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Impact of sciatica on daily life and well-being: An overview

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Abstract
Sciatica is a painful and function-limiting condition that profoundly affects physical functioning, emotional well-being, social participation, and economic productivity. It typically arises from irritation or compression of the lumbar or sacral nerve roots, most commonly due to intervertebral disc herniation, spinal stenosis, or degenerative disc disease. Symptoms include radiating leg pain, sensory disturbances, weakness, and impaired mobility, often leading to substantial reductions in daily functioning and quality of life. Although many individuals recover within the initial months, a considerable proportion continue to experience persistent or recurrent symptoms that may progress to chronic sciatica. The severity and duration of symptoms strongly predict disability, healthcare utilization, and productivity loss.

The physical impact of sciatica includes pain, reduced mobility, avoidance of physical activity, and increased dependence on healthcare services. Psychological consequences such as stress, anxiety, and depression are common, often exacerbated by persistent pain, lifestyle disruption, and fear-avoidance behaviors. Coping strategies vary widely, ranging from adaptive behavioral modifications to maladaptive patterns that may further reduce activity and social engagement. Social implications include strained relationships, reduced participation in social roles, and increased social isolation, all of which influence pain perception and recovery trajectories.

Sciatica also imposes significant economic burdens. Healthcare expenditure, frequent medical consultations, physiotherapy, and adherence to treatment recommendations contribute substantially to direct costs. Indirect costs arise from absenteeism, presenteeism, and long-term loss of productivity, with chronic cases generating costs nearly ten times higher than short-duration episodes. Despite this, integrated preventive and early intervention models remain limited. Emerging preventive strategies-such as GP-based screening using the Sciatica Screen and Modified Oswestry Disability Questionnaire-may help identify high-risk individuals earlier and guide timely interventions.

Overall, sciatica is a multidimensional condition requiring comprehensive clinical, psychological, social, and economic consideration. Improved preventive screening, patient-centered management, and targeted rehabilitation strategies are essential for reducing chronicity and its far-reaching impacts.

Keywords: Sciatica, lumbar nerve root compression, radiating leg pain

Introduction

Sciatica is a common and debilitating neuromuscular condition characterized by radiating leg pain, sensory disturbances, or weakness resulting from irritation, inflammation, or compression of the lumbar or sacral nerve roots. Most frequently associated with degenerative disc disease, particularly disc herniation. It is essential to differentiate true sciatica from non-radicular leg pain originating in somatic structures such as muscles, joints, or pelvic organs. The sciatic nerve travels from the lumbar spine through the gluteal region to the foot; compression anywhere along this pathway can produce sharp, burning, or electric pain, numbness, or motor deficits that follow distinct dermatomal patterns. Symptoms typically worsen with sitting, coughing, or prolonged standing and may improve with movement or stretching. Sciatica is most prevalent in adults aged 40-50 years, with one-month prevalence ranging from 2-43% and lifetime prevalence from 13-43%. While many individuals recover within the first three months, a considerable proportion experience persistent or recurrent symptoms lasting a year or longer. Longer pain duration, high initial intensity, and negative beliefs about recovery are consistently associated with poorer prognosis. Psychological factors especially anxiety and depression play an important role, often contributing to heightened pain perception, delayed recovery, and chronic disability.

The physical consequences of sciatica extend beyond pain to include reduced strength, sensory loss, limited mobility, and avoidance of activities that aggravate symptoms. These limitations hinder activities of daily living, disrupt sleep, and contribute to deconditioning and reduced physical activity. Fear-avoidance behaviors may further restrict movement, reinforcing chronicity and functional decline. The emotional burden is equally significant; chronic sciatic pain is associated with distress, frustration, fear of worsening disability, and depressive symptoms. Emerging evidence linking chronic stress to impaired axonal regeneration through mitochondrial dysfunction highlights the biological relevance of psychological well-being in recovery.

