Spine Pathway (V14) 03.06.2019

SELF-CARE AND SELF-MANAGEMENT

Integrated MSK Service Website: https://sussexmskpartnershipcentral.co.uk/

OUTCOME MEASURES

- MSK-HQ
- STarT Back Tool

Cauda Equina Syndrome

Spinal pain
With systemic symptoms
(including IVDUs, renal and immuno-compromised patients)

Thoracic back pain
Mechanical thoracic pain

Osteoporosis

Insufficiency fractures

Spinal infection

Inflammatory back pain

Metastatic disease

Metastatic spinal cord compression - MSCC

Myelopathy (cord compression)

Nerve root pain (radiculopathy)
Acute motor deficit
Acute painful foot drop with 48h functional deficit (defined as MRC grade of 3/5 or less)

Nerve root pain (radiculopathy)
Acute motor deficit
Non acute painful foot drop (more than 48h)

Nerve root pain (radiculopathy)
Non painful foot drop

Nerve root pain (radiculopathy)
Acute motor deficit
Quads palsy / quads weakness

Referral reason / Patient presentation	Cauda Equina Syndrome
Primary Care Management	Symptoms suggestive of cauda equina syndrome (compression of the cauda equina). Back pain **plus** one or more of: • Change in sexual function – erectile dysfunction, problems with ejaculation, loss of vaginal sensation • loss of bowel control (faecal or flatus incontinence) and unexpected laxity of anal sphincter • loss of bladder control (urinary retention or incontinence) • saddle anaesthesia or paraesthesia (loss or change of perianal and perineal sensation) • severe or progressive neurological deficit in the lower extremities or gait disturbance **CES Warning Signs** • Loss of feeling/pins and needles between your inner thighs or genitals • Numbness in or around your back passage or buttocks • Altered feeling when using toilet paper to wipe yourself • Increasing difficulty when you try to urinate • Increasing difficulty when you try to stop or control your flow of urine • Loss of sensation when you pass urine • Leaking urine or recent need to use pads • Not knowing when your bladder is either full or empty • Inability to stop a bowel movement or leaking • Loss of sensation when you pass a bowel motion • Change in your ability to achieve an erection or ejaculate • Loss of sensation in genitals during sexual intercourse
Thresholds for Primary Care to initiate a referral	**Immediate referral by telephone to the on-call (Spinal) Orthopaedics Registrar** **OR** **Refer to A&E with a letter**
Management Pathway for the Integrated MSK Service	**N/A** **At triage:** If suspected CES within the referral letter- call the patient to clarify the symptoms and if CES suspected, advise patient to attend A&E, email letter to patient and fax letter to A&E, inform GP. Admin will follow up with a phone call and send letter to GP. **In clinic:** advise patient to attend A&E and give letter to patient to take to A&E, inform A&E that patient is going to attend, inform GP and admin to send letter to GP. **From diagnostics:** Evidence of CES on scan; check SystmOne for symptoms and signs, call patient. If the patient presents with signs and symptoms, AP to advise patient to attend A&E, admin to send letter and images to relevant hospital, AP to document on SystmOne and notify referring clinician, notify GP, admin to send letter to GP. If the patient does NOT present with signs and symptoms of CES, document on SystmOne and notify referring clinician, notify GP, admin to send letter to GP.
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	**Emergency appropriate surgery as soon as possible.**

Referral reason / Patient presentation	**Spinal pain** With systemic symptoms (including IVDUs, renal and immuno-compromised patients)
Primary Care Management	**Investigation:** • History • Unexplained weight loss, severe night pain, fever • Inflammatory markers • Examination and Assessment • Systemic symptoms • Recent foreign travel **Diagnostics:** • Consider appropriate blood tests
Thresholds for Primary Care to initiate a referral	**Use 2WW pathway if suspected condition is covered.** **Refer as emergency to acute hospital if patient is seriously unwell, suspected spinal abscess, discitis or infection.** **If not covered under 2WW and patient not seriously unwell, refer URGENTLY to Advanced Practitioner – Appointment within 14 days (for example a patient presents with back pain and has a history of IVD use).**
Management Pathway for the Integrated MSK Service	**1 Patient information** **2 Assessment and examination** **3 Investigations** • Request urgent MRI **4 Management** • Review MRI scan report **If scan reveals metastatic disease or metastatic spinal cord compression please refer to serious pathology pathways document, if infection refer urgently to secondary care or A&E if patient is seriously unwell.** SMSKP Serious pathology pathways ' • Consider referral on to Haematology • Consider referral onto General Medicine
Thresholds for referral for Intervention Offer patient choice of provider	Offer patient choice of provider if patient needs and wants surgery, is fit for surgery and is appropriate surgical candidate. Offer patient choice of provider for onwards referral to Haematology / General Medicine
Management pathway for Specialist In-patient care	**Surgery as appropriate**

