0)	

CONCLUSIONS AND RELEVANCE Treatment with opioids was not superior to treatment with nonopioid medications for improving pain-related function over 12 months. Results do not support initiation of opioid therapy for moderate to severe chronic back pain or hip or knee osteoarthritis pain.

TRIAL REGISTRATION clinicaltrials.gov Identifier: NCT01583985

JAMA. 2018;319(9):872-882. doi:10.1001/jama.2018.0899

CANNABIS TERAPEUTICA???

Cannabis and Cannabinoid Research
Volume 5, Number 4, 2020

DOI: 10.1089/can.2019.0077

REVIEWS

Cannabis Use and Low-Back Pain: A Systematic Review

Lucas First,[1,*] William Douglas,[1] Behnum Habibi,[1] Jaspal Ricky Singh,[2] and Michael T. Sein[2]

Conclusions

This systematic literature review revealed that there is a significant lack of quality evidence regarding the role of cannabinoid products in the treatment of low-back pain. Low-back pain is experienced by a majority of adults during their lifetimes and linked to significant financial burden in the United States' health care system. As the medical community at large continues to grapple with the ongoing opioid crisis, there is a need to investigate alternative analgesic treatment modalities. Greater research into the analgesic properties of cannabis could serve as an important step in the development of novel treatments. The clinical applications of cannabis and cannabinoid products, including the treatment of low-back pain, clearly deserve further exploration.

TRATTAMENTI INVASIVI???

Pain Medicine, 20(7), 2019, 1281–1293
doi: 10.1093/pm/pny154
Advance Access Publication Date: 10 September 2018
Review Article

GENERAL & SELECTED POPULATIONS SECTION

Are Invasive Procedures Effective for Chronic Pain? A Systematic Review

Wayne B. Jonas, MD,* Cindy Crawford,† Luana Colloca, MD, PhD,‡ Levente Kriston, PhD,§ Klaus Linde, MD, PhD,¶ Bruce Moseley, MD,‖ and Karin Meissner‖,**

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Correspondence to: Wayne B. Jonas, MD, Executive Director, Samueli Integrative Health Programs, H&S Ventures, 1800 Diagonal Road, Suit 617, Alexandria, VA 22314, Tel: (703) 647-7435; Fax: (703) 647-6009; Email: wayne@hsventures.org

treatments accounted for 87% of the effect compared with active treatment across all conditions. **Conclusions**. There is little evidence for the specific efficacy beyond sham for invasive procedures in chronic pain. A moderate amount of evidence does not support the use of invasive procedures as compared with sham procedures for patients with chronic back or knee pain. Given their high cost and safety concerns, more rigorous studies are required before invasive procedures are routinely used for patients with chronic pain.

E quindi?

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain
The SPACE Randomized Clinical Trial

CONCLUSIONS AND RELEVANCE Treatment with opioids was not superior to treatment with nonopioid medications for improving pain-related function over 12 months. Results do not support initiation of opioid therapy for moderate to severe chronic back pain or hip or knee osteoarthritis pain.

TRIAL REGISTRATION clinicaltrials.gov Identifier: NCT01583985

Cochrane
Cochrane Library
Coronavirus (COVID-19) resources

Opioids for the treatment of chronic low-back pain

Published:
27 August 2013

Authors:
Chaparro L, Furlan AD, Deshpande A, Mailis-Gagnon A, Atlas S, Turk DC

REVIEW ARTICLE

Evidence-based treatment recommendations for neck and lo back pain across Europe: A systematic review of guidelines

Nadia Corp | Gemma Mansell | Siobhán Stynes | Gwenllian Wynne-Jones | Lars Morso | Jonathan C. Hill | Danielle A. van der Windt

Cochrane Library
Cochrane Database of Systematic Reviews

Paracetamol for low back pain (Review)

Saragiotto BT, Machado GC, Ferreira ML, Pinheiro MB, Abdel Shaheed C, Maher CG

Cannabis and Cannabinoid Research
Volume 5, Number 4, 2020
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DOI: 10.1089/can.2019.0077

