



LUMBAFIT

From Back Pain to Recovery

A Physio's Guide

*Stop guessing. Understand what's causing your pain,
learn what actually works, and build a personalized path
towards a healthy back.*



Anas Boukas

Physiotherapist

Important disclaimer

This guide is strictly educational. Its aim is to help you better understand your lower-back pain and discover strategies to ease it. It is in no way a substitute for the advice, diagnosis or treatment of a health professional.

Do not attempt any of the exercises or advice presented here without first making sure they are right for your situation. If in doubt, or if you have a particular medical condition (cardiac, respiratory, neurological or other), check with your doctor first.

If you experience any of the “red flags” described in this guide, seek care without delay. The author and Lumbafit accept no liability for any injury or harm resulting from the use of the information in this book.

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Introduction

A few words about the author

If you've gone to the trouble of getting this guide, chances are you suffer from back pain — or have in the past.

My name is Anas Boukas. I'm a physiotherapist, trained at the University of Montreal in Canada. Over the years, I've worked with more than 25,000 people dealing with back problems, across several countries.

And everywhere, it's the same story. Despite differences in culture and lifestyle, one thing stays constant: a huge part of the population lives with lower-back pain that eats away at their quality of life.



The scenario is often identical. The pain, quiet for a long time, suddenly becomes more frequent... and disabling. You look for answers online, but the information leaves you even more confused (and anxious). You hesitate to exercise, afraid of making things worse. You put off seeing the doctor, convinced they'll simply hand you a prescription. You dread the idea of an injection, and you want to avoid surgery at all costs.

Meanwhile, the pain keeps poisoning your daily life — and your mood — and robs you of the activities you love.

That's when it hits you: back pain won't just vanish on its own. If anything, it seems to get worse over time. So what now?

If this sounds like you, you're probably also starting to worry about the future. You don't want to lose your mobility or your independence, and you want to stay fit for as long as possible. Maybe your back is already keeping you from a sport or hobby you care about.

Good news: your simple willingness to inform yourself with quality content is already an excellent starting point. As a physiotherapist who specialises in back pain, I can assure you that the information shared here is grounded in medical research and has been tested with thousands of patients.

What this guide will give you

This guide gives you a clear, practical roadmap for tackling your back pain. My experience leaves no doubt: a well-informed patient dramatically improves their odds of recovery. You'll come away with a solid understanding of your problem and of the different options for getting back the life you deserve.

This isn't just a theoretical guide. It's deliberately hands-on: I've packed it with exercises and self-treatment techniques you can start using today.

One essential point: this guide does not replace a health professional. In fact, I'll tell you when and who to consult, and in which situations it's imperative to see a doctor. When in doubt, always ask an expert.

To write this guide, I drew on the sessions I run in my clinic. By following it in order, you'll do, from the comfort of your own home, the equivalent of a real consultation:

1. a quick look back at the history of your back problem;
2. a full subjective assessment to pin down your pain;
3. a personalised physical assessment to spot your imbalances;
4. the non-physical factors (often overlooked) that keep the pain going;
5. and above all, treatment: self-treatments, exercises, and every option worth considering.

By the end of this guide, you'll be able to:

- trace the history of your pain (how long, and what caused it);
- measure its impact on your daily life and set clear goals;
- understand why pain sometimes radiates down the leg;
- tell the difference between a disc herniation, sciatica, arthritis and facet joint syndrome;
- identify your "directional preference" and your muscle imbalances;
- recognise the psychosocial factors and the role of sleep and nutrition;
- spot the symptoms that call for urgent care;
- apply 7+ self-treatment techniques to ease your symptoms;
- know which therapist to see, and when to consider medication, injections or surgery;
- and stay motivated so you don't give up along the way.

Key takeaways

- Back pain is common, but rarely a life sentence.
- An informed patient recovers better: that's the whole point of this guide.
- This guide complements — but does not replace — the advice of a health professional.

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Your medical history: the story of your back

How long: when did it start?

The first question to ask is simple: when did your pain first appear?

Most people swing between pain-free spells and flare-ups of back pain. What matters here is the TOTAL duration, from the very first onset until today. Your back may have been bothering you for two weeks... but the underlying problem goes back two years.

| *"The longer pain lingers, the harder it becomes to treat."*

A few useful benchmarks. More than 80% of the population will experience lower-back pain at some point in their lives. Good news: nearly 90% of episodes settle within a month. When pain persists beyond 3 to 6 months, we call it chronic — that's the case for 10 to 23% of back-pain episodes after three months.

I often tell my patients: if the pain didn't appear overnight, it won't disappear overnight either. Chronic pain has, in a sense, become "wired in" to your central nervous system — your brain — which makes it more stubborn. But rest assured: there is ALWAYS something you can do to feel better.

Your turn:

My back problems started _____ months / years ago.

The cause: how did it all begin?

The second key element: how did the pain start? There are really only two possibilities. Either it followed a specific event (a traumatic injury), or it crept in gradually, with no accident at all.

Pinning down the exact cause isn't always easy. But if you can spot a change in your life that coincided with the pain appearing, you'll understand the problem better — and find better solutions.

A few common triggers:

- a change of job (new position, new chair, a switch to — or away from — desk work);
- a new physical activity (training for a race, CrossFit, hiking);
- a change in your training programme (loads, intensity, new exercises);
- a long trip by car or plane;
- a longer walk than usual;
- lifting heavy objects (moving house, carrying children);
- repeated bending forward (spring cleaning, playing on the floor);

- an old fall that left a weakness or an imbalance;
- an injury or surgery to another joint (knee, hip, ankle);
- a psychologically or emotionally traumatic event.

My back problems started after:

The impact on your activities

Let's pause before we go on. Back pain can be truly disabling — to the point of blocking your movement, and sometimes even your breathing. But pain isn't the only thing that drives change. More often, what pushes us to act is no longer being able to do what we love.

For some, it's no longer being able to walk the dog as long. For others, it's no longer playing with their children or grandchildren. Maybe you've given up a sport or a hobby because of your back.

Take a moment to jot down the activities that matter to you but that your back keeps you from doing fully. This step may seem trivial, but it's essential: it turns vague pain into concrete goals.

Activities I've had to cut back on or give up because of my back:

Your goals for a pain-free future

This step is crucial — don't skim over it. If you don't write your goals down, at least think them through carefully. To help, just look back at the list of activities you've just made: doing one of them again can become a goal in itself.

A good goal is never vague. "To walk without pain soon" means nothing. "To commit, within three months, to a daily 30-minute walk with my partner, without needing painkillers afterwards" — now that's a useful goal.

To frame it well, use the SMART method:

- **Specific** — tailored to what you enjoy and what motivates you.
- **Measurable** — something you can quantify (how long, how many times), so you can reassess it later.
- **Ambitious (yet acceptable)** — big enough to be a real challenge.
- **Realistic** — realistic in your expectations, or you'll lose motivation.

- **Time-bound** — with a clear deadline.



You can only manage what you measure!

My SMART goals for beating my back pain:

There are no wrong answers: these goals exist only to guide you. They'll give you the clarity you need to move forward — a principle that holds in every area of life, by the way.

Key takeaways

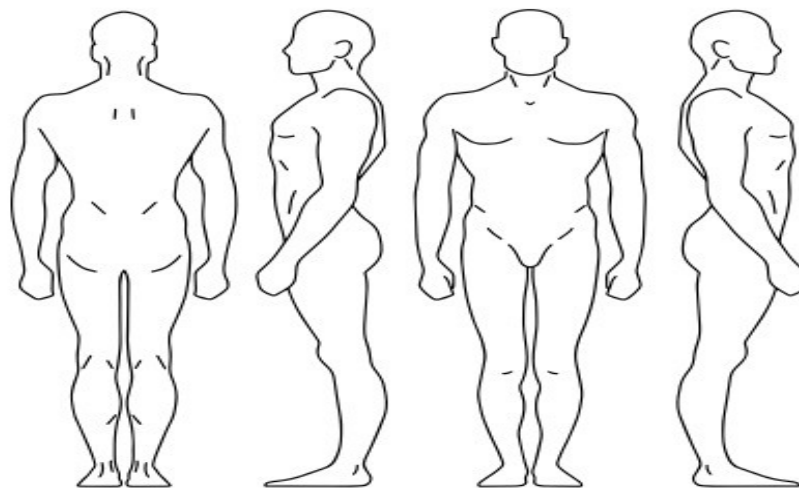
- What counts is the total duration of the problem, not just the current episode.
- Identifying the trigger helps target the treatment.
- SMART goals, written down in black and white, turn pain into a plan of action.

