# Back problems in general practice

Treating back problems is generally regarded as a cumbersome, uphill task; and the question arises whether post-graduate courses and protocolling might perhaps offer a solution. But after reading this issue of *Huisarts & Praktijk* – which consists entirely of contributions from general practice – this seems rather an oversimplification.

As could be expected, the study of care provided by general practitioners confronted with back symptoms discloses a considerable degree of variation, although there are no very pronounced differences in the approach to low back pain, the most frequent diagnosis in the group presented here.

It becomes quite evident that our knowledge and understanding of the natural history of back problems and the effects of various therapies are seriously deficient. As a result, it is by no means a sinecure to formulate guidelines, working agreements or protocols for general practice. It therefore seems a foregone conclusion that the problem is caused not so much by insufficiencies in general practice as by deficient medical knowledge. Further research is therefore urgently required.

The natural history and treatment of low back symptoms are discussed in three contributions – by Van Weel, Schellekens et al. and Rutten et al. The localization of back pain proves to be the principal predictor of the prognosis: radiation has a decidedly unfavourable prognosis. Treatment of back pain with radiation is more intensive in terms of more referrals to medical specialists and more radiology. Follow-up consultations by the general practitioner, and the physiotherapist is more often or more quickly involved.

However important the difference between radiating and non-radiating pain may be, it hardly influences the physical examination made by the general practitioner (apart from the Lasègue test); and this fact has its implications in protocolling general practice procedures. In addition, the general practitioner's care proves to be more homogeneous for non-radiating than for radiating back pain.

The question arises whether radiating and non-radiating back pain are different clinical entities. Individual patients are known sometimes to show transition from one type of pain to the other.[1] A longitudinal analysis of the various diagnoses yields few indications in support of the notion that lumbago, sciatica and lumbar disc disease are simply different manifestations of the same syndrome. A small subgroup of patients have recurrent problems, and another small subgroup rapidly pass through the various phases of radiating/non-radiating pain. In most patients, however, back pain is a problem which disappears relatively quickly, with few recurrences and requiring few follow-up encounters.

This does not necessarily mean that the patient is always rid of his complaints, as demonstrated in a study by Rutten et al. which is interesting also in that it combines the results of a inquiry among patients with data provided by the general practitioners: 22 per cent of the patients who sought no follow-up encounter with the family doctor, were still having symptoms when questioned later. All the more reason to consider the question why patients with back problems do seek medical advice (De Geus and Van der Horst). For more general conclusions about this question, a reliable measuring instrument is required. And this brings us to the exchange of information between general practitioner and patient.

Regardless of all medical „technology", the general practitioner confronted with back pain will have to rely above all on the history, i.e. on asking questions. This is apparent also in the protocols so far developed. In this respect the patient's perception of his back can provide a valuable clue to the nature of the problem. Oosterhuis gives a fascinating analysis of the terminology used by patients in presenting their complaints.

Even though there may be unmistakable gaps in our knowledge and understanding, the general practitioner must take action when confronted with back problems; and he must base himself on existing opinions, views and uncertainties.

In this situation two articles in this issue offer the general practitioner information: Crul concerns himself with back problems and work, while Hoekstra discusses asymptomatic abnormalities of the back. General practitioners prove to be well-informed about work and working conditions, and the latter are frequently discussed explicitly when patients present with back problems. Lack of exercise is probably just as important as „overstrain". If one considers the question whether abnormal findings which do not (yet) cause complaints require intervention, one enters the field of prevention. With special reference to back problems this places increased emphasis on the importance of understanding the natural history and the effects of treatment. However, a true understanding of the significance of most problems is lacking, and there is virtually no quantitative information. In view of these facts the principles of screening, prevention and anticipatory medicine cannot be applied here.

An additional problem is that many data originate from specialized clinical literature and therefore cannot be immediately applied to patients in general practice.[2] An example par excellence is juvenile idiopathic scoliosis. Interest in this anomaly has recently revived, and more and more pleas are made for screening in this respect. However, a recent revision of the available information leads to the conclusion that screening for scoliosis is useless because requirements for screening – as formulated by Wilson and Jungner – are not met.[3] However carefully and prudently one formulates ideas, at this time there is little to warrant any attitude other than the greatest reservation of the part of the general practitioner in these cases.

There are finally three articles on protocols, working agreements and guidelines. Mesker-Niesten et al.

describe their procedure of protocolling the general practitioners' care for back pain. Kerkhof reports on working agreements about diagnostic radiology of the lumbar spine, and Crebolder discusses the experiences of a group of general practitioners trying to make agreements with physiotherapists about the treatment of low back pain.
The pros and cons of protocols have been a subject of much discussion. An important question concerns the consequences for the patient of deviations from the protocol; another important question is whether the protocol does sufficient justice to specific general practice aspects like family medicine and course-of-life medicine.
A very interesting aspect is that of internal consistency: as measured by the criteria of the protocol, general practitioners who work rather superficially and randomly in the phase of problem clarification, continue to do so in the subsequent phases of consultation. A more general characteristic of this general practitioner's approach is thus outlined. Given the repeatedly mentioned deficient understanding of the natural history and the significance of intervention, it is not surprising that in the present situation only relative importance can be attached to guidelines, protocols, etc.
Parallel with this we find that interpretation of working agreements poses problems and we see considerable variation, for instance, in requests for radiological examination. The same applies to physiotherapy: general practitioners request physiotherapy at widely diverse moments and on widely diverse grounds; and physiotherapists subsequently give widely diverse treatments. That longstanding, intensive cooperation can bear fruit in the long run, however, is apparent from the fact that the use of physiotherapeutic facilities by a number of general practitioners working in close cooperation with physiotherapists, shows hardly any diversity (Van Weel).
An interesting question of course concerns the consequences which makers of protocols will infer from these observations.
The main objective of this issue is to present practical information and transmit new scientific facts in order to support the general practitioner in his efforts to provide proper care for his patients with back problems. One of the – perhaps surprising but certainly important – conclusions may be that general practice procedures in connection with back problems are far less incoherent than they have been assumed to be; and that precisely in the confrontation with actual practice important impulses can be found for further development of general practice care.

Finally, attention may be asked for an experiment. Although *Huisarts en Wetenschap* has long been publishing English summaries of articles which might be important also to non-Dutch readers, the editorial board is aware of the limitations of such summaries. This is why in this issue of *Huisarts & Praktijk* the five articles that present detailed quantitative information are provided with a more extensive type of summary: a *synopsis*. The synopsis follows the article more closely, albeit with special emphasis on the results of the study. In this connection some of the tables and figures in the original articles are likewise presented in English.

Dr. C. van Weel

[1] Hodgkin K. Towards earlier diagnosis in primary care. Edinburgh, etc.: Churchill Livingstone, 1978.
[2] Velden HGM van der. Diagnose of prognose. Huisarts en Wetenschap 1983; 26: 125-8.
[3] Leaver JM, Alvik A, Warren MD. Prescriptive screening for adolescent idiopathic scoliosis. Int J Epidemiol 1982; 11: 101-1.

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