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# PAIN IN THE LOWER BACK: A DIFFERENTIATED THERAPY

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**ABSTRACT:**

**Pain in the lower back is one of the most frequent reasons for patients to see a doctor. 30-60% of the population in developed countries suffers from recurrent back pain, and up to 80% of all back pain occurs in the lumbar region of the back. All age groups can suffer from lumbar pain, but the peak incidence occurs at the age of 30 to 60 years. This is largely due to the aging processes of inter vertebral discs (macroscopic changes in the fibrous ring and the pulpous nucleus). However, the degenerative process in the spine itself can only be considered a prerequisite for pain in the lower back, but not the direct cause. Sources of pain impulses in vertebral pain can be not only altered inter vertebral discs, but also spinal ligaments, periosteal joint tissue and periarticular tissue, spasmodic muscles surrounding the affected vertebral motor segment.**

**KEYWORDS: nervous system, radicular, musculoskeletal system, chronic back pain.**

## INTRODUCTION:

Unfortunately, a simplified understanding of the problem of spinal osteochondrosis prevents attempts to find out the true causes of back pain and develop differentiated approaches to its treatment. Features of pain syndrome Neurological manifestations of spinal osteochondrosis account for up to 70% of all diseases of the peripheral nervous system mainly during active work. However, it should be noted that there is no correlation between the severity of radiological data and the clinical picture of the disease. Thus, according to the literature, up to 50% of patients with changes in the spine expressed on radiographs do not experience back pain ever. Lower back pain can be acute (up to 3 weeks), subacute (3-12 weeks), and chronic (more than 12 weeks or more than 25 episodes per year). Clinically there are 4 types of back pain: local, projection, radicular (root) and pain due to muscle spasm. According to the mechanism of occurrence, pain is distinguished: * nociceptive - local, reflected (projection, reflex); * neuropathic-root (radiculopathy), non-root (sciatic nerve neuropathy, lumbosacral plexopathy); • psychogenic (psychyalgia). Local pain is usually permanent, diffuse with localization in the area of the spine lesion. The nature of the pain varies depending on the position of the body. Projection pain is common, from the spine to the lumbar and sacral regions. They are more diffuse in nature, there is a tendency to surface their spread, but in intensity and character they are close to local.

**MAIN PART:**

Radicular, or root, pain usually has a shooting character. They can be dull and aching, but movements that increase the irritation of the roots significantly intensify the pain, it becomes sharp, cutting. Bending forward or lifting straight legs, compression of the jugular veins, as well as other provoking factors (coughing, sneezing, straining), which lead to increased intravertebral pressure and displacement of the roots, increase the radicular pain as a result of their stretching. Myofascial syndrome currently, in the Genesis of pain in the lower back, great importance is attached to myofascial pain syndrome, which is manifested not only by spasm, but also by the presence of painful seals in tense muscles (areas of hypertonus) and trigeminal points (myofascial trigger points). Most often, it is not associated with osteochondrosis of the spine, and occurs independently of it. Despite the fact that the clinic of myofascial pain syndrome has been described by many authors, there is still no complete histological, biochemical or electrophysiological explanation of the nature of trigger points. The literature suggests that the formation of these points is caused by secondary hyperalgesia against the background of Central sensitization. In the Genesis of trigger points, damage to peripheral nerve trunks is not excluded, since there is an anatomical correspondence between myofascial trigger points and peripheral nerve trunks. The pain that occurs with muscle spasm is clinically close to local, but anatomical and physiological differences allow us to distinguish it. Chronic muscle tension can cause dull and sometimes spastic pain.

BP cannot be considered only from the point of view of anatomical and functional injuries of the musculoskeletal system. In the process of chronicling BP, psychosocial factors and the presence of maladaptive behavioral strategies in patients often come out in the first place. Various concepts of the causes and pathogenesis of BP were put forward. Currently, based on the data of numerous studies, it can be argued that there is no direct relationship between changes, including in intervertebral discs, detected by magnetic resonance imaging (MRI), and the development of BP. In MRI, changes are detected in patients not only without acute back pain, but also without a history of pain. In addition, the development of anatomical changes in the spine does not coincide with the occurrence of BP and is not a predictor of the effectiveness of therapy. The role of various physical causes in the development of BP has been discussed for a long time. Despite the apparent indisputable influence of static loads, awkward posture, lifting weights and twisting on the development of BP, analysis of data from 8 systematic reviews showed that such a relationship is unlikely. A population-based study conducted by Dutch clinicians found a U-shaped relationship between exercise and BP. People who lead a sedentary, sedentary lifestyle and patients with regular physical activity had an equally high risk of developing BP.