Referral reason / Patient presentation	Thoracic back pain Mechanical thoracic pain
Primary Care Management	• History • Examination and Assessment • Consider heel toe walk **Investigations:** • Consider appropriate blood tests • Consider appropriate imaging as indicated (X-Ray, MRI, CT, NM) **Management (including condition-specific self-care options):** • First six weeks manage in primary care if investigations are within normal limits • Analgesia in line with agreed formularies / guidance • Consider self-referral to physiotherapy
Thresholds for Primary Care to initiate a referral	**Refer to General Physiotherapy if:** • not resolved > 6 weeks management in Primary Care or consider self-referral to physiotherapy **Refer to Advanced Practitioner (ICATS) if:** • investigations are outside normal limits • pain is not adequately controlled / resolved
Management Pathway for the Integrated MSK Service	**1 Patient information** **2 Assessment and examination** **3 Differential diagnosis** 1. Mechanical thoracic pain 2. Osteoporosis / insufficiency fracture **See Fracture Liaison Service pathway** 3. Unclear presentation ± red flags (rule out spinal infection, inflammatory back pain, metastatic disease, metastatic spinal cord compression) 4. Myelopathy (see below) **4 Investigations** • Consider appropriate blood tests • Consider appropriate imaging as indicated (X-Ray, MRI, CT, NM) **5 Management** • Analgesia modification • Physiotherapy • Consider nerve blocks • Consider thoracic facet joint denervation • Kyphoplasty –AP to discuss with pathway lead until C&H / Mid Sussex CEC has been agreed • Vertebroplasty –AP to discuss with pathway lead until C&H / Mid Sussex CEC has been agreed **6 Outcome tools** MSK-HQ

Thresholds for referral for Intervention Offer patient choice of provider	Offer patient choice of provider if patient needs and wants injections / denervation is fit for the intervention and is appropriate candidate.
Management pathway for Specialist In-patient care	**N/A** *Please note:* *This section of the guidelines may need to be reviewed once the CEC guidelines have been published.*

Referral reason / Patient presentation	**Osteoporosis**
Primary Care Management	**See Fracture Liaison Service Pathway**
Thresholds for Primary Care to initiate a referral	**N/A**
Management Pathway for the Integrated MSK Service	**N/A**
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	**Insufficiency fractures**
Primary Care Management	**See Fracture Liaison Service Pathway**
Thresholds for Primary Care to initiate a referral	**N/A**
Management Pathway for the Integrated MSK Service	**N/A**
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	Spinal infection
Primary Care Management	• History • Examination and Assessment • Consider heel toe walk • Consider infection if history of TB **Investigations:** • Consider appropriate blood tests • Consider appropriate imaging as indicated (X-Ray, MRI, CT, NM) **Management (including condition-specific self-care options):** • Explanation of cause • None
Thresholds for Primary Care to initiate a referral	**<u>Urgent referral to A&E</u>** **DO NOT send to SMSKP**
Management Pathway for the Integrated MSK Service	• Urgent referral to A&E **<u>At triage:</u>** **Urgent referral to A&E**: If suspected spinal infection within the referral letter- call the patient to clarify the symptoms and if spinal infection is suspected, advise patient to attend A&E, email letter to patient and fax letter to A&E, inform GP. Admin will follow up with a phone call and send letter to GP. If patient refuses to go to A&E, refer patient back to GP immediately (speak to GP) **<u>In clinic:</u>** **Urgent referral to A&E (only if patient is physically unwell)** Advise patient to attend A&E and give letter to patient to take to A&E, inform A&E that patient is going to attend, inform GP and admin to send letter to GP. **If patient is well,** and you suspect infection, urgently organise whole spine MRI and request FBC and inflammatory markers. **<u>From diagnostics:</u>** **Urgent referral to A&E if patient is unwell**: Evidence of spinal infection on scan; check SystmOne for symptoms and signs, call patient. If the patient presents with signs and symptoms of spinal infection, AP to advise patient to attend A&E, admin to send letter and images to relevant hospital, AP to document on SystmOne and notify referring clinician, notify GP, admin to send letter to GP. Or **refer urgently to secondary care** if scan confirms infection but patient is well.
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	**Surgical preference** **Spinal decompression surgery**