Sciatica also carries major social and occupational implications. Persistent pain disrupts social relationships, reduces participation in leisure activities, and contributes to feelings of isolation or being misunderstood. Intimate and family relationships may suffer due to altered roles and reduced physical capacity. At work, pain and sensory deficits affect concentration, posture, mobility, and task performance, leading to absenteeism, presenteeism, reduced productivity, or even job loss. Individuals must often reorganize daily routines around pain, leading to significant lifestyle changes.

Economically, sciatica imposes a substantial burden on individuals and healthcare systems. Healthcare utilization including diagnostic imaging, physiotherapy, consultations, and medication is significantly higher among individuals with sciatica than among those with non-radicular leg pain. Chronic cases generate nearly ten times the cost of acute episodes, underscoring the importance of early recognition and intervention [1].

Given its multifactorial nature, sciatica requires a biopsychosocial understanding that integrates physical, psychological, social, and economic dimensions. Early identification of high-risk patients and timely interventions such as physiotherapy, lifestyle modifications, and psychological support may help prevent chronicity and long-term disability. However, evidence gaps persist regarding the most effective screening strategies, management pathways, and rehabilitation models. This review synthesizes current knowledge on the clinical, emotional, social, and economic impacts of sciatica to improve understanding of its burden and highlight areas for future research and healthcare planning.

Understanding Sciatica

Sciatica is primarily characterized by unilateral leg pain accompanied by altered sensation or weakness, arising from compression, inflammation, or sensitization of lumbar or sacral nerve roots. It is most often linked to degenerative lumbar disc disease. Although various rare conditions may cause sciatica, the condition is best understood by distinguishing it from non-sciatic lower limb pain, which originates from somatic structures such as joints, muscles, ligaments, or pelvic organs. The sciatic nerve exits the lumbar spine, passes through the gluteal region, and extends to the foot; irritation or compression along this path produces radiating pain, sensory abnormalities, and mechanical or chemical hypersensitivity.

Sciatica is a frequent cause of clinical consultations, medicolegal cases, and diverse therapeutic interventions. Symptom severity and duration strongly predict levels of disability, healthcare use, productivity loss, and economic burden. Research on these outcomes is therefore essential for improving prognostic understanding and developing effective interventions.

Patients often describe sciatica as a profoundly disruptive condition. Severe pain limits normal movement, affects communication and social interactions, and makes routine activities difficult or impossible. Many patients reduce their activities to basic tasks and spend substantial time resting or seeking medical care. Persistent sciatica increases risks of job loss, relationship strain, and comorbidities such as decreased fitness, weight gain, and long-term medication use. Sudden onset frequently triggers anxiety about worsening disability, while persistent symptoms lead to fears of long-term impairment or hopelessness about recovery. Protective behaviors and avoidance of painful movements, although instinctive may further reduce mobility and reinforce chronicity.

Sciatica is most common in adults aged 40-50 years, with decreasing prevalence in older age groups. Prevalence estimates vary widely: one-month prevalence ranges from 2-43%, lifetime prevalence from 13-43%, and consultation rates from 2-17%. Although rarely studied alongside comorbid conditions, sciatica is considerably more common in those with chronic low-back pain, with one-month estimates ranging from 2-5.3%. While most individuals improve in the first few months, a significant minority experience symptoms for 12 months or longer. Psychological factors-especially anxiety and depression-are independently associated with poorer outcomes.

Definition of Sciatica

Sciatica, sometimes referred to as radiculopathy, may be difficult for non-professionals to distinguish from other forms of back or leg pain. It occurs when the sciatic nerve is compressed or irritated, causing pain radiating from the lumbar spine through the hips, legs, and into the feet. Symptoms include low-back pain, tingling, numbness, burning sensations, weakness, or sharp shooting pain along the leg. These symptoms often worsen with sitting, standing for long periods, coughing, or sneezing, and may improve with stretching or gentle physical activity.