Subjective assessment: understanding your pain

This step is essential: pinning down your symptoms lets us identify where they come from, and therefore ease them more effectively. Let's focus on a few key points.

Location

Where is your pain? Only in the lower back, or more to one side? Does it radiate down the leg? If so, how far — the buttock, the knee, the ankle?



Where is your pain?

Location influences the prognosis. As a rule, pain that stays concentrated in the lower back heals more easily and more quickly. Conversely, the further pain travels down the leg (all the way to the toes, for example), the less favourable the outlook.

But why does pain travel down the leg? Because the body is connected everywhere: we don't come "in separate parts," as I often joke. So pain felt in one place can actually come from irritation somewhere else. This is what we call referred pain.

| *"Pain felt in one place can come from an injury located elsewhere: that's referred pain."*

This concept is crucial, because it prevents a lot of treatment mistakes. The pain you feel in your leg doesn't necessarily come from the leg muscles: it can come from irritation at the lumbar level. Treating the leg alone would mean missing the real cause.



The sciatic nerve originates from the lumbar vertebrae and travels down the leg

A little anatomy. Nerves leave the spine (the “nerve roots”), run all the way down to the toes and change name along the way. They provide sensation (touch, temperature, pain) and make certain muscles contract. The roots from the lower back join at the buttock to form the famous sciatic nerve.

A quick clarification: when a patient tells me they have “sciatica,” they’re really naming a simple anatomical structure, not an injury. The more accurate term would be “sciatalgia” — but it stays vague, because it only means there’s pain in the region of the nerve, without explaining the cause.

Why does the pain radiate down the leg?

Let’s look at the possible causes — and the common diagnoses that go with them. First, remember one vital principle: a structural anomaly is not the same as disease. Some people have an “imperfect” back on imaging yet never hurt; others have a perfectly healthy back... and very real pain. We’ll come back to this.

1. Disc herniation or bulge

You’ve surely heard of discs and disc herniations. The intervertebral discs are cushions of soft cartilage sitting between the vertebrae. There are five in the lumbar region. They separate the vertebrae, allow movement and absorb shock.



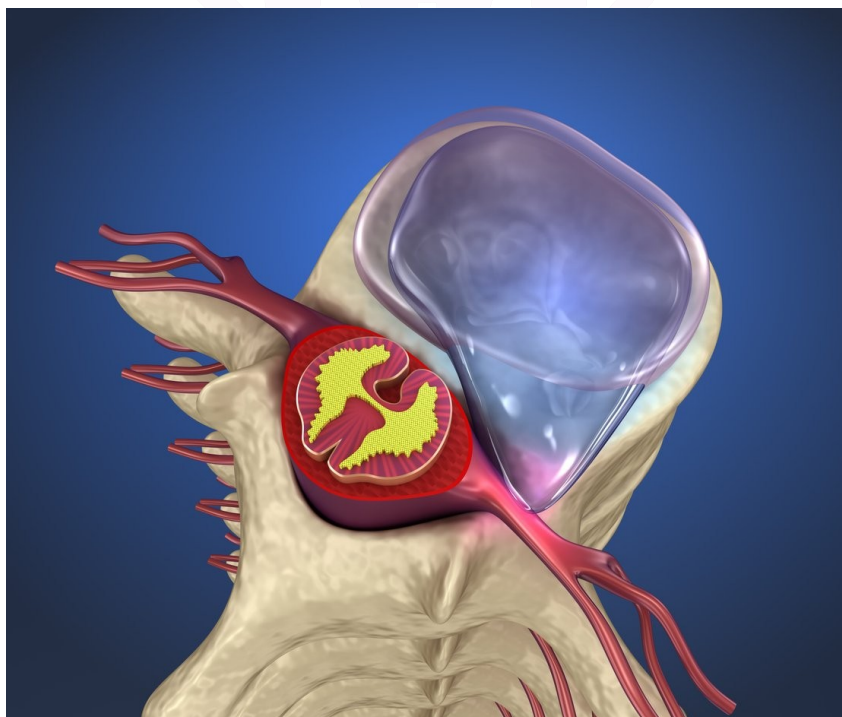
The intervertebral discs sit between the vertebrae

An interesting fact: discs are part of the reason we get shorter with age. They wear down, dry out and lose height. Since they make up 20% of the spine's height, it's normal to lose 4 to 5 cm by the age of 80. But that's not the real issue.

Each disc is made of a gel-like core (the nucleus) surrounded by a fibrous ring (the annulus). To picture it, imagine a jam-filled doughnut: the jam is the core; the dough is the ring. Under pressure, the jam can shift, push on the edges, even burst through the dough.



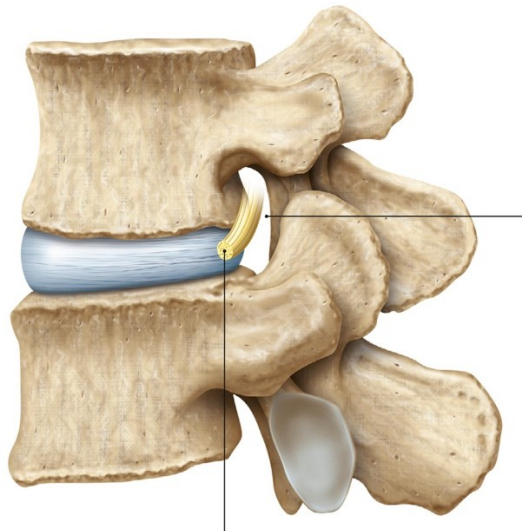
That's exactly what happens to a disc. When the core deforms the ring, we call it a bulge (protrusion); when it breaks through, we call it a herniation. Since nerve roots run right alongside, a deformed disc can irritate them. The result: discomfort, electric-shock sensations, pins and needles, or numbness down the leg.



The core pushes on the ring and irritates the nerve root

2. Lumbar arthritis and facet joint syndrome

The facet joints connect the vertebrae and allow them to move. Between them sits the intervertebral foramen, a small canal through which the nerve roots pass. This space is narrow, which can put the nerves travelling through it at risk.

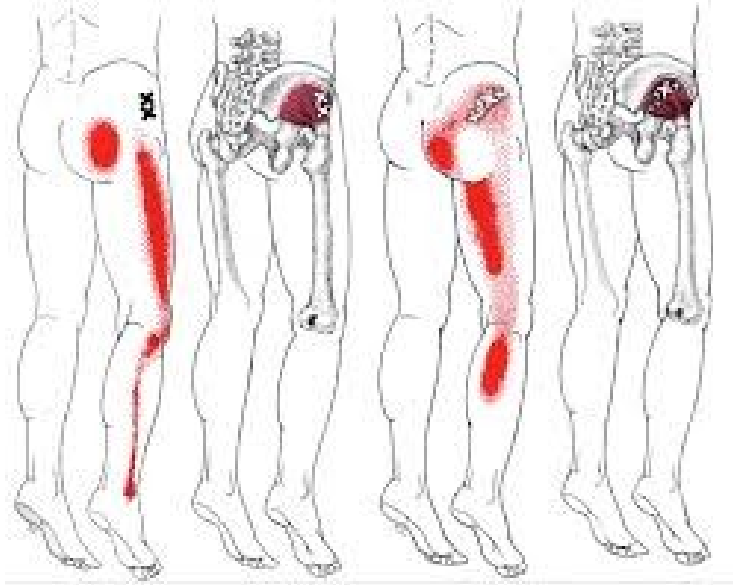


In facet joint syndrome, these joints become irritated and inflamed. A degenerative process can also wear down the cartilage and lead to arthritis, sometimes with bony overgrowths (bone spurs). The foramen then narrows, and the nerve root risks being irritated — or even pinched — which, once again, causes pain that travels down the leg.

3. Muscular pain (trigger points)

Some leg pain has a purely muscular origin. Have you ever felt a jolt down your leg when pressing on a tight muscle in the buttock or lower back? That's the principle of a trigger point: a tiny knot of contracted muscle.

Careful, though: not all trigger points are a problem. We have them all over the place without them hurting. The ones that interest us are the “active” ones — those that reproduce your exact pain. We'll see later how to treat them yourself.



What makes it worse, and what makes it better

"The goal: spot the positions and movements that aggravate (or ease) your symptoms, then link them to a spinal posture."

Aggravating factors. Which positions or movements ramp up your pain? If it increases with prolonged sitting or when you bend forward, we can link flexion to an aggravating factor. If it's more when walking or standing, we suspect an extension problem. And if it's rolling over in bed, we suspect a rotation component.

Think back to every time you've been in pain, and link each episode to your spine's position at that moment.

