

QUICK REFERENCE TRIAGE ALGORITHM
Patterns of Low Back Pain

DESCRIPTIVE SYMPTOMS	FINDINGS ON OBJECTIVE ASSESSMENT
Pattern 1: Back dominant pain aggravated by flexion	
<ul style="list-style-type: none"> • Low back dominant pain: felt most intensely in the back, buttock, over the trochanter or in the groin • Pain is always intensified by forward bending or sustained flexion • Pain may be constant or intermittent • No relevant neurological symptoms 	<p>This pattern is divided into two groups:</p> <ul style="list-style-type: none"> • Fast Responders: Increased pain on flexion and relief with lumbar extension • Slow Responders: Increased pain on flexion and on extension <p>The neurological examination is normal or non-contributory</p>
Pattern 2: Back dominant pain aggravated only by extension	
<ul style="list-style-type: none"> • Low back dominant pain; felt most intensely in the back, buttock, over the trochanter or in the groin • Pain is NEVER intensified with flexion • Pain is <i><u>always intermittent</u></i> • No relevant neurological symptoms 	<p>The neurological examination is normal or non-contributory</p>
Pattern 3: Constant leg dominant pain	
<ul style="list-style-type: none"> • Leg dominant pain: felt most intensely below the gluteal fold above or below the knee • Pain is <i><u>always constant</u></i> • Neurological symptoms <i><u>must</u></i> be present 	<p><u><i>Never give exercises to a Pattern 3</i></u></p> <p>Neurological examination must be positive for either an irritative test or a newly acquired focal conduction deficit.</p>
Pattern 4: Intermittent leg dominant pain aggravated by activity	
<ul style="list-style-type: none"> • Leg dominant pain: felt most intensely below the gluteal fold above or below the knee • Pain is brought on by activity and relieved by rest in flexion • Pain is <i><u>always intermittent</u></i> • Neurological symptoms are usually absent at rest • Generally found in patients over 50 – often associated with degenerative changes in the spine 	<p>Neurological examination at rest is normal or identifies an established focal conduction defect.</p> <ul style="list-style-type: none"> • negative irritative test • possible conduction loss • straight leg raise is negative • pheasant test (test pre/post dorsi flexion with resistance)
<p>Please see corresponding Treatment Algorithm (Patterns 1-5) for treatment schedules</p>	

Follow-up questions:

1. Ask the patient – Did it work?
2. Location of Pain
3. Intensity of Pain
4. Frequency of Pain periods
5. Effect of the recommended treatment