REVIEWS

Cannabis Use and Low-Back Pain: A Systematic Review

Lucas First, William Douglas, Behnum Habibi, Jaspal Ricky Singh, and Michael T. Sein

SNLG Regioni 1

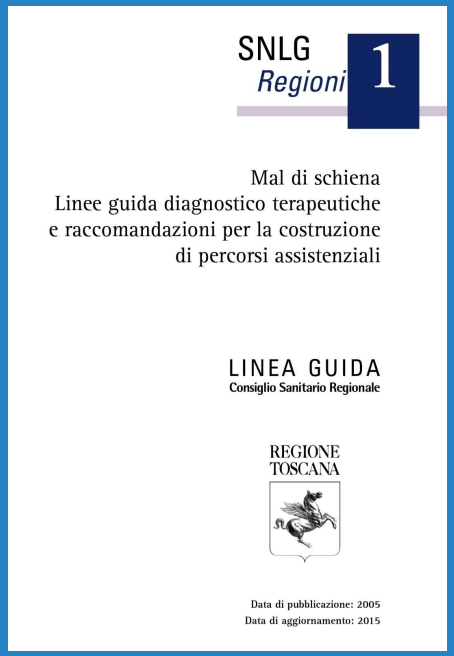
Mal di schiena
Linee guida diagnostico terapeutiche e raccomandazioni per la costruzione di percorsi assistenziali

LINEA GUIDA
Consiglio Sanitario Regionale

REGIONE TOSCANA

Data di pubblicazione: 2005
Data di aggiornamento: 2015

TRATTAMENTO LOMBALGIA ACUTA NON SPECIFICA



Prendersi cura del paziente con mal di schiena **senza** eccesso di medicalizzazione.

Consigli su attività fisica e comportamento:

- rassicurare il paziente;
- comunicare l'alta probabilità di prognosi favorevole legata alla natura benigna del disturbo, ma anche l'alta possibilità di recidive;
- raccomandare di rimanere attivi e, se possibile, non lasciare il lavoro;
- sconsigliare il riposo a letto.

Terapia farmacologica:

- il paracetamolo +/- oppioidi deboli (1° scelta);
- FANS con attenzione agli effetti collaterali;
- i miorilassanti possono essere farmaci di seconda scelta, ma non apportano effetto addizionale ai FANS;
- l'uso di antiepilettici non è indicato;
- la terapia steroidea non è consigliata.

TRATTAMENTO LOMBALGIA ACUTA NON SPECIFICA

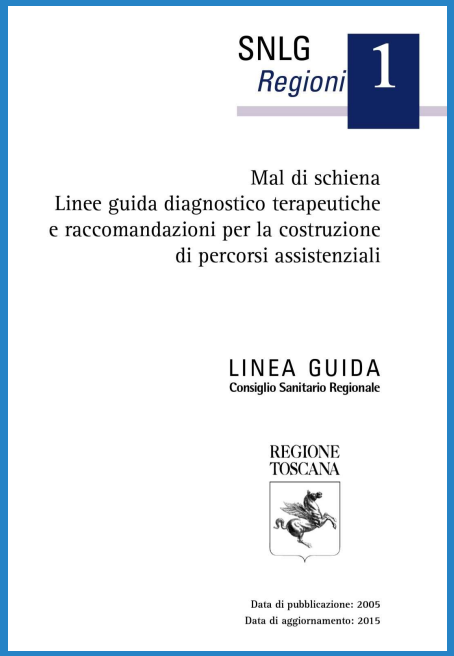
Terapie fisiche:

- l'applicazione di calore è utile;
- l'efficacia delle back school è limitata all'ambito lavorativo;
- manipolazioni dopo 2-3 settimane e prima di 6 dall'esordio possono essere consigliate.

Valutazione specialistica:

- i pazienti con lombalgia non specifica, senza segni di radicolopatia o di cause gravi, non hanno bisogno di consulenza specialistica.