My pain is made worse by:

Relieving factors. You've no doubt already tried medication, ice, heat or various creams. These help, but they don't treat the cause. What interests us here are the movements and postures that reduce your pain — because we'll be able to use them to relieve you. For example, standing is sometimes more comfortable (often because sitting hurts more).

My pain is relieved by:

Thanks to this subjective assessment, you can now locate your pain, tell whether it radiates, and spot what makes it better or worse. There's a full form in the appendix: fill it in and, if you ever see a therapist, hand it over to them.

Key takeaways

- Leg pain can come from the lower back, not necessarily from the leg itself.
- Disc herniation, lumbar arthritis and trigger points are common causes of radiating pain.
- Spotting what makes it worse or better points directly to the treatment.



Physical assessment: how your body moves

Enough thinking — it's time to move! We're going to find out whether there's a "directional preference": a movement that improves your symptoms and that we can use to treat you.

Before each test, always take stock of your current symptoms. Give your pain a score (0 = none, 10 = unbearable) and note exactly where it is: lower back, buttock, behind the knee, calf, foot? Note too whether the back and leg pain seem connected.

Right now, my pain is ____/10 and is located: _____

Postural correction

Let's start by straightening the curve of your back. As you read these lines, you're probably slouched. If you're lying down, sit up on a chair without leaning your back against it. Then straighten up, exaggerating the curve of your lower back: grow tall, puff out your chest and draw your shoulders back.



Straightened posture: chest out, back gently arched, navel forward

Notice your symptoms in this new position: more intense, unchanged, or eased? A little stiffness is normal, given the arched position. Be sure to tell pain and stiffness apart: pain persists even when you change position, whereas stiffness only bothers you at the extreme and disappears at rest.

If the pain eases when you arch your back, a lumbar support will probably help you day to day — at your desk or in the car. No support handy? A rolled-up towel in the small of your back does the job nicely.



A lumbar support (or rolled-up towel) placed in the small of the back

The key concept: centralisation

When you correct your posture, the pain can shift location. In some people, pain that used to radiate to the buttock “moves back up” toward the lower back. We call this concept CENTRALISATION — and it’s an excellent sign!

“Bringing pain that radiated down the leg back toward the spine signals a favourable long-term prognosis.”

So our aim is to bring the symptoms back up from the leg toward the spine (before making them disappear entirely). So, if a movement slightly increases the back pain but reduces the buttock or calf pain, that’s a good sign. Conversely, if the symptoms travel further down toward the foot, that’s PERIPHERALISATION — to be avoided, because it signals a less favourable outlook.

Finding your directional preference

Now let’s try to identify a direction of movement that eases your symptoms. This concept comes from the McKenzie method and is widely used; many physios rely on it to treat their patients.

Movement 1 — lumbar flexion

First, note your pain (intensity and location). Then, standing, bend forward to try to touch the floor, knees slightly bent if needed.



Lumbar flexion in standing

At the bottom, has the pain changed in intensity or location? If in doubt, repeat about ten times. If the pain increases and doesn't return to baseline (it gets worse with each bend), stop immediately: flexion isn't your directional preference, but an aggravating factor to limit — especially if the pain travels down the leg.

Let's also test it sitting. Note your pain (it may differ from standing, since the spine is positioned differently), then bend forward and repeat about ten times.



Lumbar flexion in sitting

Careful: flexion doesn't always hurt. In some people, bending forward RELIEVES the pain. In that case, flexion is your directional preference — we'll use it at the treatment stage.

Last test, lying on your back on a firm surface (a yoga mat rather than a soft mattress). Bring your knees toward your chest by wrapping your arms around them, add gentle pressure for a few seconds, return to the start, and compare how it feels. Repeat about ten times.



Lumbar flexion lying down (knees to chest)

Movement 2 — lumbar extension

Standing, first note your symptoms. Place your hands above your buttocks and lean your trunk backward. Hold the position; a little stiffness is normal, as long as it fades at rest. Repeat about ten times to see the effect on intensity and location.



Lumbar extension in standing

A complementary test, lying face down (firm surface). First check that this position is tolerable, then note your pain. The movement is similar to the cobra yoga pose: hands under the shoulders, push to lift the upper trunk while keeping the pelvis on the floor. If the lower back is uncomfortable, move your hands a little further forward. Compare your symptoms at the top position, then repeat about ten times.



Lumbar extension on the floor, start and end position ("cobra" style)

During an acute flare-up, lying face down can be unbearable. In that case, place a pillow under your stomach and simply hold the position for 1 to 2 minutes, without moving. After a while, the body gets used to it and you'll be able to remove the pillow.



A pillow under the stomach helps if lying face down is too uncomfortable.

In the vast majority of back pain, the directional preference is either extension or flexion. Note yours: we'll come back to it at the treatment stage.

My directional preference seems to be: _____

Note: it's possible that no directional preference can be found. This doesn't mean there's no treatment — only that we can't use this particular method to relieve you.

Identifying your muscle imbalances

| *"A back that 'seizes up' is the consequence of an underlying problem, not the cause."*

You've maybe already made a wrong move that "locked" your back, with spasms to match. Anti-inflammatories and muscle relaxants calmed the flare-up. But treating the pain without tackling the underlying factors is like putting a bandage on a fracture. Medication is the easy fix — rarely the best one in the long run.

Most often, muscle and joint imbalances explain why the back seized up. Some muscles are too stiff, others too weak. These imbalances often sit in the hips and legs, which are closely tied to the lower back through the muscles and the fascia — the tissue that wraps the body and gives it its structure.

An example: a right hip that's far stiffer than the left. With every rotation to the right, the spine has to compensate. Repeated thousands of times, that extra effort ends up overloading the lower back... and hello, back problems.

That said, be careful: not every imbalance is serious. The body often adapts very well. Think of scoliosis — that "S" or "C" curve of the spine. You might assume it always causes pain, but many cases of scoliosis are completely symptom-free, meaning they cause the person no pain at all.



Some imbalances, however, **CAN** be a source of pain. Here are a few self-tests to spot them. Do them in front of a mirror, or ask someone to watch you, and always compare the right and left sides.

Slump test

Sit on a chair, back unsupported. Slump your trunk, bring your chin toward your sternum. Straighten your right leg, pulling your toes toward you until you feel tension. Return, then repeat with the left leg.



Slump test, leg extended

Compare the range (does one leg lift less high?) and where the tension is (thigh, calf, back). Repeat as needed to spot a difference between the two sides.

What this test assesses:

- the mobility of the nerves, including the sciatic;
- hamstring flexibility;
- calf flexibility.

Side glides

Standing in front of the mirror, arms crossed horizontally in front of you. Without moving your shoulders, shift your hips as far as possible to the right. Return, then go to the left.



Side gliding of the pelvis

Compare the range on each side, and note where you feel the symptoms (lower back, hip, leg).

What this test assesses:

- the side-to-side movement of the spine;
- the flexibility of the oblique abdominal muscles;
- even weight distribution.

Proprioception (single-leg balance)

In front of the mirror, with something to hold on to nearby. Balance on your right leg and count the seconds. Repeat on the left.



Balancing on one leg

Notice whether the pelvis wobbles more on one side, and where your muscles work hardest. When pain radiates into a leg, that leg is often weaker and less stable.

What this test assesses:

- proprioception (body awareness in space);
- trunk stability;
- leg strength and endurance.

Single-leg calf raise

Standing on one leg (something to hold on to nearby), rise onto the ball of your foot, then lower slowly. Do as many as you can, then switch legs.



Rising onto the ball of the foot, on one leg

Compare the number of reps between the two legs and note where you fatigue (calf, sole of the foot, lower back).

What this test assesses:

- leg stability and endurance;
- the S1 myotome (the function of the first sacral nerve root).

Dorsiflexion balance

Standing on your right leg (support if needed), lift your toes and forefoot off the floor so you're resting only on your heel. Repeat on the left.



Single-leg balance on the heel, forefoot lifted

Compare: is it possible on both sides? Is one side easier? Note how much support you need to keep your balance.

What this test assesses:

- proprioception and stability;
- the L5 myotome (the function of the last lumbar nerve root).

Straight-leg raise (Lasègue) test

Lying on your back, a towel around your foot, slowly raise your right leg keeping the knee straight, up to your tolerance. Return, then do the left.



Straight-leg raise, leg lifted

Compare the end position of both legs and note where the symptoms are, plus any pins and needles or numbness.

What this test assesses:

- sciatic nerve mobility;
- hamstring and calf flexibility.

Single-leg bridge

On a firm surface, bend your right leg and keep the left straight. Pushing through your right foot, lift your pelvis and hold as long as you can. Count the seconds, then switch sides.