Medical gymnastics/ Acute 1A 1A
Fitness programs Chronic 1A 1A
Prevention 1A 1A
Interactive educational Acute 1E 1E
Programs for patients Chronic 1E 1E
Prevention 2 1A
Saving daily Sharp 1A 1A
Activity in acute BP

Note. Levels of evidence-based effectiveness: 1A-confirmed by RCI meta-analyses; 1E-insufficient evidence to form certain conclusions

Often, patients with BP experience fear and anxiety, believing that the pain syndrome is caused by life-threatening diseases.

Accordingly, one of the most important components of successful therapy is to explain to patients the causes of pain and its benign nature, as well as the importance of maintaining daily activity during the pain syndrome. Determination of the terms of disability should be carried out individually, depending not only on the severity of the pain syndrome, but also on the nature of the patient's work. For example, office employees can monitor their position during work, take breaks for warm-up or gymnastics, and thus return to work as soon as possible. At the same time, patients who are engaged in physical work, often accompanied by uncomfortable poses, need more time to recover.

Currently, there are several ways to solve the problem of NSAIDs-associated gastropathies. However, the actual anti-inflammatory and analgesic effect in this case can be significantly reduced. Secondly, the use of combinations of NSAIDs with gastroprotection, such as proton pumps inhibitors. Certain prospects for solving the problem of gastropathies are associated with the use of combined drugs that are both COX inhibitors and nitric oxide (NO) donators. This group of drugs is called NO-NSAIDs (COX-inhibiting nitric oxide donors — CINODs). Experimental studies have shown that a moderate increase in the concentration of NO in the gastric mucosa can have a protective anti-carcinogenic effect. It is assumed that simultaneous activation of the NO-releasing part with the active metabolite of NSAIDs can significantly reduce the gastro toxicity of this class of compounds. Another class of compounds are so-called NO-associated NSAIDs, which "do not carry" the no molecule, but their action is based on starting the production of endogenous NO. As a rule, NO production occurs due to stimulation of capsaicin receptors of the gastric mucosa, which is possible if the NSAID molecule contains a vanillin group.

The results of practical experience and RCT data show high efficiency and safety of tizanidine (Sirdalud ® ), a Central — acting muscle relaxant, used in BNS. Tizanidine has both myorelaxing and Central analgesic effects. Tizanidine also has gastroprotective properties, which are due to its adrenergic and spasmolytic activity. When taking the drug, basal and induced acid secretion in the stomach decreases, and the balance of glycoproteins in the gastric mucosa and gastric secretions is restored. The gastroprotective activity of tizanidine has been proven in clinical studies. In patients receiving a combination of ibuprofen and tizanidine, the frequency of gastrointestinal side effects, including bleeding, was significantly lower ($p=0.002$) than in patients receiving a combination of IBU-profen and placebo.

At present, sufficient experience has been accumulated to demonstrate the high effectiveness of manual therapy for non-specific BP. Analysis of data from a systematic review indicates similar effectiveness of manual therapy and conventional pharmacotherapy in acute and chronic BP. Using a combination of different manual therapy techniques improves the short-term prognosis for acute BP, but does not affect the long-term prognosis. Rational combined use of medication and manual therapy can significantly increase the effectiveness of treatment; reduce the duration of medication and, consequently, the risk of developing HP. In the classic approach, it is recommended to conduct manual therapy sessions twice a week for 2-3 weeks. In accordance with current recommendations, short-term courses of manual therapy are used.

**CONCLUSION:**

Data on the effectiveness of massage, acupuncture, and physical therapy in acute non-specific BP are few and contradictory. Most studies have shown a moderate positive effect on chronic back pain. The available evidence base will not allow us to recommend massage and acupuncture for non-specific BP.

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