Referral reason / Patient presentation	Inflammatory back pain
Primary Care Management	**See Rheumatology pathway**
Thresholds for Primary Care to initiate a referral	**N/A**
Management Pathway for the Integrated MSK Service	**N/A**
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	Metastatic disease
Primary Care Management	SMSKP Serious pathology pathways '
Thresholds for Primary Care to initiate a referral	**N/A**
Management Pathway for the Integrated MSK Service	**N/A**
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	**Metastatic spinal cord compression - MSCC**
Primary Care Management	SMSKP Serious pathology pathways '
Thresholds for Primary Care to initiate a referral	**N/A**
Management Pathway for the Integrated MSK Service	**N/A**
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	**Myelopathy (cord compression)** i.e. • Arm pain, numbness, and weakness • Spasticity of legs • Sensory changes in legs • Sphincter involvement • Sensory ataxia
Primary Care Management	**Investigation:** • History • Examination and Assessment • Provisional diagnosis **Diagnostics:** • **None** **Management (including condition-specific self-care options):** • Explanation of cause • Useful test: heel toe walk
Thresholds for Primary Care to initiate a referral	**Myelopathy is a slow progressive disorder.** **If myelopathy is suspected refer to neurosurgery or spinal orthopaedics. Progression of symptoms is considered urgent referral.** **History of acute trauma / onset (48h): refer to A&E.** **Exclusions:** • Rheumatoid Arthritis with neck pain • Additional neuro signs – e.g. cranial nerves, impairment of consciousness • Down's Syndrome ***The above exclusions list require emergency referral to orthopaedics via A&E***

Management Pathway for the Integrated MSK Service	**<u>At triage:</u>** If myelopathy is suspected, ring patient to ascertain symptoms and organise DAPOT as required. **<u>In clinic:</u>** If myelopathy is suspected, organise urgent MRI scan (but may be routine depending on the severity of the symptoms) **1 Patient information** **2 Assessment and examination** **Urgent MRI scan:** Clinical signs to look out for: • Change in balance / proprioception • Brisk reflexes • +/- clonus • +/- up going plantar(s) • +/- myotomal weakness • +/- +ve Hoffman's • +/- Multisegmental weakness **3 Investigations** • Review MRI scan report **4 Management** • Urgent referral to Secondary care **5 Outcome tools** • MSK-HQ **<u>From diagnostics:</u>** Evidence of myelopathy on scan; check SystmOne for symptoms and signs, call patient. If the patient presents with signs and symptoms of myelopathy, refer to neurosurgery or spinal orthopaedics. Progression of symptoms is considered urgent referral If the patient does NOT present with signs and symptoms of myelopathy (but has it on scan), document on SystmOne and notify referring clinician, and refer to neurosurgery or spinal orthopaedics (but safety net in case symptoms get worse).
Thresholds for referral for Intervention Offer patient choice of provider	Offer patient choice of provider if patient needs and wants surgery, is fit for surgery and is appropriate surgical candidate.
Management pathway for Specialist In-patient care	**Spinal decompression surgery**

Referral reason / Patient presentation	**Nerve root pain (radiculopathy)** **Acute motor deficit** **Acute painful foot drop with 48h functional deficit (defined as MRC grade of 3/5 or less)**
Primary Care Management	**Investigation:** • History • Examination and Assessment Painful and myotomal weakness of 3/5 or less on MRC scale • Provisional / working diagnosis(es) **Diagnostics / Imaging:** • **<u>None</u>** **Management (including condition-specific self-care options):** • Explanation of cause • None
Thresholds for Primary Care to initiate a referral	**If acute painful foot drop with 48h functional deficit: urgent referral to A&E (for BSUH to spinal team)**
Management Pathway for the Integrated MSK Service	• Urgent referral to A&E **<u>At triage:</u>** **Urgent referral to A&E**: If suspected acute painful foot drop within the referral letter- call the patient to clarify the symptoms and if acute painful foot drop is suspected, advise patient to attend A&E, email letter to patient and fax letter to A&E, inform GP. Admin will follow up with a phone call and send letter to GP. **<u>In clinic:</u>** **Urgent referral to A&E** Advise patient to attend A&E and give letter to patient to take to A&E, inform A&E that patient is going to attend, inform GP and admin to send letter to GP. **<u>From diagnostics:</u>** **Urgent referral to A&E**: Evidence of acute painful foot drop on scan, check SystmOne for symptoms and signs, call patient. If the patient presents with signs and symptoms of acute painful foot drop, AP to advise patient to attend A&E, admin to send letter and images to relevant hospital, AP to document on SystmOne and notify referring clinician, notify GP, admin to send letter to GP.
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	**Surgical preference** **Spinal decompression surgery**

