

Low back pain

The *Lancet* Low Back Pain Series Working Group (June 9, p 2384)¹ is to be commended for its call for action on low back pain. Unmet needs in health care, public health, and clinical research must be highlighted. However, the implication that patients with a common symptom of low back pain can adequately be lumped together under a homogeneous biopsychosocial umbrella conflicts with the WHO International Classification of Functioning, Disability and Health, which focuses on body function and structure, in addition to activity, participation, and personal and environmental factors.

Non-specific low back pain as a diagnosis assumes that because a nociceptive source of symptoms is not readily identifiable, such a source in fact does not exist. Rather, this interpretation reflects the limitations of how popular diagnostic investigations, clinical tests, and imaging are used, all of which lack specificity when considered in isolation.² We disagree that these limitations should result in purposeful disregard for potential pathoanatomical causes of low back pain.

We agree that unvalidated syndromes can be deleterious. However, our group and others³⁻⁵ think that efforts in accurate and specific diagnosis of low back pain are important in advancing research and understanding regarding what is currently considered non-specific low back pain. This is not in conflict with phenotyping biopsychosocial factors, for which an approach based on positive health might be effective. Advances in pathoanatomical understanding are vital to address the causes of non-specific low back pain. Both approaches are required and should be done in parallel. Only in that way can the burden of low back pain be addressed adequately, without disregard for patients whose pain is pathoanatomical or for those for whom biopsychosocial factors play a part.

We declare no competing interests.

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- 1 Buchbinder R, van Tulder M, Oberg B, et al. Low back pain: a call for action. *Lancet* 2018; **391**: 2384-88.
- 2 Maher C, Underwood M, Buchbinder R. Non-specific low back pain. *Lancet* 2017; **389**: 736-47.
- 3 Nguyen C, Boutron I, Baron G, et al. Intradiscal glucocorticoid injection for patients with chronic low back pain associated with active discopathy: a randomized trial. *Ann Intern Med* 2017; **166**: 547-56.
- 4 National Institute of Arthritis and Musculoskeletal and Skin Diseases. Roundtable on the Role of Disc Degeneration in Neck and Back Pain. Oct 27, 2014. <https://www.niams.nih.gov/about/meetings-events/roundtables/roundtable-role-disc-degeneration-neck-and-back-pain> (accessed Sept 27, 2018).
- 5 Kennedy DJ, Schneider BJ. The challenges of research on interventions for low back pain. *Ann Intern Med* 2017; **166**: 601-2.

We are not convinced that the proposals made by the *Lancet* Low Back Pain Series Working Group,¹ which broadly reflect current national guidance,² are rational or supported by sufficient evidence. Pain is a symptom, not a diagnosis. Without a diagnosis there is little rationale for intervention. Only with a meaningful diagnosis can there be discussion of the risks and benefits of potential interventions. Interventions not based on diagnosis risk being dishonest.

People with problems such as irritable bowel syndrome, fibromyalgia, and atypical chest pain might have more in common than they have differences, and their symptoms might thus be manifestations of a common

underlying problem. People with back pain without structural explanation might well be similar to this group.³ This functional back pain might be the most common form of back pain, but our view is that a diagnosis should be made before any intervention is recommended.

People seeking help for back pain are a diverse group; their pain is a final common pathway of multiple pathologies. Investigation underpins diagnosis, which underpins treatment strategies, prognostication, and research efforts. As Hippocrates recognised, without a diagnosis, treatment is irrational. Only by understanding and diagnosing the specific cause of an individual's back pain, whether this be structural or functional, will we begin to address this major health issue.

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- 1 Buchbinder R, van Tulder M, Oberg B, et al. Low back pain: a call for action. *Lancet* 2018; **391**: 2384-88.
- 2 NICE. Low back pain and sciatica in over 16s: assessment and management. November, 2016. <https://www.nice.org.uk/guidance/ng59> (accessed Oct 7, 2018).
- 3 Wessely S, Nimnuan C, Sharpe M. Functional somatic syndromes: one or many? *Lancet* 1999; **354**: 936-39.

The *Lancet* Series papers on low back pain (June 9, p 2356)^{1,2} provide a comprehensive review of the causes, prevention, and treatment of low back pain. One possible cause of low back pain often missed by physicians is abdominal aortic aneurysm rupture (or impending rupture).³⁻⁵ Ruptured abdominal aortic aneurysms are associated with mortality rates as high as 80% and are often misdiagnosed because of non-specific presenting symptoms, including shock, syncope, low back pain, and nausea or vomiting.³ A systematic review



For more on the *Lancet* low back pain Series see <https://www.thelancet.com/series/low-back-pain>

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