1. **Do not discharge patients with osteoporotic fractures without an assessment and/or treatment for osteoporosis**

Studies of patients with osteoporotic fractures have found that they are at significantly greater imminent risk of suffering a new fracture compared to the general population. This risk is particularly marked in but not restricted to elderly patients. Despite this, there are still reports of inadequate clinical pathways for the management of these patients before discharge.

Osteoporosis assessments and/or treatments before discharge are clinically very important and moreover may be highly cost effective even after taking account of the additional resources associated with providing these services.

**EVIDENCE SUPPORTING RECOMMENDATION 1**


2. **Do not prescribe spinal orthotics or bed rest of more than two days for patients with non-specific low back pain**

There is insufficient and conflicting evidence on the effectiveness of spinal orthotics and other forms of lumbar support for treating or preventing low back pain, either as an intervention in its own right or as a supplement to other interventions.

There is similarly inconclusive evidence that bed rest is a more effective means of managing low back pain than other approaches, including advice to stay active. While there is no evidence that short term bed rest is harmful, long periods of bed rest can lead to complications such as muscular atrophy. The only randomised control trial to assess optimal periods of bed rest suggests that if bed rest is to be prescribed, two days is as effective as any longer period.

**EVIDENCE SUPPORTING RECOMMENDATION 2**


NICE Low Back Pain and Sciatica in Over 16s: Assessment and Management. NICE Guideline, No. 59 2016.


3. **Do not use mini mental state examination as the only tool to assess cognitive deficit in acquired brain injury**

Numerous studies suggest that the Montreal Cognitive Assessment (MoCA) is one of the most effective means of assessing cognitive deficits in acquired brain injury (for instance after transient ischemic attack and stroke) and is to be preferred to the Mini Mental State Evaluation (MMSE). MMSE may under-detect cognitive impairment in acquired brain injury, although it is an accurate screen for dementia.

**EVIDENCE SUPPORTING RECOMMENDATION 3**


4. **Do not routinely use splinting for prevention and/or management of contractures after stroke**

Extensive reviews of the evidence on the use of hand splinting for stroke victims have been unable to find conclusive evidence that it leads to improvements in managing spasticity and preventing contractures or more generally improving upper limb function. Moreover, there is high quality evidence that stretch, whether administered from splints or other means, does not have clinically important effects on joint mobility in people with or without neurological conditions, at least for the periods it is typically prescribed.

**EVIDENCE SUPPORTING RECOMMENDATION 4**


5. Do not use imaging for diagnosing low back pain in the absence of red flags

The majority of acute low back pain episodes are benign, self-limited cases that do not warrant the use of imaging. Extensive reviews of the evidence have found that early imaging for low back pain in the absence of red flags does not facilitate improvements in primary outcomes such as pain and function, even for older patients. If anything such imaging may be harmful insofar as it may reveal incidental findings that divert attention and increase the risk of having unnecessary interventions and invasive treatments including unnecessary surgery.

EVIDENCE SUPPORTING RECOMMENDATION 5


