Derby and Derbyshire
Integrated Care Board

CLINICAL POLICY ADVISORY GROUP (CPAG)

Injections for Isolated Lower Back Pain without Sciatica

Statement

Derby and Derbyshire ICB, in line with its principles of Evidence Based Interventions has deemed that **Injections for Isolated Lower Back Pain without Sciatica** should not routinely be commissioned unless the criteria within the policy are met.

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by the ICB.

1. Background

Many types of spinal injections do not have a strong evidence base. This guidance is focused on the use of diagnostic spinal injections (local anaesthetic only), radiofrequency denervation and NOT therapeutic injections for people with isolated lower back pain without sciatica.

This policy may be read in conjunction with other DDICB Policies and Position Statements which can be found at:

- http://www.derbyshiremedicinesmanagement.nhs.uk/clinical-policies-home/clinical-policies/orthopedics

2. Recommendation

Injections for Isolated Lower Back Pain without Sciatica can be offered if the following criteria are met.

1. Medial branch blocks (a spinal injection)

- CAN be used diagnostically for patients with isolated lower back pain who have not responded to rehabilitation, e.g. CPPP (combined physical and psychological programmes).
- Should NOT be used therapeutically for patients with isolated lower back pain.

2. Radiofrequency denervation should be offered for patients with isolated lower back pain who meet all of the following criteria:

- the main source of pain is thought to come from structures supplied by the medial branch nerve; and
- they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent); and
- after a positive response (defined as an improvement of 50% in the first 6 hours, ideally should be through diary exercises) to a diagnostic medial branch block with 1 ml or less of local anaesthetic at each level (No steroids).

3. Diagnostic sacroiliac joint injections (local anaesthetic only) should be used in patients whose pain is believed to arise from this joint

4. For people with isolated low back pain the following injections **should not be** offered:

- Intra-articular facet joint injections
- Intradiscal therapy
- Platelet rich plasma
- Stem cell therapy
- Prolotherapy
- Trigger point injections with any agent, including botulinum toxin
- Epidural steroid injections for isolated back pain or for neurogenic claudication in patients with central spinal canal stenosis
- Any other spinal injections not specifically covered above

5. Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Alternative options are

suggested in line with the National Back Pain Pathway.

The scope of the guidance does **NOT** cover the following:
Epidurals/nerve root blocks (local anaesthetic and steroid) which should be considered in patients who have acute and severe lumbar radiculopathy. Please see following link to DDICB Position Statement https://www.derbyshiremedicinesmanagement.nhs.uk/assets/Clinical-Policies/Clinical_Policies/PLCV/ortho/Epidurals_for_all_forms_of_Sciatica.pdf

4. Rationale for Recommendation

Isolated back pain is common, often multifactorial and amenable to multimodal non-operative treatment (e.g. lifestyle modifications, weight loss, analgesia, exercise). Imaging (e.g. plain film radiographs, MRI) in the absence of focal neurology (e.g. sciatica) or 'red flags' may identify incidental, if not trivial, findings of age-related changes which can unnecessarily create a health anxiety for some patients, where simple reassurance would otherwise usually suffice.

Combined psychological and physical programmes (CPPP) involve multidisciplinary teams with intensive physical and psychological elements, using cognitive behavioural principles throughout the programmes. The effectiveness of these programmes is supported by NICE CG59. It is recommended that patients with isolated lower back pain are offered CPPP as part of their rehabilitation package.

NICE guidelines recommend that spinal injections should not be offered for the treatment of isolated lower back pain. Diagnostic spinal injections, specifically medial branch blocks do have a role as part of the diagnostic pathway for patients who may be suitable for facet joint denervation therapy.

Radiofrequency denervation is a minimally invasive and percutaneous procedure performed under local anaesthesia or light intravenous sedation. Radiofrequency energy is delivered along an insulated needle in contact with the target nerves. This focused electrical energy heats and denatures the nerve. NICE supports denervation therapy for patients who meet the treatment criteria stated above.