Around 90% of cases present with unilateral leg pain, although bilateral symptoms occur in specific conditions. Severe neurological deficits such as foot drop may appear and require evaluation through tests like the straight-leg-raise. Sciatica is most commonly caused by mechanical compression from a herniated disc, spinal stenosis, osteoarthritis, congenital narrowing, or spondylolisthesis. Aggravating factors such as pregnancy, muscle spasm, poor posture, or sedentary lifestyle typically contribute to existing nerve compression rather than serving as primary causes.

Causes of Sciatica

Sciatica is frequently associated with degenerative disc disease, particularly disc herniation. Pain is severe, radiating along the nerve pathway, and aggravated by bending, twisting, coughing, sneezing, or prolonged sitting. Patients often show reduced lumbar mobility, muscle spasms, weakness such as diminished strength in the m. tibialis anterior or m. gluteus maximus and positive Bragard and Lasegue signs on examination.

It may develop suddenly after lifting a heavy object or

gradually due to long-term mechanical strain, poor posture, or occupational loading. Initial episodes may resolve quickly, but recurrence usually becomes more frequent, severe, and prolonged.

Disc herniation remains the most common cause. Age-related degeneration and reduced blood supply weaken the intervertebral disc. Between ages 35-40, tears in the annulus fibrosus allow the nucleus pulposus to protrude into the spinal canal, compressing nerve roots and generating classic sciatica symptoms.

Symptoms of Sciatica

Sciatica presents as pain, sensory changes, or weakness originating from irritation or compression of lumbar or sacral nerve roots. Disc herniation and spinal stenosis are the most common causes, though structural pathology is not always identifiable. Patients with sciatica report greater symptom severity, disability, and work absence than those with non-radicular leg pain. While many recover within months, a substantial minority experience chronic or recurrent symptoms [2]. Poor prognosis is associated with longer pain duration, greater initial symptom severity, and beliefs of delayed recovery.

Sciatica is considered a form of radiculopathy, although the term is sometimes misused to describe any leg pain. True radiculopathy refers specifically to lower motor neuron dysfunction caused by spinal nerve root irritation or compression, with symptoms following dermatomal patterns [3].

Physical impact of sciatica

Sciatica causes pain radiating from the lower back down the posterior thigh, leg, or heel, resulting from disc herniation, spinal stenosis, or direct nerve injury. In addition to pain, patients may experience sensory loss, reduced strength, or muscle paresis. Activities involving sitting, standing, or lifting often exacerbate pain, leading patients to avoid movement and reduce physical activity. This limitation significantly disrupts daily activities and can lead to emotional distress, including anxiety and depression [2].

Back and leg pain are among the most frequent complaints in primary care. Sciatica influences illness behaviors such as increased worry, changes in daily functioning, missed work or school, and high healthcare utilization, including GP visits, physiotherapy, and alternative medicine [1]. Emotional consequences are common, with anxiety and depression often co-occurring. Pain intensity strongly correlates with reduced participation in work, household tasks, transportation, and leisure activities. Social connections and recreational activities may be restricted, contributing to diminished quality of life.

Pain and Discomfort

Pain and discomfort were the most consistently reported impacts of degenerative cervical radiculopathy (DCR), paralleling findings in sciatica research [1]. Participants described varying pain sensations, including burning, shooting, or aching pain, triggered by actions such as turning the head, lifting, or maintaining prolonged postures [4]. Patients employed various coping strategies, including ergonomic adjustments, physiotherapy, posture modifications, or rest. Relief varied depending on symptom type; some found relief through rest, while others noted temperature sensitivity or reliance on medication. Despite temporary relief measures, most participants reported that pain and discomfort significantly impacted their daily functioning.

Mobility Limitations

Mobility refers to the ability to move or walk freely. Mobility limitations may result from impaired balance, sensory deficits, muscle weakness, spasticity, or loss of trunk or lower-limb function. In sciatica, both perceived and objectively measured mobility limitations are common, particularly in the early phase of symptoms [5]. Patients with severe symptoms or long-lasting disability require close monitoring to prevent chronic mobility impairment. Fear-avoidance behaviors may also contribute to reduced mobility and physical activity, reinforcing a cycle of disability.