TRATTAMENTO DELLA RADICOLOPATIA ACUTA (SCIATALGIA /CRURALGIA)



Consigli su attività fisica e comportamento:

- non è consigliato l'invio al chirurgo prima di un mese di terapia;
- il riposo a letto è sconsigliato, salvo pochi giorni per sciatica grave;
- è consigliabile continuare l'abituale attività anche lavorativa, nei limiti consentiti dal dolore.

Terapia farmacologica:

- gli steroidi per via sistemica per brevi periodi;
- il paracetamolo e i FANS sono utili per ridurre la sintomatologia dolorosa;
- gli oppioidi possono essere utilizzati da soli o in associazione quando FANS o paracetamolo non controllano il dolore;
- l'uso di antiepilettici non ha indicazione;
- le infiltrazioni di steroidi epidurali possono ridurre a breve termine il dolore radicolare, se non vi sono risultati con il trattamento farmacologico per via sistemica.

TRATTAMENTO DELLA RADICOLOPATIA ACUTA (SCIATALGIA /CRURALGIA)

Terapie fisiche:

• trazioni e corsetti non sono utili;

• terapie fisiche (TENS, massaggi, ultrasuoni, diatermia a onde corte) non sono utili.

Terapia chirurgica:

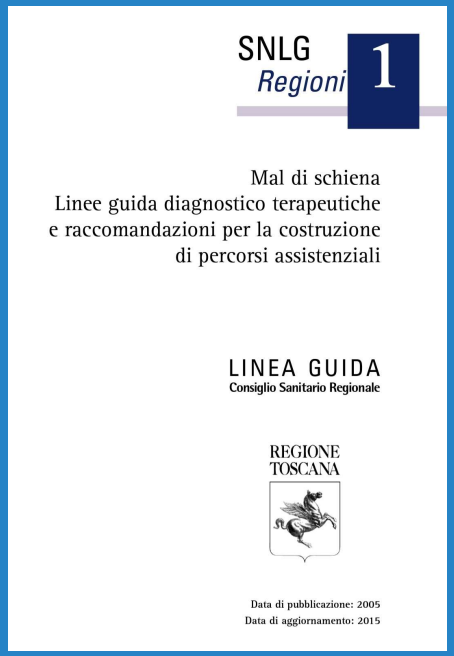
• valutazione chirurgica, prima di un mese di terapia conservativa, solo se c'è peggioramento neurologico, se il dolore è grave e resistente a qualunque trattamento conservativo o per comparsa di un semaforo rosso;

• nei pazienti con ernia del disco e radicolopatia, la discectomia è indicata se non c'è miglioramento con la terapia conservativa;

• ci sono prove insufficienti dell'utilità dell'ozonoterapia intradiscale;

• programmi intensivi di esercizi, iniziati 4-6 settimane dopo l'intervento, riducono i tempi della ripresa funzionale e del ritorno al lavoro.

TRATTAMENTO DEL MAL DI SCHIENA ACUTO PERSISTENTE/ SUBACUTO e CRONICO



Dopo le due settimane, in totale assenza di miglioramento della sintomatologia algo-disfunzionale nonostante i trattamenti prescritti, considerazione fattori psicologici, sociali e ambientali che possano influire sul passaggio da un quadro acuto a uno cronico e invalidante.

TRATTAMENTO DEL MAL DI SCHIENA ACUTO PERSISTENTE/ SUBACUTO e CRONICO

Se si possono **escludere bandiere rosse**, se non vi è stata sufficiente attenzione ai consigli e al trattamento proposti, è opportuno:

• riformulare strategie e modalità di comportamento;

• modificare il trattamento sintomatico che non si è rilevato efficace:

- eventuale sostituzione e/o adeguamento posologico del paracetamolo e/o del FANS e/o di altri analgesici, anche oppiacei

- eventuale prescrizione di miorilassanti

• breve trattamento fisioterapico, specialmente in presenza di significativa riduzione funzionale e limitazione dolorosa.

