Pain Pathway (V8) 22.04.2019

REFERRALS

Referrals to the pain pathway should be considered following exclusion of serious pathology.

Please refer via this link: http://sussexmskpartnershipcentral.co.uk/for-health-professionals/referral-forms/

SELF-CARE AND SELF-MANAGEMENT

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

OUTCOME MEASURES

MSK HQ

USEFUL LINKS

Medicines Management

Brighton & Hove : https://www.gp.brightonandhoveccg.nhs.uk/prescribing

Horsham & Crawley and Mid Sussex : https://www.horshamandmidsussexccg.nhs.uk/your-health/medicines/

STarTBack Tool:

- https://www.keele.ac.uk/sbst/startbacktool/sbtoolonline/

Please note STarTBack score:

If low risk: try to manage in primary care for initial 6 weeks

If medium / high risk: consider self-referral to physiotherapy or onward referral ICATS services

Referral reason / Patient presentation	CERVICAL RADICULOPATHY RADICULAR ARM PAIN
Primary Care Management	**Please note:** **Many patients will improve within 6-12 weeks. Try to manage them in primary care.** **Be alert for new symptoms, red flags, and changes to the patient's normal presentation. Act accordingly.** **Biopsychosocial Assessment:** - History - Examination to include assessment for: Myotomal weakness, change in reflexes, change in sensation, +/- neurodynamics (ULTTs) **Management (If no significant motor loss of MRC grade 4 or above):** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Review analgesia in line with agreed formularies and local guidance, alongside national guidelines for managing neuropathic pain: https://www.nice.org.uk/guidance/cg173 - Promote maintenance of normal ADL's including work or supporting return to work. Consider referral to https://www.possabilitypeople.org.uk/ - Review any previously agreed flare up plans or develop a management plan with the patient - Consider sign posting to community based physical activity and exercise programmes. https://www.possabilitypeople.org.uk/ - Consider self-referral to physiotherapy - Consider sign posting to community based counselling services e.g. time to talk / wellbeing services
Thresholds for Primary Care to initiate a referral	**Refer to Physiotherapy** if not improving with primary care management **Urgent Referral to Advanced Practitioner (ICATS)** - If significantly deteriorating symptoms or high levels of distress - Multi-level myotomal weakness and/or loss of multi-segmental sensation - MRC grade for muscle strength drops to 3/5 or below **Routine referral to Advanced Practitioner (ICATS)** - Persistent pain - If unclear presentation and/or symptoms are unresponsive to conservative management **Note: if you are concerned please follow Advice and Guidance process to contact the MSK Service. Email: Brighton.mskpartnership@nhs.net**
Management Pathway for the Integrated MSK Service	**Assessment:** - History - Examination - Pain rating score (NPRS) - Consider differential diagnosis and refer to appropriate pathway guideline **Management:** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Offer local support services where appropriate for supported self-management - Consider referral to physiotherapy - Be aware of medication options as per local guidelines. Liaise ICATS prescriber if any queries from clinician or patient regarding optimising current analgesia, polypharmacy or any other concerns. Liaise as appropriate with GP. Consider sign posting to local pharmacy service.

	- Consider referral to other pathways as appropriate eg. MSK Spine, Rheumatology. - Consider referral for 1:1 Pain Practitioner and / or psychology support - Refer for consideration of a Pain Management Programme where all appropriate investigations and treatments have been explored. Patient must be willing to engage in a self-management approach - Consider MDT case review where appropriate
Thresholds for referral for Intervention Offer patient choice of provider	**Consider referral for cervical epidural injection when:** - Moderate - Severe radicular pain - Conservative management not effective https://sussexmskpartnershipcentral.co.uk/pain/ *All cervical injections need to be discussed with the lead pain consultant prior to referral.
Management pathway for Specialist In-patient care	**Consider referral for:** - Surgery as appropriate - Spinal cord neuromodulation
Referral reason / Patient presentation	**CHRONIC REGIONAL PAIN SYNDROME (CRPS)** CRPS is a chronic condition characterised by limb pain, and dysfunction with the motor, sensory and autonomic nervous systems. https://www.rcplondon.ac.uk/guidelines-policy/complex-regional-pain-syndrome-adults
Primary Care Management	**Please note: Be alert for new symptoms, red flags, and changes to the patient's normal presentation. Act accordingly.** **Biopsychosocial Assessment:** - History - Examination **Diagnosis:** - The diagnosis is based on clinical criteria (appendix one) and cannot be based on imaging or laboratory tests - Consider differential diagnosis (appendix two) - Prompt diagnosis and early treatment are considered best treatment in order to avoid secondary physical and psychological problems **Management:** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Consider early referral to physiotherapy - Review analgesia in line with agreed formularies and local guidance, alongside national guidelines for managing neuropathic pain: https://www.nice.org.uk/guidance/cg173 - Encouragement of gentle limb use and active lifestyle is recommended for all patients - Promote maintenance of normal ADL's including work or supporting return to work. Consider referral to https://www.possabilitypeople.org.uk/ - Consider sign posting to community based physical activity and exercise programmes. https://www.possabilitypeople.org.uk/ - Consider sign posting to community based counselling services e.g. time to talk / wellbeing services
Thresholds for Primary Care to initiate a referral	**Refer to Physiotherapy if** the referrer is certain that there is no identifiable underlying cause