Single-leg bridge

Compare how long you can hold, any shaking, and where you feel the effort (thigh, buttock, lower back).

What this test assesses:

- trunk stability;
- the strength of the spinal muscles, glutes and hamstrings.

Piriformis stretch (hip rotation)

Lying on your back, knees bent, cross your right ankle over your left knee. Pull your left leg toward you until you feel tension. Return, then switch.



Piriformis stretch, ankle crossed over the opposite knee

Compare the range on both sides and note what limits you (a stretch in the buttock, a sensation in the hip, back pain).

What this test assesses:

- hip mobility;
- glute and piriformis flexibility.

Side plank

Careful: if you have neck or shoulder problems, this test may not suit you. Ease into it and stop at the slightest discomfort in the neck or arms.

On your right side, propped on your elbow, feet on the floor, lift your pelvis to form a plank (a side-bracing position). Hold as long as you can, then switch sides.



Side plank on the elbow

Compare how long you can hold on each side and where the symptoms are (lower back, side of the trunk, leg).

Advanced version (only if the previous one is pain-free): in the side plank, lift the top leg and hold it in the air.



Side plank with top leg lifted (hip abduction)

Key takeaways

- Postural correction can “centralise” the pain — an excellent sign.
- Your directional preference (flexion or extension) will guide your treatment.
- The self-tests reveal the right/left imbalances that may need correcting.

21-DAY VIDEO PROGRAM

You’ve found your weak spots — now train them.

Get a physio-guided 21-day plan built specifically for back pain.



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The other causes of your back pain

Picture the scene. You've been seeing your doctor about a back that's hurt for months. They send you for an MRI. A week later, the verdict lands: "We didn't find anything. Go back to your normal activities." You're relieved... but baffled. If the MRI shows nothing, why does it hurt so much? Could the pain really be "in your head"?

The answer comes down to a single word: back pain is multifactorial. Several factors keep the pain going. So far, we've explored the mechanics of the body. But there are causes that are NOT biomechanical — and they're often just as important.

The psychosocial factors

When something hurts, we think muscles, nerves, ligaments, joints. But pain is first and foremost a signal sent by the brain. Most of the time, that signal is useful: it protects us, like when we touch a hot pan. But sometimes the brain "overplays" the pain because it senses a threat... even when there isn't one.



Think of a smoke alarm going off while you're quietly cooking: it's flagging a danger that doesn't exist. Your brain can do the same thing — send pain to your back even when your tissues aren't damaged.

Remember this: pain has a large emotional component. Separating the physical from the psychological is a common mistake. Did you know that fear, anxiety and a tendency to "catastrophise" are strongly linked to pain and disability? Think back to a stressful stretch of life: your back was surely more tense in the days that followed.

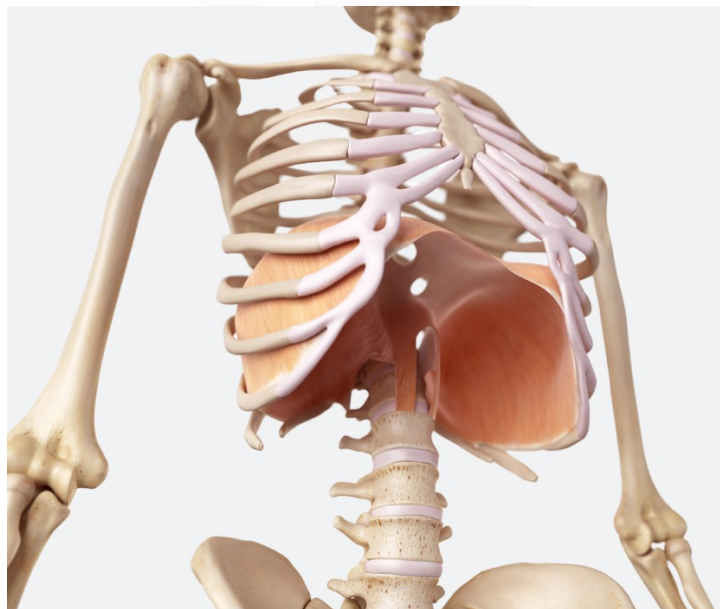
Another trap: kinesiophobia, the fear of movement. We assume that by avoiding movement we protect the back. It's the opposite: the muscles weaken, the back stiffens, and the pain settles in deeper. By correcting these false beliefs, we can genuinely change the perception of pain and support recovery.

Let's be clear: your pain is very REAL. When I explain that the brain becomes oversensitive, some people take it badly, as if I were saying "it's all in your head." Not at all. There's very likely a mechanical component to your pain — that's exactly why I put you through all those tests. I'm simply saying that psychosocial factors play a part too, especially once pain becomes chronic. Let's look at how to "desensitise" your nervous system.

Breathing

You're probably wondering what breathing is doing here — and what I could possibly teach you, since you already breathe perfectly well! And yet people with back pain breathe DIFFERENTLY from healthy people. Here are the main differences:

- the diaphragm moves less;
- the breathing muscles have less endurance;
- the ribcage expands less;
- the diaphragm sits "stuck" in a high position (Kolar et al., 2012).



I'm not claiming your pain will vanish just by breathing better. But, like strengthening a muscle or fixing your posture, adding breathing exercises will do you good.

Slow breathing

First things first: check with your doctor if you have a respiratory, lung or heart condition. If you get the green light, slow breathing is disarmingly simple — you just slow your rhythm down. Breathe as usual (nose or mouth), but inhale and exhale more deeply. Ideally aim for 6 breaths per minute, building up gently and stopping at the slightest discomfort.

Too simple? All the better. This exercise brings real physiological benefits, according to several studies (Russo et al., 2017): better diaphragm mobility, better oxygenation, better venous return, a possible drop in blood pressure, less strain on the heart, and activation of the parasympathetic system (the “rest and relax” one).

Diaphragmatic breathing

A step up, this type of breathing puts the emphasis on the diaphragm, the dome-shaped muscle beneath the lungs. Using it well improves the oxygenation of your blood and helps your muscles relax. Here's how:

6. Lie on your back in a quiet spot.
7. One hand on your chest, the other on your belly. Only the belly hand should move.
8. Breathe in through your nose, letting your belly balloon out.
9. Hold your breath for 2 seconds.
10. Breathe out slowly through your mouth, all the way to the end.
11. Repeat around ten times, gently, several times a day. To progress, rest a book on your belly.

The exercise may feel hard at first, or make you a little light-headed; that fades with practice. Every good exercise programme should include breathing: it has proven its worth in chronic low back pain (Anderson et al., 2017).

Mindfulness

No, meditating doesn't turn you into a yoga guru. Mindfulness simply means observing and accepting what's happening inside you, without trying to change it.

What does that have to do with your back? Science has an answer. A study published in JAMA showed that meditation was more effective than painkillers, and that from the very first month. By calming the mind, you release tense muscles. But it's not just a “psychological” effect: mindfulness has measurable physiological effects. Some people have seen their cortisol (the stress hormone) drop, with benefits for pain, stress and quality of life (Ardito et al., 2018), and even for heart rate and blood pressure (Pascoe et al., 2017).



How to get started? No prior knowledge needed, and there are plenty of apps to guide you. In the meantime:

- Find a quiet place.
- Get comfortable (sitting or lying down), without waking the pain.
- Close your eyes or fix your gaze on a point.
- Put ALL your attention on your breathing (normal, or slow and diaphragmatic).
- Thoughts will pop up: whatever you do, don't block them. Welcome them, then let them drift by, as if you were watching someone else, without judging.
- It's an exercise in patience. Many people want to give up because they're in pain, can't relax, or fall asleep. The key: always come back to your breath, without forcing it. Start with short sessions, then lengthen them. Over time it gets much easier — and the benefits start to show.

The support of a professional

One last option: seeing a professional (doctor, psychologist, psychiatrist). Thankfully, mental health is less and less of a taboo. The link between psychosocial factors and back pain is clear, and you've surely noticed the effect of your back on your mood — more irritable, more discouraged, less patient.



Breathing and mindfulness are an excellent start. But if your situation is more serious, a qualified professional will help you better. Talk to your doctor, especially if you notice any of the following signs:

- frequent panic attacks;
- intense feelings of guilt;
- constant fatigue for no reason (a permanent urge to sleep);
- difficulty keeping up with your social, family or work responsibilities;
- rising alcohol or tobacco use;
- sudden weight loss, or disordered eating;
- suicidal thoughts.

Sleep

Did you know that 80% of people with chronic low back pain also have sleep problems? Is it the back that keeps you from sleeping, or the poor sleep that worsens the pain? Both, in fact — a genuine vicious circle.