Impact on Physical Activity

Although research specifically addressing sciatica's effect on physical activity is limited, insights can be drawn from studies on chronic musculoskeletal and spinal cord injuries. Healthcare guidelines recommend at least 150 minutes of moderate activity weekly, yet 73% of adults fail to meet these levels. Sedentary behavior increases risks of obesity, cardiovascular disease, diabetes, cancer, emotional disturbances, sleep problems, and reduced life expectancy.

Physical inactivity is especially harmful for those with spinal cord injuries (SCI). Reduced muscle mass, impaired control, and environmental barriers contribute to low physical activity levels [6]. Psychological barriers including lack of knowledge, low self-efficacy, and limited access to rehabilitation facilities also reduce participation. In SCI populations, reduced activity is associated with cardiometabolic disease, diabetes, and poorer general health. Evidence suggests that targeted, lifestyle-oriented physical activity programs may improve outcomes, as individuals with higher physical activity levels report better overall lifestyle quality.

Emotional and psychological effects

Chronic pain is common among individuals with long-standing health conditions and significantly reduces quality of life. Persistent spinal pain is frequently associated with other chronic pain syndromes, including headache disorders. Sciatica, a form of low back pain often brings emotional and psychological burdens that people around the patient may not fully comprehend [7]. Pain, defined as both an “unpleasant sensory” and “emotional experience,” is subjective, multidimensional, and becomes chronic when lasting more than three months. This chronicity contributes to continuous suffering through intertwined physiological and psychological factors. Emotionally, chronic sciatica may cause loss of interest in life, increased risky behaviors, alterations in thoughts and actions, withdrawal from loved ones, loss of joy in previously pleasurable activities, and heightened self-isolation. Patients often experience fear of social spaces, frustration from being misunderstood, and emotional shutdown that affects interpersonal communication.

Stress and Anxiety

Chronic stress has been shown to hinder sensory axon regeneration by damaging mitochondrial cristae and impairing oxidative phosphorylation (OXPHOS) [8]. In

spinal cord injury (SCI), persistent pain, physical limitations, and major lifestyle changes increase vulnerability to long-term psychological stress, anxiety, and depression. Although stress is known to negatively influence recovery, its biological links to axon regeneration are only now being understood. Research shows that chronic stress induces mitochondrial dysfunction in sensory neurons, raising reactive oxygen species and neuronal hyperactivity factors that impair axonal regeneration. Thus, psychological stress management is essential for effective rehabilitation.

The SCI Rehab Project reported that anxiety symptoms correlate significantly with reduced life satisfaction [9]. Higher anxiety levels predict poorer life satisfaction, and depression strongly moderates this relationship. SCI patients typically have elevated rates of both anxiety and depression compared with able-bodied controls. Because life satisfaction is linked to mental health and future behaviors including suicide risk monitoring both conditions is crucial. Given their frequent co-occurrence, treatment responses should be measured for both anxiety and depression. Medications such as SSRIs are effective for managing both conditions, and cognitive-behavioral therapies for depression also reduce anxiety and avoidance. Clinicians should therefore routinely assess both conditions to ensure comprehensive psychological care.

Depression and Mood Changes

Depression, a common psychiatric disorder, significantly influences daily living and behavior. Among patients with sciatic disease, depression exacerbates pain symptoms and reduces quality of life. Studies consistently show higher prevalence of depression in patients with spinal cord injury than in the general population, and depression intensifies pain severity, pain interference, and decreases quality of life [10]. However, research on mood states specifically among patients with lumbar canal stenosis causing sciatica remains limited.

