CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

PATIENT INFORMATION

Low back pain

What you're feeling

Low back pain means pain between your lower ribs and your buttock crease. It can stay in your back or spread down your leg. If it has lasted more than 3 months, it is called chronic. If it started recently and has lasted less than 6 weeks, it is called acute.

Most back pain is mechanical, which means it comes from the way your back moves and carries load rather than from a damaged nerve. You might notice it most when you bend, lift, or sit for a long time. It often flares after activity, or when you first get out of bed in the morning. Some people find it disturbs their sleep, and the more often the pain comes, the more it can affect rest.

The pain can make everyday tasks harder. Getting out of a chair, putting on shoes and socks, carrying shopping, or standing at the bench cooking a meal can all become difficult. Work, especially jobs involving lifting or long periods of sitting, may feel like a struggle.

A few things are worth knowing. If you have had back pain before, you are more likely to have it again. Pain that is present when you start a shift at work also raises the chance of it continuing. Other health problems can make back pain harder to treat, and low back pain often goes hand in hand with soreness elsewhere, such as the hips or neck.

Most people who see a doctor about back pain are told they have non-specific or mechanical low back pain, meaning no single damaged structure or trapped nerve has been identified. That is a common finding, not a sign that something has been missed. Sometimes pain from the sacroiliac joint, where your spine meets your pelvis, can feel like back pain too.

Your surgeon will look at more than just how much you hurt. How you move, sleep, cope, and manage day to day all matter when planning what helps next.

What's actually happening

Your spine is a stack of bones called vertebrae. There are 33 of them, in five groups: the neck, the chest, the low back, and two fused sections at the base. The sacrum and tailbone are fused solid, which leaves 24 segments that can move. The bones in your low back are the largest, because they carry the most weight.

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Between the moving bones sit cushions called discs. Each disc has a soft, gel-like centre and a tough outer ring of layered fibres, a bit like a tyre with a strong sidewall around a squishy core. The centre holds water and spreads pressure out evenly when you lift or bend. The outer ring keeps it contained. Behind each disc are small joints, and strong muscles and ligaments wrap around the whole column to hold it steady.

The bones carry most of the load, about 70% to 90% of it. The small joints behind take another 10% to 20% when you stand. Your low back has a natural forward curve, and the muscles along your spine work like guy ropes to hold that curve and protect the nerves running through the middle.

With wear and tear, the discs lose water and their cushioning softens. The disc space narrows, the bones sit closer together, and the small joints behind take on more load than they were built for. This wearing process in the low back is common, affecting somewhere between 40% and 85% of people. It is one reason the low back is a common trouble spot: the joints where the spine meets the pelvis carry extra demand, and stiffening there can overload the segments around them.

When these parts stop moving smoothly and sharing load evenly, the tissues around them become sore. That is the ache you feel when you bend, lift, or sit, and it is why the pain tends to flare after activity rather than from one clear injury.

What we can do about it

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, starts with the least invasive options that suit your condition. Patients are generally referred to our clinic by their GP; if a physiotherapist has suggested you see us, you will still need a referral from your GP in order to be eligible for the Medicare rebate. At your first visit we take a history, examine your back, and arrange imaging only where it will change what we do next.

For most back pain, no single damaged structure can be found, so treatment aims to reduce pain and improve function rather than fix one part. We usually start with treatments that do not involve medicine or surgery. Staying active and adjusting how you move and work can settle symptoms. Physiotherapy uses exercise to ease pain and improve how much you can do, and many different types of exercise help, including yoga. Other options we may discuss include hands-on treatment such as osteopathy, acupuncture, and programs that look at how pain affects your sleep, mood, and daily life as well as your body. These programs involve several health professionals working together with you. We give each approach a fair trial before moving on, and we will explain what each one is meant to achieve and what to expect from it.

Pain medicine can help you stay active while the other treatments do their work. It works alongside exercise and activity change, not instead of them. We do not offer injections for this condition.

Surgery is considered when non-operative care has not given enough improvement and there is a clear reason why an operation would help. For back pain without nerve involvement, the role of operations such as spinal fusion or disc replacement is limited, and we approach these decisions carefully with you. Where surgery is an option, we talk through what it involves, what it can and cannot change, and what recovery would look like, so the decision is one you make together with us.

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What to expect

Back pain rarely follows a straight line. Some people settle within weeks. Others have pain that comes and goes, good days and bad days, over a year or more. Full recovery within 6 months is uncommon, so it helps to plan for steady progress rather than a quick fix.

Over the longer term, most things stay much the same or improve slowly. About 4 in 10 people find they can do noticeably more of their normal activities over time. A few people have bothersome pain most days. Many others have weeks with no pain at all. There is no single pattern, and your course will be your own.

What tends to shape that course is not what shows on a scan. Changes seen on imaging do not predict who does well and who does not. What matters more is how you feel about your back and how much the pain stops you doing things. Worrying that movement will cause damage, or feeling low or stressed, is linked with more difficulty day to day. Having had back pain before also makes a new episode more likely, as we noted earlier.

Left alone, back pain can drag on and limit what you do. Managed well, the picture is usually brighter. Staying active, keeping fear of movement in check, and doing an exercise program suited to you all help. People who join a structured program tend to stick with it, attending nearly every session over about 10 weeks. That consistency is part of what makes exercise work.

It is also worth knowing what back pain does not do. Ongoing back pain does not directly cause depression or anxiety, though the two can occur together. And few people end up off work long term or on a disability pension because of their back.

The honest summary: your back may grumble for months, but with the right plan most people keep working, keep moving, and keep doing the things that matter to them.

When to see someone

Most back pain settles with time and simple care, and you can manage it with your GP's help. See your GP if pain lasts more than 6 weeks without improving, if it disturbs your sleep, or if it stops you working or doing daily tasks. Ask for a specialist review if you have had back pain before and it keeps coming back, or if pain from the sacroiliac joint, where your spine meets your pelvis, is suspected. Go to an emergency department if you have new weakness or numbness in your legs, or loss of control of your bladder or bowels. These signs suggest a nerve problem that needs same-day assessment.

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