	Early referral to ICATS pain triage: - For confirmation of diagnosis of CRPS - For moderate to severe presentation in symptoms - To exclude ongoing pathology (See appendix 2) - When pain treatment is unsuccessful (this is essential even if other management is ongoing E.G physiotherapy) **Routine referral to Advanced Practitioner (ICATS)** if persistent pain despite previous treatments **Note: if you are concerned please follow Advice and Guidance process to contact the MSK Service. Email: Brighton.mskpartnership@nhs.net**
Management Pathway for the Integrated MSK Service	**Biopsychosocial Assessment:** - History - Examination - Pain rating score (NPRS) - Consider differential diagnosis (appendix 2) and refer to appropriate pathway **Management** - Consider early referral to physiotherapy - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Offer local support services where appropriate for supported self-management - Be aware of medication options as per local guidelines. Liaise ICATS prescriber if any queries from clinician or patient regarding optimising current analgesia, polypharmacy or any other concerns. Liaise as appropriate with GP. Consider sign posting to local pharmacy service. - Consider referral to other pathways as appropriate - Consider referral for 1:1 Pain Practitioner and / or psychology support - Refer for consideration of a Pain Management Programme where all appropriate investigations and treatments have been explored. Patient must be willing to engage in a self-management approach - Consider MDT case review where appropriate
Thresholds for referral for Intervention Offer patient choice of provider	**Intravenous regional sympathetic blocks (IVRSB):** - Consider IVRSB following discussion with lead consultant *Please note: IVRSB with guanethidine should not be used routinely in the treatment of CRPS: https://www.rcplondon.ac.uk/guidelines-policy/complex-regional-pain-syndrome-adults
Management pathway for Specialist In-patient care	**Consider referral for:** - Spinal cord neuromodulation should be considered in patients who have not responded to appropriate integrated management.

Referral reason / Patient presentation	CHRONIC WIDESPREAD PAIN
Primary Care Management	**Please note: Be alert for new symptoms, red flags, and changes to the patient's normal presentation. Act accordingly.** **Biopsychosocial Assessment:** - Symptoms: Duration, sites, severity and frequency - History of fatigue, poor sleep, poor concentration, low mood - Function: ADLs - PMH/Co-morbidities/Peri-menopausal - The patient does not have a disorder that would otherwise explain pain - Rule out red flags and systemic symptoms i.e. rashes, fever, risk factors family history, smoking - Organ specific symptoms to exclude: systemic disease, depression, anxiety. PHQ9 and GAD7 may be helpful - Yellow flags (psycho-social): Work, relationships, leisure, QOL - Requires full examination including lymph nodes, breasts and thyroid **Diagnosis of Fibromyalgia (please follow fibromyalgia pathway)** This should be made in Primary care following these diagnostic criteria: https://www.rheumatology.org/FMS-diagnosis-criteria **Management:** - Patient education/information - Supported self-management and review as necessary. - Simple analgesics in line with agreed formularies/NICE guidance (avoid opioids) - https://www.brightonandhove/non-malignant-chronic-pain-prescribing - https://www.nice.org.uk/advice/ktt21 (Medicines optimisation in long-term pain) - Psycho-social support - Vitamin D supplementation as necessary - https://www.brightonandhove/Vitamin-d-prescribing (Prevention, Investigation and Treatment of Vitamin D Deficiency and Insufficiency in Adults) - Treat abnormal investigations as appropriate
Thresholds for Primary Care to initiate a referral	**Refer to Consultant Rheumatologist if:** - Evidence of synovitis - Investigations abnormal - Suspected inflammatory process **Refer to Advanced Practitioner (ICATS)** if unclear presentation and / or pain is unresponsive to conservative management **Urgent Referral to Advanced Practitioner (ICATS)** if significantly deteriorating symptoms or high levels of distress **Refer to Appropriate Speciality** if investigations are outside normal limits **Refer to Chronic Fatigue Syndrome Service** If appropriate. www.sussexcommunity.nhs.uk/CFS