Recent studies indicate a high prevalence of negative mood states among patients with spinal canal stenosis or sciatica, driven by factors related to both the disease and the injury [11]. Depression is the most frequent comorbidity affecting daily functioning in individuals with chronic pain or disability. Patients with nerve injury exhibit significantly higher depression rates than the general population, even though many have no prior psychiatric history. The difficulty of adapting to sudden life changes whether due to spinal or brain injury heightens depression risk. Mood states, however, vary according to disease severity, functional disability, and anxiety levels. Even minimal physical impairment may provoke significant negative mood changes, highlighting the importance of early psychological screening and intervention.

Coping Mechanisms

The distress caused by sciatica often pushes individuals to adopt new coping strategies cognitive, behavioral, and emotional that help them manage daily life challenges. Coping strategies include both adaptive and maladaptive responses and can reshape personal beliefs, social relationships, and health-seeking behaviors [12]. Coping develops over time and encompasses thoughts, behaviors, and reframing responses to stressors such as illness, job loss, or disability. Illness disrupts an individual's foundational beliefs regarding health, medical systems, treatment, and personal coping resources [13].

Elderly individuals with sciatica may detach from responsibility for their own health, leading to increased dependence on the medical system and passive attempts to seek care. Conversely, patients who consider themselves responsible may actively seek knowledge and treatment sometimes increasing stress due to long waiting times or repeated doctor consultations. Coping also involves adjustments in relationships with family, friends, and healthcare providers. Social roles may shift, and individuals may modify their interactions based on perceived support or lack thereof.

Common coping strategies in sciatica include preventing triggers, avoiding painful movements, and adopting behaviors that temporarily reduce discomfort. Some turn to medications, increased mobility, or lifestyle changes to manage symptoms such as constipation or sleep disturbances. If current methods fail, individuals accumulate a repertoire of coping strategies some effective, others maladaptive based on prior experiences.

Social implications of sciatica

Pain strongly influences social functioning. About 61% of individuals with mild-to-moderate pain report moderate to major impacts on daily life, while 49% with moderate-to-severe pain report similar impacts, despite higher pain intensity [7]. Many patients (77%) state that pain affects overall life satisfaction. Clinicians may benefit more from assessing how pain interferes with daily life rather than focusing solely on intensity. External factors may distort patient-reported experiences, complicating the relationship between pain intensity and quality-of-life measures.

Despite challenges, many individuals cope effectively with sciatica and report improved life perspectives after adjusting for demographic and health factors. However, others experience complications beyond pain, particularly in social and occupational domains.

Impact on Relationships

Chronic sciatica often disrupts interpersonal relationships, including those with partners, children, family, and friends. Patients frequently report emotional strain due to changes in physical ability and identity. Intimate relationships may suffer due to decreased companionship, misunderstanding, or resentment from partners who fail to grasp the patient's limitations. Many patients feel isolated when partners misinterpret reduced activity as laziness or lack of effort.

Friendships also deteriorate, as patients struggle to participate in shared activities and feel misunderstood. Friends often minimize the severity of sciatica, reinforcing emotional distance. Respondents reported fewer meaningful conversations, decreased engagement in social roles, and difficulties discussing illness openly. Even supportive partners may misinterpret behavioral changes, leading to emotional distance, sorrow, and strained relationships.

Social Isolation

Longitudinal research highlights the profound influence of social isolation (SI) on pain appraisal and coping [14]. Surprisingly, increased social isolation can reduce the perceived impact of pain, while decreased isolation heightens pain interference. This emphasizes the need to assess individuals' social contexts when evaluating chronic

pain. The study also demonstrated the feasibility of generating reliable SI scores even with changing assessment items.

Understanding SI allows clinicians to design better interventions such as promoting social inclusion, connecting patients with peer support, or reinforcing engagement with supportive networks. SI affects not only the presence of pain but the extent to which individuals engage with coping strategies. For those who feel disconnected from others who understand their pain experience, referrals to peer supporters may enhance coping and treatment outcomes.

