

Kent and Medway Policy Recommendation and Guidance Committee
Policy Recommendation

Policy:	PR 2017-14: Spinal injections for low back pain in over 16s
Issue date:	September 2017
Review date:	September 2020
<p>The Kent and Medway Policy Recommendation and Guidance Committee (PRGC) considered national guidance, evidence of clinical- and cost-effectiveness, the baseline position, other CCG policies and the views of stakeholders. All decisions were made with reference to the Ethical Framework. Taking these into account, the PRGC recommends that:</p> <ul style="list-style-type: none"> • Therapeutic spinal injections (including facet joint injections, medial branch blocks, intradiscal therapy, prolotherapy and trigger point injections) for low back pain¹ are not routinely commissioned. • Medial branch block injections are only commissioned when used as a diagnostic tool to establish whether the patient is likely to respond to radiofrequency denervation². <p>See overleaf for background information and supporting rationale.</p> <p>This policy recommendation will be reviewed in light of new evidence or guidance from NICE.</p> <p>Clinical Commissioning Groups in Kent and Medway will always consider appropriate individual funding requests (IFRs) through their IFR process.</p>	

Supporting documents

NEL CSU HciAG (2017) *Spinal injections and radiofrequency denervation for low back pain – Scoping report*

Equality Analysis Screening Tool – Spinal injections for low back pain (2017)

¹ This policy applies to low back pain as defined in NICE guideline (NG) 59 as the following: discogenic pain, degenerative disc disease, lumbar disc herniation, secondary to lumbar degenerative disease, facet joint pain. This policy does not apply to people who have low back pain related to conditions of a non-mechanical nature, including inflammatory causes of low back pain (e.g. ankylosing spondylitis or diseases of the viscera), serious spinal pathology (e.g. neoplasms, infections or osteoporotic collapse), neurological disorders (including cauda equina syndrome or mononeuritis) and adolescent scoliosis. The policy also does not apply to pregnancy-related back pain, sacroiliac joint dysfunction, adjacent-segment disease, failed back surgery syndrome, spondylolisthesis or osteoarthritis. Studies were excluded from consideration in NG59 if osteoarthritis was an inclusion criteria or primary focus of the trial, as NICE guidance on the treatment of osteoarthritis already exists (i.e. CG177).

² See PR2017-15 for policy recommendation on radiofrequency denervation for low back pain.

Key points and rationale

What is low back pain?

Worldwide, low back pain causes more disability than any other condition. Serious causes of low back pain are rare. Episodes of back pain usually do not last long, with rapid improvements in pain and disability seen within a few weeks to a few months. Although most back pain episodes get better with initial primary care management, without the need for investigations or referral to specialist services, up to one-third of people say they have persistent back pain of at least moderate intensity a year after an acute episode needing care, and episodes of back pain often recur. When a back pain episode becomes a long-term, persistent pain condition, quality of life is often very low and healthcare resource use high.

How is low back pain managed?

Managing low back pain follows a stepped approach: (1) initial assessment – identify specific aetiologies, any sinister pathology and other red flag symptoms; (2) management – (once specific pathologies have been excluded) a combination of advice on self-management, exercise programmes, manual therapies, psychological therapy and pharmacological interventions; (3) if pain persists – combined physical and psychological programmes and invasive procedures such as spinal injections and surgery may be offered.

What are spinal injections?

These are injected agents which aim to either reduce inflammation in tissues (e.g. steroid injections), induce inflammation to stimulate healthy tissue regrowth (e.g. prolotherapy) or reduce firing of nerve fibres that may be contributing to pain (e.g. local anaesthetic). However, medial branch block injections can be used as a diagnostic tool to establish whether the person is likely to respond to radiofrequency denervation.

What does national guidance say?

According to NICE guideline (NG) [59](#) (2016) and NICE quality standard (QS) [155](#) (2017) on low back pain and sciatica, spinal injections should not be offered for treating low back pain, with the exception of medial branch block injections when used as a diagnostic tool to establish whether the person is likely to respond to radiofrequency denervation.

