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

Neck Pain

Acute torticollis

Acute neck pain

Chronic neck pain

Neck pain whiplash
Acute

Referral reason / Patient presentation	**NECK PAIN**
Referral reason / Patient presentation	**NECK PAIN** **Acute torticollis** It usually resolves within 24-48 hours Occasionally symptoms may take up to a week to resolve. Recurrence is common Much more common in children and adolescents
Primary Care Management	• Investigation • History **Examination and Assessment:** • Unable to rotate head • Head often held in side flexed position **Management (including condition-specific self-care options):** Analgesia in line with agreed formularies / guidance (NICE 2015) Advise gentle exercise within the comfort zone Intermittent heat or a cold pack to help reduce pain and spasm Sleeping on a low firm pillow. Advise against: • Routine use of a soft cervical collar. If pain on moving the neck is severe, then wearing a soft collar for a few days may help. It is preferable to keep the neck mobile with gentle exercise. • Driving, as it is not possible to rotate the head to view traffic.
Thresholds for Primary Care to initiate a referral	**To be manged in primary care.** **Referral to Physiotherapy** if: • Locked neck, unable to rotate and it does not spontaneously resolve after a week
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	**NECK PAIN** **Acute neck pain** Acute neck pain (less than 6 weeks), evidence suggests the risk of chronic neck pain is established for 6 weeks
Primary Care Management	**Assessment:** • History • Examination • Working / differential diagnosis If Red Flags Present, in particular any head and neck trauma consider urgently referring to emergency department **Diagnostics:** • Not indicated **Management (including condition-specific self-care options) (NICE 2015):** • Reassure that neck pain is a common problem that usually resolves within a few weeks. • Encourage activity and a return to a normal lifestyle (including work) as soon as possible. • However, advise the person not to drive if the range of motion of the neck is restricted. • Discourage the use of cervical collars because this restricts mobility and may prolong symptoms • Advise that a firm pillow may provide comfort at night. It should provide lateral support and support the hollow of the neck and the position should be comfortable. Using two pillows may force the head into an unnatural position. • Offer analgesia to relieve symptoms. Choice of analgesia depends on pain severity, personal preferences, and risk of adverse effects. • No evidence for exercises in acute neck pain.
Thresholds for Primary Care to initiate a referral	Ongoing pain for more than 6 weeks. No radiation of symptoms would trigger referral to physiotherapy.
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	**NECK PAIN** **Chronic neck pain** Neck pain nonspecific chronic phase more than 12 weeks (these guidelines should reflect chronic LBP guidelines)
Primary Care Management	• History • Examination • Working / differential diagnosis **BSP Assessment** **Management (including condition-specific self-care options):** Analgesia in line with agreed formularies / guidance, including trial of a low-dose tricyclic antidepressant Re-examine psychosocial factors periodically Consider physiotherapy Be alert for new symptoms and red flags. Management (including condition-specific self-care options): Patient education Develop a management plan to aid the patient in understanding what to expect and their role and responsibilities in managing the pain. Continue to offer reassurance and positive messages that encourage the patient to return to normal activities. If signs of serious disease are still absent, consider initially offering the following: • Physical activity and exercise programmes • Further drug therapy (alternative to the list above if the response to the first-line therapy is not satisfactory) Brief educational interventions aimed at reducing sick leave and disability may be useful although NICE do not recommend education as a sole intervention. Employment status – involve Occupational Health if affecting ability to work or ongoing disability. 'phased return' should be explored in each case.
Thresholds for Primary Care to initiate a referral	**Refer to General Physiotherapy if:** presentation worsening and unable to manage in primary care **Refer to Advanced Practitioner (ICATS) if:** • No better with physiotherapy and analgesia • Previously in BIC / PMP **Urgent Referral to Advanced Practitioner (ICATS) if**: suspecting serious spinal abnormality or significantly worsening symptoms