Changes in Work Life

Sciatica significantly affects occupational functioning. Pain may disrupt concentration, posture, mobility, and the ability to perform tasks requiring prolonged sitting, standing, or fine motor skills. Patients often describe their work routines being shaped by constant awareness of body posture and pain. Radiating leg pain, numbness, and discomfort influence how individuals sit, travel, or perform manual tasks.

Misunderstanding from colleagues or family exacerbates stress, as others may underestimate the challenges associated with sciatica. Emotional responses to pain, worry about future functioning, and reconstruction of daily routines create complex layers of past, present, and anticipated experiences. Patients may struggle to balance work responsibilities with the physical and cognitive burdens of pain, leading to reduced productivity, modified roles, or withdrawal from certain tasks. Everyday activities such as carrying objects, bending, cutting, or organizing items become sources of fear, caution, and hyper-awareness.

Economic consequences

The economic burden of sciatica has received comparatively limited research attention, despite extensive literature on low back pain in general. Existing studies indicate substantial health care expenditures and productivity loss linked specifically to sciatica, though evidence remains scarce and primarily derived from societal-level cost analyses. Reported health care costs vary widely due to differences in study duration, national health systems, and inclusion of demographic or clinical confounders such as age, sex, RTSG, or baseline leg pain. Standardized cross-country cost comparison remains difficult [1].

Although initial implementation costs for national rehabilitation or management programs may be high, long-term economic returns are likely, as chronic sciatica generates health care costs nearly ten times higher than short-term cases. Further research is needed to produce uniform national estimates of direct and indirect sciatica-related costs and to analyze variations by socioeconomic status, educational level, work factors, general health, and co-morbidities.

Medical Costs

Sciatica's uncertain prognosis and complex treatment contribute substantially to medical expenditure. Evidence on service-utilization costs and societal impairment remains limited; thus, studies have evaluated primary care patients with recent sciatica to quantify service use and productivity loss [1]. Using POET study data, researchers assessed primary care costs tied to treatment and treatment-recommendation adherence over 36 months, as well as productivity loss during the first 12 months. Baseline factors like age, sex, education, duration of symptoms, pain intensity, Edinburgh Claudication Score, and disability were analyzed using multivariable regression adjusted for study site.

Findings showed sciatica imposes a significant healthcare burden. Over 36 months, mean costs reached £2,670 per patient, primarily from treatment-recommendation adherence. Additional medical service use added £313 per patient. Both adherence and service use were substantially higher in sciatica patients compared with those with referred leg pain. Productivity losses were also considerable, including work absence (£837), reduced work performance (£79), and non-work activity losses costing £97 per month per patient. These results underline the major economic burden beyond treatment itself, encompassing lost productivity and prolonged functional impairment [15].

Loss of Productivity

Chronic pain conditions including lower back pain, neck pain, sciatica, fibromyalgia, and arthritis collectively account for more than 80 million lost workdays annually, amounting to nearly $4 billion in lost income and additional billions in healthcare expenditures. Globally, nearly 100 million individuals experience chronic pain, with most reporting it as the most negatively impactful factor in daily life; only 5% report no daily impact [16]. Sacroiliac (SI) joint pain is particularly common and often chronic, reflecting the multifactorial and complex nature of pain.

Unmanaged sciatica further compromises workplace productivity through absenteeism, presenteeism, unrealistic workloads, or trauma-related stress, particularly among military personnel. Individuals with chronic pain work fewer hours and suffer reductions from medically related absenteeism and presenteeism, with presenteeism exerting nearly six times the economic impact of absenteeism. Chronic musculoskeletal pain predicts chronic sick leave, restricted activity, and reduced output, underscoring the need for workplace health initiatives.

Impact on Employment

Sciatica most frequently affects the lumbar region at L4-L5 or L5-S1. L4-L5 herniation causes groin pain radiating to the anterior thigh and knee, with advanced cases showing quadriceps atrophy and possible renal or bladder dysfunction. L5-S1 herniation results in gluteal pain radiating to the heel and lateral foot, accompanied by paresthesia and weakness in muscles such as the tibialis anterior, peroneus longus/brevis, and abductor hallucis. Severe cases may involve urinary retention and sphincter disturbances.

