Dynamic Chiropractic

BACK PAIN

AHCPR Low Back Guidelines and Chiropractic Care

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As the panel chairman for the Agency for Health Care Policy and Research acute low back pain guideline project, I had the privilege to work with a distinguished and dedicated group of clinicians and scientists from disciplines of medicine, chiropractic, osteopathy, physical therapy, and the basic sciences. The National Library of Medicine's database identified over 10,000 abstracts that addressed the issue of back pain in humans. Nearly 4,600 complete studies were retrieved and reviewed for stringent rules of evidence, of which only 260 (for all treatment and diagnostic approaches) were of adequate scientific quality. Following many months of review, revision, and careful explicit consensus efforts, the panel drafted the guideline's "findings and recommendation statements," which were then submitted to nearly 100 peer reviewers from all clinical disciplines (including 10 chiropractic physicians).

Two key studies were identified which clearly documented a role for manipulation in relieving pain during the course of maintaining activities. These studies on manipulation survived the stringent review criteria and persuaded the panel to rate manipulation as useful for that part of treatment dealing with patient comfort: neither were conducted by chiropractors. However, since DCs are very well trained in this procedure, and provide patients with most of the spinal manipulation in the United States, it is reasonable to expect a great deal of interest from the chiropractic community.

The panel's recommendations were quite generic and essentially characterized the value of a short-term role for manipulation (equivalent to analgesics) in pain control. This can be especially useful to assist a patient with acute low back pain in maintaining or returning to normal activities and to tolerate performance of exercise intended to build activity tolerance. While a number of reasonable studies on manipulation for low back pain have been done by chiropractors, and/or include care by DCs, the AHCPR panel did not single out any type of provider or specialty to review or comment upon. In fact, the panel made every effort to be blind to types of providers and focus exclusively on recommendations for specific methods. In this way, we were able to provide recommendations based solely on clinical and scientific merit, devoid of so many of the political and turf squabbles that have plagued back care over the years.

It is for these reasons that I strongly discourage misrepresentation and promulgation of half-truths by some providers and marketers regarding the application of the guidelines purely for sensationalistic public relations value. The purpose of these guidelines is to synthesize the current state of science in treatment approaches for acute low back problems in adults by focusing the paradigm on treating the activity limitation, not just focusing on pain. They cannot undo any past social or political battle scars. However they can be used, quoted, and reprinted, as they appear, to help both patients and clinicians make better informed decisions on how to cope with back problems that limit activity. To extrapolate them beyond this can be not only inaccurate, but eventually damaging to the credibility of those who try to use a twist of science to continue an unneeded social and political battle.

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