5. Personalised Care

Personalised care simply means that people have more control and choice when it comes to the way their care is planned and delivered, considering their individual needs, preferences and circumstances. It includes supporting shared decision making and self-management.
Shared decision-making means people are supported to:

- *understand the care, treatment and support options available and the risks, benefits and consequences of those options*
- *decide on a preferred course of action, based on evidence based, good quality information and their personal preferences.*

Supported self-management means increasing the knowledge, skills and confidence a person has in managing their own health and care. This involves using self-management education, peer support, and health coaching.
Decision support tools, also called patient decision aids support shared decision making by making treatment, care and support options explicit. They provide evidence-based information about the associated benefits/harms and help patients to consider what matters most to them in relation to the possible outcomes, including doing nothing.

6. Useful Resources

- NHS Website: Back pain. https://www.nhs.uk/conditions/back-pain/
- BRAN leaflet – Shared decision making supports individuals to make the right decision for them. This easy-to-use leaflet supports this people to consider their treatment options

7. References

- NICE Guidance NG59. Low back pain and sciatica in over 16s: assessment and management. https://www.nice.org.uk/guidance/ng59
- Academy of Medical Royal Colleges. Injections for Non-specific Low Back Pain without Sciatica https://ebi.aomrc.org.uk/interventions/injections-for-nonspecific-low-back-pain-without-sciatica-2/
- UK Spine Societies Board: Improving Spinal Care Project https://www.ukssb.com/improving-spinal-care-project
- Benyamin RM, Manchikanti L, Parr AT, Diwan S, Singh V, Falco FJ, et al. The effectiveness of lumbar interlaminar epidural injections in managing chronic low back and lower extremity pain. Pain Physician. 2012 Jul- Aug;15(4):E363-404.
- Choi HJ, Hahn S, Kim CH, Jang BH, Park S, Lee SM, et al. Epidural steroid injection therapy for low back pain: a meta-analysis. Int J Technol Assess Health 2013 Jul;29(3):244-53.
- Cohen SP, Bicket MC, Jamison D, Wilkinson I, Rathmell JP. Epidural steroids: a comprehensive, evidence-based review. Reg Anesth Pain Med. 2013 May-Jun;38(3):175-200.
- Faculty of Pain Management (2015) Core Standards in Pain Management Services in the UK.
- National Back Pain and Radicular Pain Pathway 1. (2017). https://www.nationalspinenetwork.co.uk/National-Back-Pain-and-Radicular-Pain-Pathway
- Establishing an Optimal 'Cutoff' Threshold for Diagnostic Lumbar Facet Blocks. Cohen, S.P., Strassels, S.A., Kurihara, C., Griffith, S.R., Goff, B., Guthmiller, K., Hoang, H.T., Morlando, B. and Nguyen, C. (2013). The Clinical Journal of Pain, 29(5), pp.382–391

8. Appendices

Appendix 1 - Consultation

All relevant providers/stakeholders will be consulted via a named link consultant/specialist. Views expressed should be representative of the provider/stakeholder organisation. CPAG will consider all views to inform a consensus decision, noting that sometimes individual views and opinions will differ.

Consultee	**Date**
Consultant Orthopaedic Surgeon, UHDBFT	November 2024
Consultant Orthopaedic Surgeon, CRHFT	November 2024
Consultant Anaesthetist, CRHFT	November 2024
Clinical Lead MSK, DCHSFT	November 2024
General Manager (Operations Dept), DCHSFT	November 2024
Physiotherapist (Operations Dept), DCHSFT	November 2024
Clinical Policy Advisory Group (CPAG)	February 2025

Appendix 2 - Document Update

Document Update	**Date Updated**
Version 5.0 Policy has been updated in line with AOMRC EBI September 2024 updated guidance - key changes include: • Inclusion of criteria for Lumbar Radiofrequency facet joint denervation (DDICB currently has a separate policy which will be retired) • Inclusion of Diagnostic sacroiliac Joint injections, platelet rich plasma and stem cell therapy • EBI update specifics that epidural/nerve root blocks are out of scope - includes link to DDICB Position Statement • Addition of 'Personalised Care' section • Reference to BRAN leaflet added to 'Useful Resources' section	February 2025