Start by finding a position that eases the pressure on your vertebrae. I recommend two:

On your back, a pillow under your knees. With the knees slightly bent, the back arches less and the facet joints are under less strain.



Sleeping position: on your back, a pillow under the knees

On your side, a pillow between your legs. This reduces the twist through the lower back. If one leg hurts, sleep on the opposite side to keep the painful leg on top (painful left leg → sleep on your right side).



Sleeping position: on your side, a pillow between the legs

And the mattress?

Your mattress can make your symptoms worse, especially if your pain started after you changed it, or after a weekend away from your own bed (hello, camping!). Contrary to popular belief, the best choice is neither very soft nor very firm, but MEDIUM-FIRM (Kovacs et al., 2003). Too soft lets the pelvis sink; too firm doesn't follow the curves of your back. In one study, a medium-firm mattress tested over 28 days reduced pain by 48% and improved sleep quality by 55% (Radwan et al., 2015).

Lack of sleep, for its part, increases irritability, stress and the risk of depression — all factors directly linked to chronic low back pain (Marshall et al., 2017). Hence a few habits that make a real difference:

- switch the television off at least an hour before bed;
- turn on your phone's "night" mode;
- avoid checking your emails right before sleep;
- don't drink large amounts of water in the evening;
- write your thoughts down on paper before bed to clear your mind;
- keep the bedroom dark and slightly cool;
- exercise during the day to lower your stress hormones;
- limit naps to 45 minutes at most.

Nutrition

Are there foods to favour or avoid when you have back pain? The research is limited, but we can start from a simple principle: some foods increase inflammation, others reduce it.

Careful, though — inflammation isn't bad in itself; it's even necessary for healing. It's its EXCESS, in certain chronic conditions, that causes trouble.



Foods recognised as anti-inflammatory (non-exhaustive list): spirulina, turmeric, kale, foods rich in omega-3, low-starch vegetables, nuts, olive oil, tomatoes.

Foods recognised as promoting inflammation (so best limited!): saturated and trans fats, excess omega-6, sugar and fructose, fried foods, processed foods, caffeine, alcohol, fizzy drinks, too much red meat.

Nothing too surprising, is it? There are few studies showing a direct effect of an anti-inflammatory diet on low back pain. But one thing is certain: a healthy diet improves your overall health, and therefore your back. For personalised advice, talk to your doctor or a dietitian. You can also test it yourself: add (or remove) a food for two weeks and watch the effect on your symptoms.

Key takeaways

- Back pain is never purely “mechanical”: stress, fear and mood all count.
- Slow breathing and mindfulness calm the nervous system — that’s proven.
- Good sleep (a medium-firm mattress, a good position) and a healthy diet support recovery.

What to do next

By this point, you understand your back far better. You've pinned down your pain, found your directional preference, and become aware of the non-mechanical factors at play. That awareness alone can make all the difference between pain that digs in and a back that heals.

Most of the time, there's a lot you can do on your own. But in certain situations, it's ESSENTIAL to seek care.

Red flags: when to seek urgent care

In rare cases (fewer than 1% of low-back complaints), the pain doesn't come from a mechanical problem and may hide something serious. These situations call for a doctor. They're exceptional, but seek care WITHOUT DELAY if you have any of these signs:

- **Pain after major trauma** — following a violent injury (a fall from height, a road accident);
- **Non-mechanical pain** — constant, progressive, eased by no position or movement;
- **Severe trunk pain** — associated severe chest or abdominal pain;
- **Constant night pain** — impossible nights, especially with sweats, chills or fever;
- **Unexplained weight loss** — with no particular diet or exercise;
- **"Saddle" numbness** — abnormal sensations around the perineum or genitals;
- **Bladder or bowel incontinence** — recent loss of control of the sphincters.



Since these situations are very rare, there's no need to alarm yourself. In your case, the pain is probably intermittent and varies with your activities: it's "mechanical" pain, with a far better outlook.

Medical imaging: is it really useful?

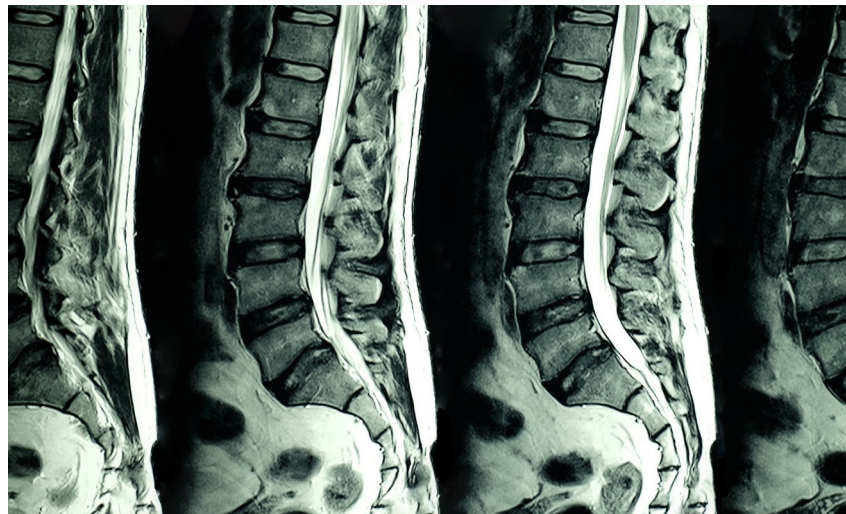
"A large share of people with NO pain at all still show disc degeneration and bulges on imaging."

Many people think an X-ray or MRI will settle everything. In most cases, the answer is NO — and in some cases, imaging can even make things worse. Why? Because a large part of the pain-free population already shows changes on imaging.

In other words, even if your MRI shows a herniation, spinal stenosis or arthritis, these changes may well have been there long before your pain. So they're not necessarily the cause. Don't panic in front of a report full of scary terms: they're often NORMAL changes, present from the age of 20. A few telling figures:

- 40% of people under 30 show disc degeneration on imaging;
- so do 90% of people aged 50–55;
- and 48% of 20–22-year-olds with NO pain at all have at least one degenerated disc.

The science is clear on this. Imaging remains valuable for detecting serious conditions (see the red flags), but some scans (X-ray, CT) expose the body to radiation. When in doubt, let a professional guide you.



Medical imaging isn't as precise as people think!

Key takeaways

- Certain signs call for urgent care: memorise the red-flag list.
- An “abnormal” MRI doesn't necessarily explain your pain.
- For typical mechanical pain, imaging is rarely needed.

Treatment: taking back control

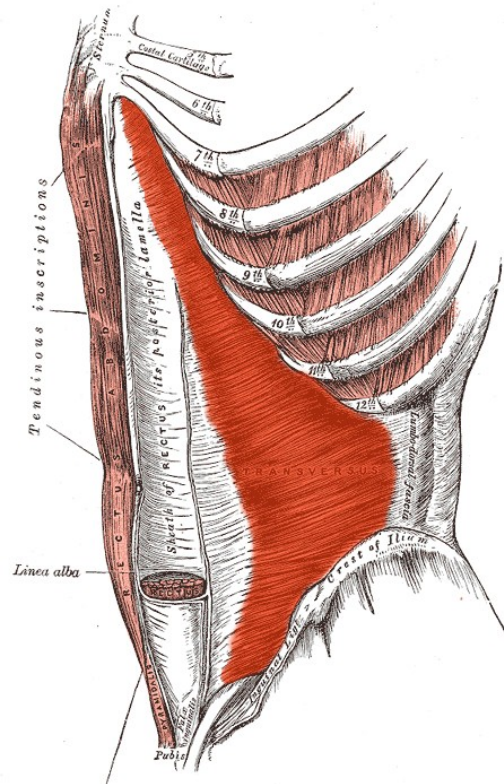
Here we are. After all that groundwork, it's time for concrete ways to reduce your pain. Those earlier steps were necessary: an educated patient heals far better. You now know your history, your imbalances, your directional preference, and the factors keeping your pain going. Congratulations — you're already halfway there.

Self-treatment techniques

We often picture treatment as a therapist acting on a passive patient. But you don't always need someone else: you can ease your own symptoms. Here are seven methods.

Self-treatment 1 — Waking up your stabilising muscles

Been told to “strengthen your abs to protect your back”? That's partly true. Several deep muscles stabilise the lumbar vertebrae, especially during movement. The catch: in people with back pain, these muscles work poorly.



Picture these muscles as a cylinder: the transversus abdominis at the front, the multifidus at the back, the diaphragm on top, the pelvic floor underneath. We'll focus on the transversus — that deep muscle nicknamed the “corset” — because it stabilises the vertebrae directly.