TRATTAMENTO DEL MAL DI SCHIENA ACUTO PERSISTENTE/ SUBACUTO e CRONICO

- Stress psicologici
- Depressione
- Alterazioni funzionali
- Insoddisfazione sul lavoro
- Evitamento da paura del dolore
- Richieste d'indennizzo
- Somatizzazioni

PREDITTORI DI PROGNOSI SFAVOREVOLE/CRONICIZZAZIONE

TRATTAMENTO DEL MAL DI SCHIENA ACUTO PERSISTENTE/ SUBACUTO e CRONICO

FATTORI DI RISCHIO di PROGNOSI SFAVORAVOLE CRONICIZZAZIONE

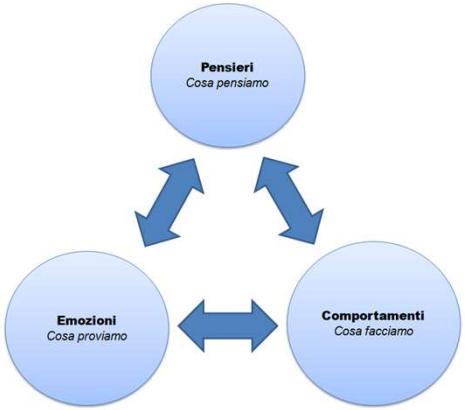
Psicologici, ambientali, sociali

Ambiente di lavoro

Contesto sociale e familiare

Psicopatologia
(disturbi di personalità)

Recupero funzionale a impronta comportamentale (CBT)



TEST DI WADDELL
Roland-Morris Disability Questionnaire

TRATTAMENTO DEL MAL DI SCHIENA ACUTO PERSISTENTE/ SUBACUTO e CRONICO

Raccomandazione Grado C

- antidepressivi (soltanto i triciclici si sono dimostrati efficaci, ma non ci sono prove per duloxetina e venlafaxina);
- paracetamolo e FANS (effetti modesti);
- miorilassanti (effetti non determinabili);
- corticosteroidi (nessuna prova di efficacia);
- oppioidi (effetti modesti);
- tramadolo (effetti modesti);
- cure termali;
- manipolazioni spinali;
- massaggi;
- denervazione delle faccette articolari;

TRATTAMENTO DEL MAL DI SCHIENA ACUTO PERSISTENTE/ SUBACUTO e CRONICO

- fasce e ortesi (supporti lombari);
- gabapentin;
- infiltrazioni di punti trigger e legamenti;
- infiltrazioni nelle faccette articolari;
- iniezione epidurale di corticosteroidi;
- lesione del ganglio dorsale con radiofrequenza;
- ozonoterapia;
- stimolazioni midollari;
- terapie fisiche (termoterapia, elettroterapia e TENS, trazioni, laser, ultrasuoni);
- terapie intradiscali (lesioni con radiofrequenza, elettrotermiche);
- tossina botulinica.

Con la Delibera della Giunta Regionale 741/2014 sono state approvate le “Linee guida regionali per l’erogazione di prestazioni di medicine non convenzionali in Emilia-Romagna a carico del Fondo sanitario regionale”.