The [full version](#) of NG59 sets out the guideline development group's (GDG) rationale for each recommendation and additional considerations:

- Overall the GDG agreed that there was no consistent good quality evidence to recommend the use of spinal injections for the management of low back pain. There was minimal evidence of benefit from injections, and reason to believe that there was a risk of harm, even if rare.
- The GDG noted that image guided facet joint injections of steroid are widely used but there is a paucity of evidence to support their ongoing use.
- The GDG also agreed that patients who experienced prolonged pain relief from medial branch blocks (i.e. an analgesic effect outlasting the expected duration of local anaesthesia) should be offered radiofrequency denervation rather than repeated medial branch blocks when seeking further treatment.

The NHS England national low back and radicular pain [pathway](#) (2017) also recommends decommissioning therapeutic injections for back pain including facet joint injections.

No new evidence on spinal injections for low back pain was identified that was considered likely to change recommendations in NG59.

What is the rationale for PR2017-14?

This recommendation is consistent with recommendations in NG59, QS155, and the NHS England national low back and radicular pain pathway. The PRGC noted the concerns of local specialists regarding decommissioning therapeutic spinal injections and acknowledged that management of persistent low back pain is a complex issue, but concluded that NICE recommendations on therapeutic spinal injections were clear, and not implementing them would be difficult to rationalise. The PRGC would encourage CCGs to consider the PRGC recommendations on spinal injections in the context of the entire treatment pathway for low back pain, especially with respect to the provision of non-invasive treatments recommended in NICE NG59; consideration of the NHS England national low back and radicular pain pathway which supports implementation of recommendations in NG59 may be helpful in this respect.

Change sheet

Reason for review:

CCGs are responsible for commissioning spinal injections. There is currently no formal Kent and Medway wide commissioning policy on spinal injections for low back pain. Kent and Medway CCGs have indicated that they would like to agree a single commissioning policy for these interventions to ensure equity of access across the region.

Changes to baseline position:

There is currently no Kent and Medway wide commissioning policy on injections for back pain, although therapeutic spinal injections are performed at acute local trusts. East Kent CCGs³ have a policy in place on therapeutic spinal injections; this policy predates publication of current NICE guidelines. According to the East Kent CCGs' policy, therapeutic spinal injections are routinely funded provided specific criteria are met (see accompanying report for details). PR2017-14 recommends decommissioning therapeutic spinal injections for low back pain (as defined in the policy recommendation).

Rationale for PR2017-14:

This recommendation is consistent with recommendations in NICE NG59 (2016), NICE QS155 (2017), and the NHS England national low back and radicular pain pathway (2017).

Estimated impact of implementing PR2017-14:

Decommissioning therapeutic spinal injections for low back pain (as defined in the policy recommendation) is likely to lead to significant reductions in activity and associated expenditure⁴. However, it is not possible to quantify the impact accurately for the following reasons:

- Activity and expenditure data on spinal injections does not distinguish between therapeutic and diagnostic spinal injections (only diagnostic medial branch blocks are recommended by the PRGC). In addition, it is not possible to reliably exclude activity data on spinal injections for conditions not covered by this policy recommendation.
- Some local specialists indicated that greater investment in non-invasive treatments recommended in NICE NG59 should be considered, especially if spinal injections are decommissioned. It is not possible to quantify these potential offset costs. Local specialists felt not funding therapeutic spinal injections may deny some patients a potentially useful treatment and may lead to offset demand and costs elsewhere in the NHS. Some specialists also felt not commissioning therapeutic spinal injections would adversely affect theatre capacity and throughput due to increased provision of radiofrequency denervation.

³ Ashford CCG, Canterbury and Coastal CCG, South Kent Coast CCG and Thanet CCG.

⁴ An estimated ~3,000 spinal injections were undertaken on Kent and Medway patients in 2016/17 at an estimated cost of £1.9 million to CCGs. See accompanying report for more information.