Two problems come up again and again in people with back pain:

- **Weak recruitment** — the transversus is thinner and contracts less well when there's pain (Hosseini et al., 2013);
- **Delayed contraction** — it fires too late during sudden movements, leaving the vertebrae to absorb the stress instead of the muscles (Davies et al., 2016).

The good news: this can be retrained. First, let's learn the neutral position of the pelvis, the one that keeps the normal curve of the lower back.

Lying on your back, arch your back by bringing your navel toward the ceiling (anterior tilt); a hollow forms under your lower back. Do the opposite by flattening your lower back into the floor (posterior tilt). The neutral position sits right in the middle of these two extremes. Keep it during all the exercises that follow.



The different positions of the pelvis: anterior tilt, neutral, posterior tilt

Basic contraction (lying down). Lying down, knees bent, pelvis neutral. Gently draw your belly in to point your navel toward the floor. To engage the pelvic floor, imagine stopping your urine mid-stream. Above all, keep breathing! Hold for 10 seconds, repeat 10 times.



Contracting the transversus while lying down

Progression 1 — with the arms. Same contraction; once you've mastered it, slowly raise one arm toward the ceiling, then the other, never letting go of the transversus. 10 times on each side.



Contracting the transversus with arm movement

Progression 2 — with the legs. Same principle: slide one heel along the floor to straighten the leg, then come back, without losing the contraction. To make it harder, keep the leg slightly lifted. 10 times on each side.



Contracting the transversus with leg movement

Progression 3 — sitting. First find the neutral pelvis, sitting on a backless seat: arch (anterior tilt), slump (posterior tilt), then settle in the middle. Then draw your belly in to recruit the transversus. Since there's no support, it's a little more demanding.



Neutral pelvis position while sitting

Progression 4 — sitting, with the arms then the legs. Sitting without back support, transversus engaged, slowly raise one arm toward the ceiling, then return; alternate, 10 times on each side. Same thing lifting the knee. It looks trivial — but many people lose the contraction the moment they move!



Arm and leg movement while sitting, transversus engaged

The real secret is consistency. You can recruit the transversus anywhere: waking up, at the wheel, at your desk, before sleep. The more you do it, the more your nervous system learns to fire it at the right moment. Think of it especially before a “risky” activity — lifting a heavy load, twisting: your stabilisers will protect you.

Self-treatment 2 — Cardiovascular exercise

We associate cardio with weight loss or marathons. Yet cardiovascular exercise can GREATLY reduce your low back pain and improve your quality of life. A glimpse of the benefits:

- it oxygenates the brain and improves cognition, memory... and even the brain's size;
- it reduces the sensitivity of the nerves (often oversensitive in chronic low back pain);
- it improves sleep and mood, and lowers anxiety and depressive symptoms;
- it fine-tunes the immune system and reduces chronic inflammation;
- it's an alternative to antidepressants for people in chronic pain.



Cardio isn't just for losing weight!

You don't need to be an athlete. The simplest option is walking. Here's the four-week programme I often give my beginner patients (max HR = 220 - your age):

- **Week 1** — 60-75 min over the week — 15 min/day, 5 days — 50% of max HR — slow pace.
- **Week 2** — 75-100 min — 20 min/day, 5 days — 50-60% of max HR — slow to moderate.
- **Week 3** — 100-125 min — 25 min/day, 5 days — 50-60% of max HR — slow to moderate.
- **Week 4** — 125-150 min — 30 min/day, 5 days — 60% of max HR — moderate pace.



Too much back pain for the gym? Try walking!

A few practical pointers:

- check with your doctor before starting, especially if you have a heart or lung condition;
- walk outdoors or on a treadmill, in comfortable trainers;
- increase only one variable at a time (either the distance or the speed);
- you should breathe faster but still be able to hold a conversation;
- use the time to practise: transversus engaged, neutral pelvis, slow breathing, mindfulness;
- if the pain climbs, reduce the speed before the distance; if it persists, end the session.

Key takeaways

- Your deep stabilisers can be retrained — mainly through consistency, not intensity.
- Walking is a treatment in its own right: simple, free and effective.
- Always progress one variable at a time.

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Self-treatment 3 — Water exercise

If walking hurts too much, the pool is an excellent alternative. I also recommend it to people with severe knee arthritis, who've been advised against long distances. Its strengths:

- **Temperature** — warm water relaxes the muscles; cold water reduces inflammation;
- **Buoyancy** — less gravity, so less stress on the joints;
- **Confidence** — a reassuring environment that rebuilds confidence;
- **Viscosity** — the water's resistance strengthens muscles without weights.



Blue gold!

As for strokes, start with backstroke after a flare-up: it keeps the lumbar curve neutral. Front crawl is possible, but demands good technique. Avoid breaststroke and butterfly at first, as they increase the arch or overload the back. Once the pain is under control, everything is allowed, gradually.

A few exercises to try (3 sets of 20 reps, unless stated otherwise):

- **Aqua walking** — water at waist height, walk; add variety by lifting your knees or bringing your heels toward your buttocks (4 × 1 min).
- **Hip abduction** — water at waist height, support if needed, take the straight leg out to the side (works the glutes).
- **Hip flexion** — bring the straight leg forward, then return (hip flexors).

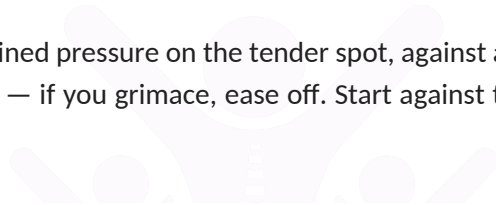
- **Adduction** — a pool noodle around the ankle, bring it back down while controlling the return (adductors).
- **Pull-push** — noodle or board in front of you, arms straight: pull it toward you, then push it away.
- **Trunk rotation** — noodle in front of you: rotate your trunk to the right then the left, without moving your legs.

One limitation, though: water exercises aren't very "functional" — they transfer poorly to real life. Use them to rebuild confidence after a flare-up, then gradually return to everyday movements. Finally, since water masks pain, it's common to hurt more that evening or the next day: consider yourself warned.

Self-treatment 4 — The tennis ball

A massage feels good, at least temporarily. A tennis ball reproduces that effect for next to nothing — no need to buy pricier massage balls, which do the same job. It's mainly used to treat trigger points, those "knots" that can radiate pain.

The principle: apply firm, sustained pressure on the tender spot, against a wall or the floor. The sensation should be strong but tolerable — if you grimace, ease off. Start against the wall (gentler), then progress to the floor.



- **Paraspinals** — near the spine (never directly on the vertebrae), 1 min static, then small movements.
- **Piriformis and glutes** — in the middle of the buttock, same protocol.
- **Hamstrings** — seated, ball behind the thigh; 1 min, then straighten and bend the leg (10 times).
- **Psoas** — lying on your front, ball on the hip flexors (without getting too close to the groin).

The ball can go almost anywhere (avoid the groin and adductors because of the nearby blood vessels). Nothing stops you using it on the traps, quads or arch of the foot too.

Self-treatment 5 — The McKenzie method

To use it, you first need to know your directional preference (see the physical assessment): whether it's extension or flexion that eases your symptoms.

If EXTENSION is what relieves you:

12. Lying on your front, prop yourself up on your elbows to gently arch the lower back. If it's tolerable, hold for 1 minute, then return.



The Egyptian sphinx!

13. Hands under your shoulders (as if for a push-up), push to lift the upper trunk while keeping the pelvis on the floor. Go as high as tolerated, look up and exhale to deepen the arch. Return. 10 reps, building up.



Like the cobra, but not quite!

14. Standing version (at work or in public): facing a wall, elbows and forearms resting on it, push your pelvis forward to hollow the lower back. Hold a comfortable stretch (3 seconds max), return. 10 reps.



Standing lumbar extension, leaning on the wall

If FLEXION is what relieves you:

15. On your back, knees bent, bring your knees toward your shoulders with your arms, add a little extra pressure, then return. 10 reps.



Lying lumbar flexion, knees toward the chest

16. Seated version: at the edge of a chair, legs apart, lower your trunk as far as possible, arms reaching toward the floor, then return. 10 reps.



Seated lumbar flexion, trunk leaning forward

A word of caution: ideally, the McKenzie method is learned with a professional. We've only covered the basics (which are enough in a large share of cases). Stop any exercise if the pain worsens without returning to normal after a short rest, or if pins and needles or numbness appear — and seek advice.