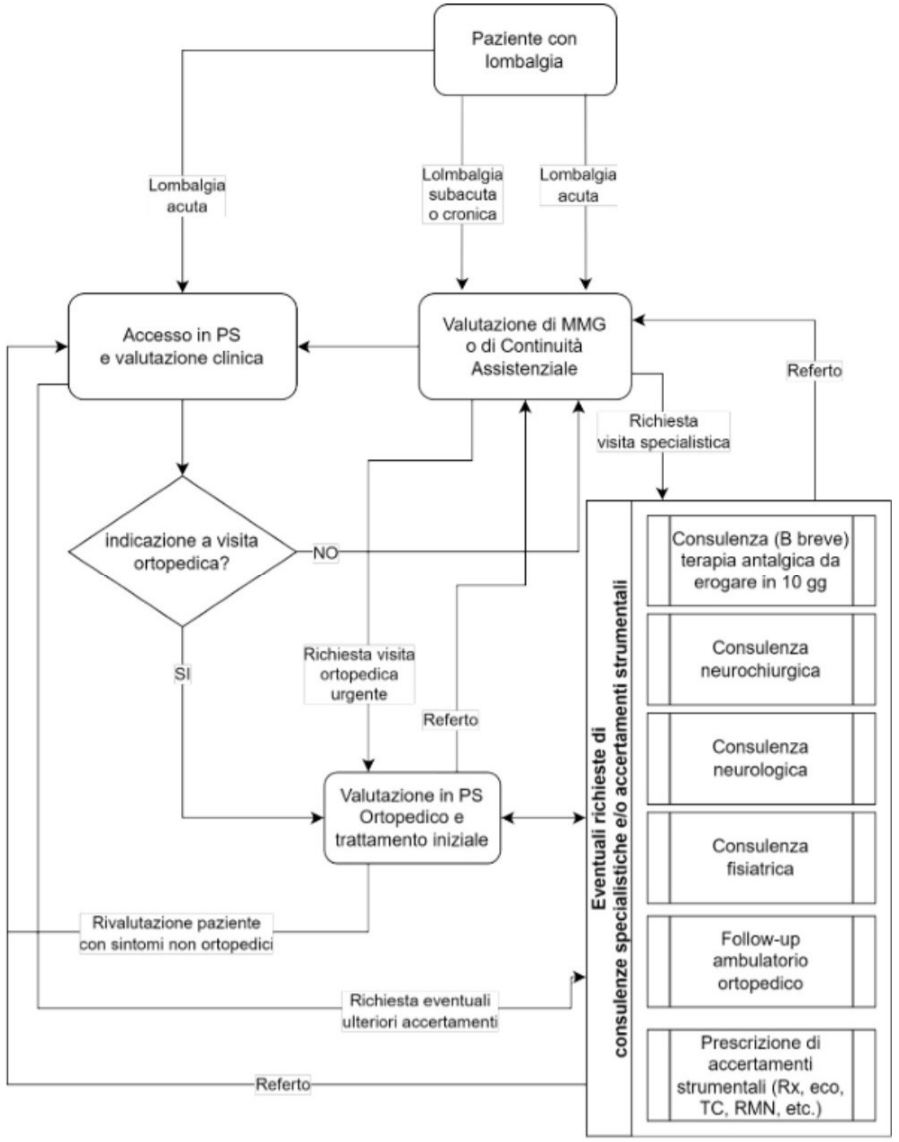
Con questo provvedimento sono state inserite tre nuove prestazioni mediche nei Livelli Essenziali di Assistenza regionali:

– agopuntura nel dolore ricorrente o cronico muscolo scheletrico lombare, con o senza sciatalgia;

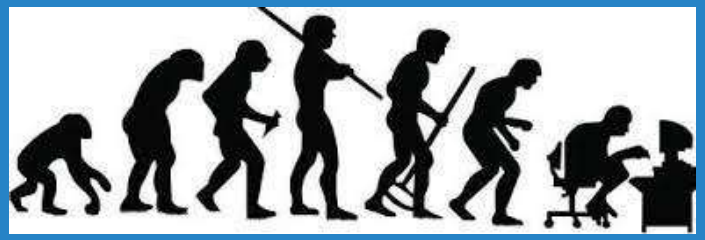
– agopuntura nella profilassi della cefalea muscolo-tensiva;

– agopuntura nella profilassi della cefalea emicranica.

Percorso clinico-assistenziale per paziente con LOMBALGIA AUSL Imola



CONCLUDENDO



- Il mal di schiena è una problematica che coinvolge principalmente le cure primarie;

- Fondamentale è riconoscere ed escludere le RED FLAGS;

- Le evidenze di classe A nella prevenzione e nel trattamento riguardano l' esercizio fisico e l'approccio cognitivo comportamentale, la prosecuzione dell'attività fisica e lavorativa con programmi di reintegro;

- Motivare il paziente, creare aspettative realistiche e evitare catastrofismo;

- L'importanza del fenotipo è fondamentale nel approccio terapeutico;

- L'approccio multidisciplinare complesso è preferibile se la disabilità è elevata o di recente insorgenza e se il paziente è fortemente motivato a risolverla.

GRAZIE PER L’ ATTENZIONE!