Referral reason / Patient presentation	**Nerve root pain (radiculopathy) Acute motor deficit Non acute painful foot drop (more than 48h)**
Primary Care Management	**Investigation:** • History • Examination and Assessment • Provisional / working diagnosis(es) **Diagnostics / Imaging:** • **<u>None</u>** **Management (including condition-specific self-care options):** • Explanation of cause • None
Thresholds for Primary Care to initiate a referral	**If non acute painful foot drop: urgent referral to Integrated MSK Service**
Management Pathway for the Integrated MSK Service	**1 Patient information** **2 Assessment and examination (Advanced Practitioner)** • If painful myotomal weakness of 3/5 or less on MRC scale – AP to request urgent MRI scan **3 Investigations** • Review MRI scan report **4 Management** • Patient needs and wants surgery, is fit for surgery and is appropriate surgical candidate, fitness for surgery, pre-operative assessment, and discharge planning undertaken - refer to spinal/ Neurosurgery (depending on local arrangements) • Consider follow up appointment for further review **5 Outcome tools** • MSK-HQ
Thresholds for referral for Intervention Offer patient choice of provider	Offer patient choice of provider if patient needs and wants surgery, is fit for surgery and is appropriate surgical candidate.
Management pathway for Specialist In-patient care	**Surgical preference** **Spinal decompression surgery**

Referral reason / Patient presentation	**Nerve root pain (radiculopathy)** **Non painful foot drop**
Primary Care Management	**Investigation:** • History • Examination and Assessment • Provisional / working diagnosis(es) **Diagnostics / Imaging:** • **None** **Management (including condition-specific self-care options):** • Explanation of cause
Thresholds for Primary Care to initiate a referral	**Refer to Advanced Practitioner (ICATS)**
Management Pathway for the Integrated MSK Service	**1 Patient information** **2 Assessment and examination (Advanced Practitioner)** **3 Investigations** • MRI scan or NCS **4 Management** • Explanation of cause • Surgical appliances re AFO as indicated • Orthopaedic opinion as required
Thresholds for referral for Intervention Offer patient choice of provider	Offer patient choice of provider if patient needs and wants surgery, is fit for surgery and is appropriate surgical candidate.
Management pathway for Specialist In-patient care	**Elective surgery** **Spinal decompression surgery**

Referral reason / Patient presentation	**Nerve root pain (radiculopathy)** **Acute motor deficit** **Quads palsy / quads weakness**
Primary Care Management	**Investigation:** • History • Examination and Assessment • Provisional / working diagnosis(es) **Diagnostics / Imaging:** • **<u>None</u>** **Management (including condition-specific self-care options):** • Explanation of cause • None
Thresholds for Primary Care to initiate a referral	**If quads pain / quads weakness: urgent referral to an Orthopaedic Consultant**
Management Pathway for the Integrated MSK Service	**Urgent referral to Orthopaedic Consultant** **<u>At triage:</u>** **Urgent referral to Orthopaedic Consultant**: If suspected acute quadriceps palsy within the referral letter- call the patient to clarify the symptoms and if acute quadriceps palsy is suspected, refer to Orthopaedic Consultant **<u>In clinic:</u>** **Urgent referral to Orthopaedic Consultant** **<u>From diagnostics:</u>** **Urgent referral to Orthopaedic Consultant**: Evidence of acute quadriceps palsy on scan; check SystmOne for symptoms and signs, call patient. If the patient presents with signs and symptoms of quadriceps palsy, refer to Orthopaedic Consultant
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	**Surgical preference** **Spinal decompression surgery**

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