Self-treatment 6 — Neural mobility

This technique is particularly effective if you have pain, pins and needles or numbness travelling down the leg, calf, foot or toes. If you reproduced your symptoms during the Slump or straight-leg-raise tests, it's probably because the nerve is irritated or too tight — nerve gliding can then help a lot.

Important: if the pins and needles or numbness INCREASE during the exercise, reduce the range or the number of reps. The symptoms should never intensify, and must return to normal before you continue.

17. Seated. In one motion, lift your head up and straighten the symptomatic leg while pulling your toes toward you. Hold 2–3 seconds, then do the opposite (head down, leg bent). 3 sets of 10.



Sciatic nerve glide, seated

18. Lying down, legs straight. Bring the symptomatic thigh toward you, grip it, then straighten the knee upward while pulling the toes back. Hold 2–3 seconds, bend. 3 sets of 10.



Sciatic nerve glide, lying down

19. Progression: lying down, legs straight, a strap around the foot, pull the straight leg toward you to a tolerable stretch. Hold 2–3 seconds, return. 3 sets of 10.

Self-treatment 7 — The Swiss ball

“Your trunk-stabilising muscles are more active when you sit on a Swiss ball.”

Many people hurt because of their sitting posture. Rather than an expensive ergonomic chair with mixed results, try a Swiss ball as your seat during work hours — and even your downtime. Your stabilisers have been shown to work harder on these big balls (carefully, of course). Some patients have seen their pain improve by sitting on one as little as 20 minutes a day.

The ball also allows plenty of trunk- and leg-strengthening exercises — you’ll find a set of them in the appendix.



Key takeaways

- The pool, tennis ball and Swiss ball relieve symptoms, but they complement active exercise — they don't replace it.
- The McKenzie method builds on your directional preference.
- With nerve gliding, symptoms should never increase.

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Manual therapy: which therapist, and when?

I'll say it again: over the long term, the proactive approach stays the best. That's why I encourage all my patients to move — without running marathons. Why exercise? Because countless studies show it: people with back pain do better when they follow an exercise programme.

"Fair enough," you might say, "but I love a massage, it soothes my back. And I find exercises boring." I understand. You may already have seen an osteopath or a chiropractor whose manipulations relieved you. We physiotherapists use hands-on techniques too. They have a real part to play.

But their effect is most often temporary: passive relief feels good for a while, then the pain comes back. Why? Because that kind of treatment doesn't tackle the real CAUSE of the problem.

For a long time we believed the therapist was "breaking down adhesions" or "putting a vertebra back in place." Recent studies suggest instead that the relief comes from a change in how the nervous system perceives things, not from a change in the tissues. In other words, manual therapy "desensitises" your nervous system in the short and medium term. That's useful for pain or stiffness, but it doesn't cure the cause — and it can create a dependence on the therapist, which is what we want to avoid.



Manual therapy has its benefits, but also its limits!

Remember this: see a therapist if you feel more pain or stiffness, or if your symptoms don't settle with the tools in this guide. Which therapist to choose? My answer is bound to be a little biased... but I regularly refer my patients to osteopath, acupuncturist and chiropractor colleagues.

The most important thing: find a therapist you trust and who gets you results. Thanks to this guide, you'll be better able to judge what's good for your back.

If you do consult, fill in the assessment form in the appendix and hand it to your therapist: they'll save time understanding your story... and you'll save time getting treated.



Medication: a tool, not a solution

A disclaimer: I'm not a doctor. Only your doctor can determine the right medications based on your history, your other health issues and your tolerance. My aim is simply to inform you, so you can be a well-informed patient in your next conversation with them.

"Take the MINIMUM of medication, at the MINIMUM dose, for the SHORTEST possible time."

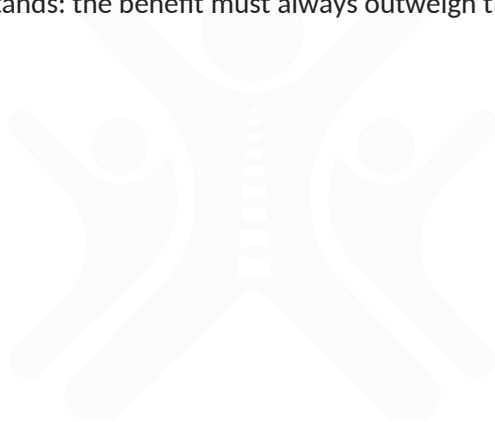
That's the whole philosophy in one sentence. If your doctor doesn't share it, they may not be following the most recent evidence. Prescribing high doses over long periods is a thing of the past: it's ineffective long-term and a source of side effects.

That's why we speak of first-, second- and third-line treatments: you exhaust one option before moving to the next. It's always better to relieve pain naturally first — this guide is full of ways to do so. But when the pain becomes disabling, medication has its place. Here's the usual approach:

- **Anti-inflammatories (NSAIDs)** — first line (unless contraindicated: stomach, kidneys, blood pressure). Acetaminophen, less effective but better tolerated, is an alternative; sometimes the two are combined.
- **Muscle relaxants** — if NSAIDs aren't enough, especially during flare-ups, and never over a long period (effects on the nervous system).
- **Opioids** — reserved for chronic cases and severe flare-ups, with a real risk of dependence, especially in vulnerable people.
- **Antidepressants** — useful when there's an emotional component (you don't need to be depressed to benefit), but with inconsistent effects.
- **Anti-seizure medication** — such as gabapentin or pregabalin, for nerve-root pain; often poorly tolerated (fatigue, dizziness, dry mouth).



Every medication has benefits (less pain) and risks. Your doctor is best placed to weigh the pros and cons in your case. The golden rule stands: the benefit must always outweigh the side effects.



Herbal remedies, creams and ointments: the natural alternatives

Personally, I hate taking medication — and I know many of you do too. So I understand why people ask me for natural alternatives: creams, ointments, herbal products, home remedies.



My view is simple: as long as it's natural and it relieves you, why not? Some people find real relief with a gel, heat, ice or glucosamine; others don't. Since the studies don't settle it, you have to go by trial and error.

Two caveats, all the same. First, getting hold of these products can be costly — and frustrating when they don't work. Second, some herbal products contain impurities or interact with your medications. So ALWAYS tell your doctor what you're taking.

Injections: understanding them so you can avoid them

Is an injection an option for back pain? Yes. Is it sometimes effective? Yes. Should it be your first thought? No.



Not for the squeamish!

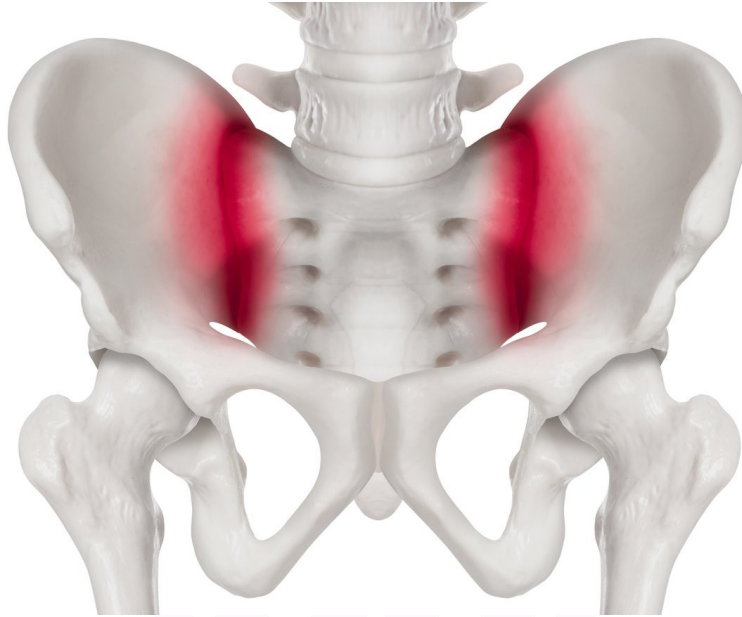
The problem is the lack of solid scientific evidence. Imagine being offered an unpleasant jab that might not work, with a (rare) risk of side effects: headaches, infection, bruising, nausea, nerve irritation, weakened bone... Hard to get excited about.

"Injections should only be considered for persistent, disabling pain that hasn't responded to at least 6 weeks of conservative treatment."

Put plainly, an injection should be the last resort before surgery — not a magic fix (otherwise it would be prescribed to everyone). Various doctors can perform it (GPs, orthopaedic surgeons, anaesthetists, physiatrists, radiologists), in several forms:

- **Epidural** — aims to reduce inflammation around a nerve root; effective mainly for nerve-root pain from a herniation, but often temporary.
- **Facet joint injection** — targets the facet joints; also used to confirm that they really are the source of the pain.