Differential diagnosis must distinguish sciatica from intervertebral sprains, osteochondrosis, lumboischialgia due to diabetes or tumors, pelvic organ disease, and inflammatory conditions. Radicular symptoms like restricted lumbar movement, irritation signs, reflex loss, hyperesthesia, hyperalgesia, pathological skin zones, and muscle atrophy further support diagnosis [17]. These symptoms significantly affect work capacity, employability, and long-term occupational functioning.

Discussion

This review highlights sciatica as a multifactorial condition with far-reaching physical, psychological, social, and

economic impacts. Although many patients experience symptom improvement within the first few months, a substantial proportion develop chronic or recurrent symptoms that influence mobility, emotional well-being, productivity, and overall quality of life. The complexity of sciatica extends beyond simple nerve compression; it encompasses biopsychosocial elements that contribute to persistent impairment, maladaptive coping mechanisms, and long-term disability.

The physical burden characterized by intense radiating pain, sensory disturbances, and reduced mobility forms the core of the patient experience. These symptoms limit daily activities and commonly lead to fear-avoidance behaviors, reduced physical activity, sleep disturbances, and deconditioning. Such patterns reinforce disability and may delay recovery. The psychological consequences, including heightened stress, anxiety, and depressive symptoms, further exacerbate pain perception and negatively influence rehabilitation outcomes. Evidence showing stress-induced mitochondrial dysfunction provides emerging biological links between psychological stress and impaired nerve recovery, emphasizing the need for integrated care approaches.

Social experiences also play a critical role in shaping illness behavior. Patients frequently report strained relationships, reduced social participation, and feelings of misunderstanding or isolation. These social disruptions, combined with work-related limitations and reduced productivity, contribute to a cycle of distress and reduced functioning. The occupational consequences are substantial, with presenteeism, absenteeism, and reduced work capacity contributing to major economic losses for individuals, families, employers, and healthcare systems.

Economically, sciatica carries a significant burden comparable to other chronic musculoskeletal disorders. Healthcare utilization, treatment-recommendation adherence, and productivity losses collectively contribute to high societal costs. Although national rehabilitation or preventive programs may require high initial investment, the potential long-term benefits reduced chronicity, improved work retention, and decreased medical expenditure justify continued exploration of scalable interventions.

Emerging preventive models, such as GP-initiated screening combined with disability questionnaires, offer promising frameworks for early identification of high-risk individuals. Early intervention through physiotherapy, behavioral support, and structured activity guidance may help mitigate progression to chronic sciatica. However, more evidence is needed to determine which screening tools, referral pathways, and intervention timings are most effective and cost-efficient. Importantly, future research should adopt multidimensional approaches, integrating clinical, psychosocial, occupational, and lifestyle factors to develop comprehensive management strategies.

Conclusion

Sciatica is not merely a physical condition; it is a complex biopsychosocial disorder that affects nearly every dimension of an individual's life. Its impacts range from debilitating pain and restricted mobility to emotional distress, social withdrawal, reduced productivity, and increased healthcare expenditure. While most individuals experience short-term improvement, a significant minority develop persistent symptoms with long-term consequences.

This review underscores the importance of early identification, targeted preventive strategies, and multidisciplinary management. Integrating GP-based screening, physiotherapy, psychological support, and patient education may help interrupt the progression to chronic sciatica and improve long-term outcomes. Addressing psychological distress, enhancing coping mechanisms, improving social support, and promoting safe physical activity are essential components of effective care.

Future research should focus on developing standardized national estimates of sciatica's economic impact, validating early detection tools, and evaluating the feasibility and effectiveness of preventive interventions. By adopting a comprehensive, patient-centered, and evidence-informed approach, healthcare systems can reduce the burden of sciatica and improve the health, productivity, and quality of life of affected individuals.

Conflict of Interest

Not available.

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