Management Pathway for the Integrated MSK Service	**1 Patient information** **2 Assessment and examination (Advanced Practitioner / Consultant Physiotherapist)** Explore: Psychosocial factors Patient understanding of psychological interventions **3 Investigations Include (if not done before or if diagnostic uncertainty):** Bloods X-ray MRI CT Bone Scan consider pathology (e.g. TB) **4 Management** Further physiotherapy / BIC (FRP) Flare up Plan Consider Third Sector support / services from Arthritis Care / NRAS / Expert Patient Programme Consider surgical interventions / injections **5 Outcome tools** MSKHQ
Thresholds for referral for Intervention Offer patient choice of provider	**Pain clinic** Chronic Neck Pain: Referral for radiofrequency denervation (RFD), consider when; • Non-surgical treatment not effective • Moderate to severe pain rated >5/10 NPRS • Symptoms from structures supplied by medial branch • or positive response to previous medial branch block / RFD (after 18 months) *Imaging is not a prerequisite for RFD in cases of chronic neck pain* Royal College Anaesthetists info for RFD **DO NOT** offer facet joint or trigger point injections for neck pain **Offer patient choice of provider: Note direct listing for cervical injections is not agreed** **Referral for surgical opinion** Consider offering surgery (*inc fusion and disc replacement*) for chronic neck pain
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	NECK PAIN Neck pain whiplash Acute
Primary Care Management	**Symptoms:** History of sudden pain or excessive neck extension, flexion, or rotation. Symptoms may be delayed for hours or days after the injury The two most common symptoms are: - Disabling neck pain, with or without referral to the shoulder or arm - Headache Additional symptoms include: - Fatigue - Dizziness - Paraesthesia - Nausea - Jaw pain - Posterior cervical sympathetic syndrome, including headaches or facial formication (sensation of ants crawling over the face) **Investigation:** - History - Examination and Assessment Examine for: • Signs of muscular spasm • Point tenderness • Neurological problems in the upper or lower limbs (Note: it is safe to assess for range of neck movements) **Attention to midline cervical tenderness as this may suggest fracture/ dislocation/ other serious injuries** **Exclude spinal cord compression (myelopathy) - if suspected refer to A&E** Assess for: • Presence of associated stress, anxiety, or depression and poor concentration • Look for psychosocial factors that indicate barriers to recovery and predispose that the acute injury could progress to a chronic problem • Concussion • Post-concussion syndrome • Memory loss **Management (including condition-specific self-care options):** - Patient education / information - Provide reassurance that whiplash-associated disorder is usually benign and self-limiting - Encourage early return to usual activities and early mobilisation – explain that usual activities may initially be painful, but this is not harmful or indicative of ongoing damage - Discourage rest, immobilisation, and the use of soft collars - Analgesia in line with agreed formularies / guidance - If Psychosocial factors present consider signposting to well-being services for CBT +/- pain management services. **This section will be updated when the pain service in Mid-Sussex have been agreed**

Thresholds for Primary Care to initiate a referral	**Manage in primary care first 6 weeks** **Refer to General Physiotherapy after 6 weeks** **Refer to Advanced Practitioner / Consultant Physiotherapy (ICATS) if:** - Progressive intractable pain - Dizziness - Unable to rotate head > 45 degrees (NICE, 2015) **If nerve pain suspected see brachialgia pathway**
Management Pathway for the Integrated MSK Service	**1 Patient information** **2 Assessment and examination (Advanced Practitioner / Consultant Physiotherapist)** Explore: - Education and early advice - Psychosocial factors - Counselling **3 Investigations** Include (if not done before or if diagnostic uncertainty): X-ray MRI Nerve Conduction Study Consider TB, and other medical presentations **4 Management** Further physiotherapy Sign posting to well-being services Consider offering referral to pain management programmes if progressing beyond 3/12 and psychosocial factors present Consideration of injection therapy – offer referral to pain clinic **This section will be updated when the pain service in Mid-Sussex have been agreed** **5 Outcome tools** Startback Tool EQ5D SURE
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	**N/A**

Spine Pathway group 4th December 2013

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