- **Trigger-point injection** — inconsistent, temporary results; try dry needling (from an acupuncturist or physiotherapist) before resorting to it.
- **Sacroiliac injection** — considered if the pain comes from this joint, though that's a hard diagnosis to confirm.



The sacroiliac joint (in red), between the iliac bone and the sacrum

A single injection isn't always enough: experts recommend a series of 1 to 3 injections spaced at least a month apart. Above all, never repeat an injection that did nothing. In short: as long as you're progressing with conservative treatment, however slowly, it's better to stick with the exercises in this guide. Injections are only worth discussing when you've plateaued and the pain is disabling.

Surgery: the very last resort



Not for the squeamish!

A few decades ago, back surgery was common. Then it turned out not to be as effective as hoped, and many surgeons reserved it for specific cases. The reality: only a minority of people with back pain get a real benefit from it.

Certain signs, however, call for URGENT assessment by a specialist (orthopaedic or neurosurgeon) and may lead to surgery:

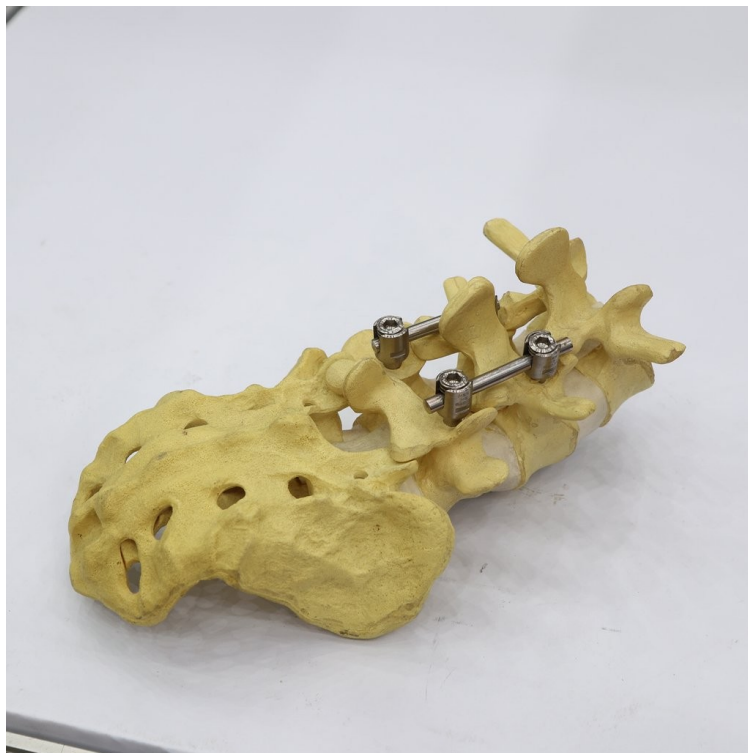
- severe, progressive leg weakness that hampers walking, with numbness;
- abnormal sensations in the genital area;
- bladder or bowel incontinence;
- severe, constant pain that isn't relieved by rest.

You'll recognise red flags here. They can signal damage to the "cauda equina" — the nerve roots of the lower back that control the legs and the pelvic organs.

Cauda equina

Outside these emergencies, some people consider surgery when pain persists despite well-run conservative treatment, several medications, injections and therapists. Often, this physical suffering comes with psychological suffering (depression, anxiety). The two main procedures:

- **Lumbar fusion** — two (or more) vertebrae are fused together and the disc deemed responsible is removed. This deliberately limits mobility — but makes the neighbouring vertebrae work harder, with a risk of degeneration over the long term.
- **Discectomy** — the pressure a disc puts on a nerve is relieved. Often combined with a laminectomy; minimally invasive techniques (endoscopy, laser) speed up healing and reduce complications.



Never forget that any surgery carries risks (infection, blood clots, embolism, nerve damage). That's why it's kept as a last resort. And bear in mind that an operation doesn't guarantee the pain will disappear: residual pain is still possible.

Taking action: the exercises

We've explored the most invasive options (medication, injections, surgery). I hope you've grasped that none is as miraculous as people sometimes believe. Given their mixed effects and their risks, they're best kept as a LAST resort. Which brings us back to the core principle: it's a PROACTIVE approach that ends back pain. And proactive means exercise.

"I don't have time," you might tell me. Stop and think for a moment: is it really time you're short of, or motivation? Nine times out of ten, it's motivation. Your exercises don't need to last hours, and you can do them at home with minimal equipment — so the money excuse doesn't hold either.



Is it really a lack of time that keeps you from being active?

I understand the fear of making your back worse by moving, too. But you're far better educated now: you know where your pain comes from and how to spot a flare-up. Thanks to Lumbafit, you have access to a safe, tailored set of exercises. And if the fear lingers — especially after an acute episode — get support from a professional.

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Conclusion

I wrote this guide for one reason: to give hope, and a way forward, to people with back pain. So you'd know that an informed patient multiplies their chances of recovery. So you'd understand that there's always something you can do. So you'd adopt a proactive approach. And so no one could exploit your distress to sell you baseless products.

If it feels like nothing works, I understand your discouragement. But if you believe you've "already tried everything," think again: you now understand your condition far better than before. You'll be more effective when it comes to choosing the right options, and you now know that back pain touches many areas of life.

I'll end on a note of hope. Tomorrow when you wake up, tell yourself you're going to heal — no matter whether you hurt that morning. Many have been there and come through. Why not you? You don't need some dramatic gesture: it's the work, the motivation and the perseverance that make the difference.

There will be plateaus, moments when you think nothing is moving, or even that it's getting worse. That's precisely when you have to draw on your strength and keep going. Surround yourself — loved ones and professionals — as needed. I promise you: it's possible to regain a good quality of life and to live without disability. You just have to believe it.

Key takeaways

- Surgery, injections and medication are last resorts, not starting points.
- Obstacle number one is almost never time: it's motivation.
- Consistency, patience and perseverance: that's your real treatment.

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Appendices

Subjective pain assessment form

This form helps you build an overall picture of your pain. Fill it in, then hand it to your therapist if you consult one.

Form to fill in, then hand to your therapist

Name:

Date:

Duration of the problem:

Mechanism of injury:

Course of symptoms (improving / worsening / stable):

Treatments tried so far:

Medical imaging done:

Limitations in daily life:

Goal 1:

Goal 2:

Goal 3:

Medical history:

History of injury:

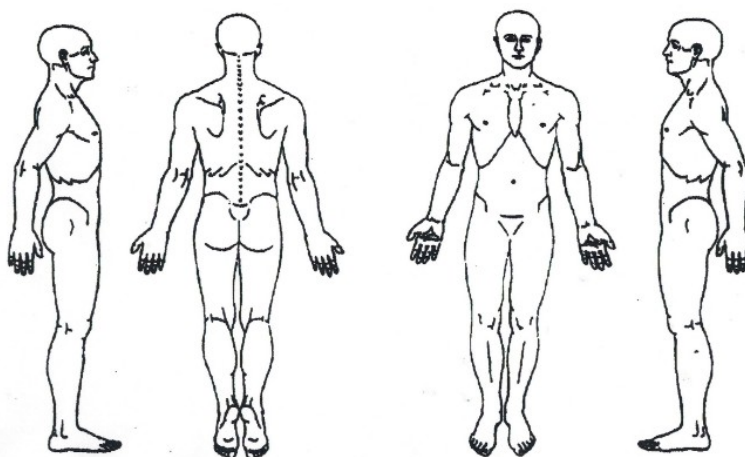
Previous surgeries:

Current medication:



Subjective assessment

Location of the pain:



Intensity (rate out of 10): _____ /10

Pins and needles / numbness in the legs: Yes _____ No _____

A feeling of weakness in the legs: Yes _____ No _____

Symptoms made worse by:

Symptoms relieved by:

Sleep quality: Excellent _____ Average _____ Poor _____

Sleep posture:

Red flags (see a doctor urgently if):

_____ Constant night pain (sweats, chills, fever)

_____ Unexplained weight loss

_____ A change in sensation in the genital area

_____ Bladder or bowel incontinence

Examples of safe, tailored exercises

What is THE best exercise for the back? The answer might surprise you: there isn't one. Everyone needs different exercises depending on their symptoms and their stage of healing. No single exercise has clearly proven superior to the others. The secret lies elsewhere: in consistency and safe execution. In short, start moving, don't stop... and enjoy it.

LINK TO THE LUMBAFIT YOUTUBE PAGE, which offers several guided sessions, tips and exercises:
<https://www.youtube.com/@lumbafit>

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