The lifetime prevalence of low back pain is 60-80%, little has been known about its pathophysiology clinically, the natural course of LBP is usually benign; Acute LBP often resolves within 1-2 weeks. But in some cases, acute LBP becomes chronic and difficult to treat, with a large socioeconomic impact. One of the spinal structures, including vertebral discs, facet joints, vertebral bodies, ligaments, or muscles, may be the cause of back pain, but unfortunately, it can be difficult to determine the type of disease. In cases where the origin of back pain cannot be determined, the diagnosis is not definite LBP. Nonspecific LBP is defined as LBP not associated with a specific pathology known as infection, inflammation, osteoporosis, fracture, structural deformity, inflammatory disorder, radicular syndrome, or cauda equina syndrome. Severity of LBP is usually assessed by visual analog scale (VAS), numerical rating scale, or disability assessment system such as Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire, etc. However, the use of this established grading system does not fully assess the characteristics of LBP. Previous studies have suggested that LBP can vary in different situations. The main purpose of this study is to evaluate the effect of anti-inflammatory drugs in the management of LBP.

Back pain can be aching or sharp and stabbing. The pain can be mild or severe, and can feel like a pounding or burning sensation. You may feel stiff, and it may be difficult to stand up straight or move your lower back. Also back pain can make your daily activities difficult.

Non-invasive treatments for lower back pain

Muscle relaxation.

This drug acts as a central nervous system depressant and increases tense muscle movements, relieving pain from muscle spasms or spasms. Muscle relaxants have no role in the treatment of chronic pain.

Narcotic pain medicine.

Drugs known as opioids or painkillers change the way we feel pain by weakening the signals sent to our brain. Narcotics are often used to treat severe, short-term pain, such as acute pain after surgery. Narcotics are rarely used to treat chronic pain because they have many side effects and can be easily addictive.

Some Alternate methods

Non-medical treatments can be called alternative or complementary treatments. The term “alternative” should not be pejorative, nor should it be traditional according to Western medical standards.

Manual manipulation.

A chiropractor or other healthcare practitioner makes physical adjustments to the spine to improve motion and reduce stiffness, discomfort, or pain. Manual treadmills of varying speeds and strength are used to adjust the structure of the spine. In some people, manual manipulation is used to relieve lower back pain.

Acupuncture.

Based on ancient Chinese medicine, acupuncture stimulates points that are thought to restore the body’s “chi,” or life force. Proper Qi is believed to reduce pain and discomfort in the body. During the session, fine needles are inserted into the skin for about an hour.

Massage therapy.

Massage therapy can relieve muscle spasms that help lower back pain. Massage also improves blood circulation in the lower back, bringing nutrients and oxygen to damaged muscles and speeding up healing.

Smart mind.

Meditation can help reduce the sensation of pain and can reduce the depression, anxiety, and sleep problems that often accompany chronic pain. Meditation techniques for pain relief include everything from deep breathing exercises to modified focus approaches.

In the light of some research and studies, how effective this method is?

Various factors are thought to cause LBP. LBP begins in the 3rd decade of life and peaks in middle age. In our series, 52 patients (20.71%) were included in the 3rd and 4th decades. Individual height, weight, and body composition were unrelated to exposure. LBP occurs in 35% of sedentary workers and 45% of heavy workers. Patients in this phase (46%) are

sedentary workers. It can be associated with abnormal posture and poorly developed back muscles. There is no risk for gender, but disc surgery is twice as common in men as women. Risk factors associated with LBP include repetitive weight lifting, use of machine tools, and operation of motor vehicles, vibration, and smoke can be modulated by various psychological effects and include enkephalin, serotonin, etc. Pain mediators like these can alter the production of chemicals, which explain more pain when people are tired or depressed. There is a gene for special pain sensitivity. Found out. Similarly, various obstacles caused by mechanical compression in spinal stenosis cause pain. Investigations such as EMG, Myelography, CT-scan, and MRI are always suspicious. All have been used and have shown disc herniation in 90-98% of symptomatic patients. In normal volunteers without special symptoms, 28-35% showed the same findings. Idiopathic LBP has a favorable natural history and 90% of patients return to work within 6 weeks. In our series, conservative treatment appears to be good, as 172 of 251 LBP patients showed pain relief and no recurrences over a 24-month follow-up period.

A prospective randomized trial demonstrated the efficacy of pain relief and return to work with a few days of bed rest and education in the program again. In his study, Nachemson reported pain relief in chronic LBP patients with less than 3 months of bed rest, pharmacologic manipulation, and general fitness training. Studies of back pain patients in England show that a tiered management approach, including prognostic assessment and a treatment approach targeting the effectiveness of primary care and physiotherapy, leads to greater health gains for low back pain patients. A significant improvement was noted in the control group in the 4- and 12-month follow-up of physical and emotional well-being, pain intensity, and work days and quality of life. A study reported an increased risk of hospitalization for sciatica in men who smoked at a young age. LBP is estimated to affect 84% of the general population at some point in their lives, and 49% report some form of LBP. In the previous 6 months, 23% experienced chronic LBP, and 11% experienced physical disability due to LBP. Various studies show that only 5-10% of adults in Canada and the United States see the disease in any given year. Prognostic criteria for clinically-based LBP are proposed to remain unclear; all patients with LBP are likely to benefit from chiropractic care. A study evaluating pain and sleep found that sleep disorders were about 58.7% among people with low back pain. Sleep disturbance was found to be related to pain intensity, where each point of increase in the 10-point scale was associated with a 10% increase in the likelihood of reporting sleep disturbance. The only evidence of treatment efficacy is a randomized double-blind controlled trial, which is difficult to perform in our setting. When it comes to the management of LBP, it is clear that an ill-judged diagnosis by surgery can lead to abnormal LBPs, leading to inappropriate treatment. A possible limitation of our study is the lack of a control group treated with another method. A total of 12

patients were excluded due to attrition.