Management Pathway for the Integrated MSK Service	**Assessment:** - Review holistic assessment - Consider differential diagnoses - Rule out red flags **Management:** - Patient education/information - Signposting for self-management advice - Medication management - Consider emotional wellbeing support - Consider Self-management programmes **Polymyalgia** See Polymyalgia pathway **Hypermobility Spectrum Disorder** See Hypermobility Spectrum Disorder pathway
Thresholds for referral for Intervention	**N/A**
Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	**Headaches** Headache disorders are classified as primary or secondary based on their clinical pattern or an underlying disorder. For further information regarding headache classification please refer to: **https://www.nice.org.uk/guidance/cg150** **https://www.ichd-3.org/** **Most common headache types can be diagnosed on clinical history and can be managed in primary care.** **Please note this pathway is for the management of primary tension type headaches, secondary cervicogenic headaches or occipital neuralgia. For all other headache types please consider referral to the appropriate pathway.**		
Headache Type	**Tension Type Headaches**	**Cervicogenic Headaches**	**Occipital Neuralgia**
Primary Care Management	**Biopsychosocial Assessment:** - History - Examination - Consider using a headache diary for a minimum of 8 weeks - Consider appropriate investigations as indicated https://www.nice.org.uk/guidance/cg150 **Management** - Review analgesia in line with agreed formularies and local / national guidance - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Promote maintenance of normal ADL's including work or supporting return to work. Consider referral to https://www.possabilitypeople.org.uk/ - Review any previously agreed flare up plans or develop a management plan with the patient - Consider sign posting to community based physical activity and exercise programmes. https://www.possabilitypeople.org.uk/ - Consider self-referral to physiotherapy - Consider sign posting to community based counselling services e.g. time to talk / wellbeing services	**Biopsychosocial Assessment:** - History - Examination - Consider using a headache diary for a minimum of 8 weeks - Consider appropriate investigations as indicated **https://www.ichd-3.org/** **Management** - Review analgesia in line with agreed formularies and local / national guidance - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Promote maintenance of normal ADL's including work or supporting return to work. Consider referral to https://www.possabilitypeople.org.uk/ - Review any previously agreed flare up plans or develop a management plan with the patient - Consider sign posting to community based physical activity and exercise programmes. https://www.possabilitypeople.org.uk/ - Consider self-referral to physiotherapy - Consider sign posting to community based counselling services e.g. time to talk / wellbeing services	**Biopsychosocial Assessment:** - History - Examination - Consider using a headache diary for a minimum of 8 weeks - Consider appropriate investigations as indicated **https://www.ichd-3.org/** **Management** - Review analgesia in line with agreed formularies and local / national guidance https://www.nice.org.uk/guidance/CG173 - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Promote maintenance of normal ADL's including work or supporting return to work. Consider referral to https://www.possabilitypeople.org.uk/ - Review any previously agreed flare up plans or develop a management plan with the patient - Consider sign posting to community based physical activity and exercise programmes. https://www.possabilitypeople.org.uk/ - Consider self-referral to physiotherapy - Consider sign posting to community based counselling services e.g. time to talk / wellbeing services

Thresholds for Primary Care to initiate a referral	**Refer to Physiotherapy** if not improving with primary care management **Refer to Appropriate Speciality** if investigations are outside normal limits **Refer to Advanced Practitioner (ICATS)** if unresponsive to conservative management	**Refer to Physiotherapy** if not improving with primary care management **Refer to Appropriate Speciality** if investigations are outside normal limits **Refer to Advanced Practitioner (ICATS)** if unresponsive to conservative management	**Refer to Physiotherapy** if not improving with primary care management **Refer to Appropriate Speciality** if investigations are outside normal limits **Refer to Advanced Practitioner (ICATS)** if unresponsive to conservative management
Management Pathway for the Integrated MSK Service	**Biopsychosocial Assessment:** - History - Examination - Consider differential diagnosis and refer to appropriate pathway guideline **Management** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Offer local support services where appropriate for supported self-management - Consider physiotherapy - Be aware of medication options as per local / national guidelines. Liaise ICATS prescriber if any queries from clinician or patient regarding optimising current analgesia, polypharmacy or any other concerns. Liaise as appropriate with GP. Consider sign posting to local pharmacy service. - Consider referral for 1:1 Pain Practitioner and / or psychology support - Consider MDT case review where appropriate	**Biopsychosocial Assessment:** - History - Examination - Consider differential diagnosis and refer to appropriate pathway guideline **Management** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Offer local support services where appropriate for supported self-management - Consider physiotherapy - Be aware of medication options as per local / national guidelines. Liaise ICATS prescriber if any queries from clinician or patient regarding optimising current analgesia, polypharmacy or any other concerns. Liaise as appropriate with GP. Consider sign posting to local pharmacy service. - Consider referral for 1:1 Pain Practitioner and / or psychology support - Consider MDT case review where appropriate	**Biopsychosocial Assessment:** - History - Examination - Consider differential diagnosis and refer to appropriate pathway guideline **Management** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Offer local support services where appropriate for supported self-management - Consider physiotherapy - Be aware of medication options as per local / national guidelines. Liaise ICATS prescriber if any queries from clinician or patient regarding optimising current analgesia, polypharmacy or any other concerns. Liaise as appropriate with GP. Consider sign posting to local pharmacy service. - Consider referral for 1:1 Pain Practitioner and / or psychology support - Consider MDT case review where appropriate
Thresholds for referral for Intervention Offer patient choice of provider	**Consider referral for myofascial trigger point injections when:** - Conservative management is not effective - When symptoms are thought to be of localised myogenic origin	**Consider referral for radiofrequency denervation (RFD) when:** - Conservative management not effective - Moderate to severe pain rated >5/10 NPRS - Symptoms suggestive of structures supplied by medial branch Repeated RFD (not to be offered sooner than 16 months) https://sussexmskpartnershipcentral.co.uk/pain/ ***Cervical MBB and RFD need to be discussed with the lead consultant prior to referral **Consider referral for myofascial trigger point injections when** - Conservative management is not effective - When symptoms are thought to be of localised myogenic origin	**Consider referral for greater or lesser occipital nerve block when:** - Conservative management is not effective - Localised tenderness +/- reproduction of symptoms on palpation of greater or lesser occipital nerve regions *Occipital nerve blocks need to be discussed with the lead consultant prior to referral

Management pathway for Specialist In-patient care	**N/A**	**N/A**	**N/A**
Management pathway for Specialist In-patient care	**LOW BACK PAIN** The term 'low back pain' is used to include any non-specific low back pain which is not due to cancer, fracture, infection or an inflammatory disease process. **https://www.nice.org.uk/guidance/ng59** (Guideline excludes sciatica)		
Primary Care Management	**Please note:** - **Many patients with low back pain will experience flare ups. These usually resolve within 6-12 weeks.** - **Be alert for new symptoms, red flags, and changes to the patient's normal presentation. Act accordingly.** **Assessment:** - History - Examination - Complete Risk Stratification STarTBack Tool: https://www.keele.ac.uk/sbst/startbacktool/sbtoolonline/ - Consider appropriate investigations as indicated **Management:** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Review analgesia in line with agreed formularies and local guidance, alongside national guidelines for managing neuropathic pain: https://www.nice.org.uk/guidance/cg173 - Promote maintenance of normal ADL's including work or supporting return to work. Consider referral to https://www.possabilitypeople.org.uk/ - Review any previously agreed flare up plans or develop a management plan with the patient - Consider sign posting to community based physical activity and exercise programmes. https://www.possabilitypeople.org.uk/ - Consider self-referral to physiotherapy - Consider sign posting to community based counselling services e.g. time to talk / wellbeing services		
Thresholds for Primary Care to initiate a referral	**Refer to Physiotherapy** if not improving with primary care management **Refer to Appropriate Speciality** if investigations are outside normal limits **Refer to Advanced Practitioner (ICATS)** if unclear presentation and / or low back pain is unresponsive to conservative management including physiotherapy **Urgent Referral to Advanced Practitioner (ICATS)** if significantly deteriorating symptoms or high levels of distress		

Management Pathway for the Integrated MSK Service	**Assessment:** - History - Examination - Pain rating score (NPRS) - STarTBack Tool if not yet completed: https://www.keele.ac.uk/sbst/startbacktool/sbtoolonline/ - Consider differential diagnosis and refer to appropriate pathway guideline **Management:** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Offer local support services where appropriate for supported self-management - Consider physiotherapy - Be aware of medication options as per local guidelines. Liaise ICATS prescriber if any queries from clinician or patient regarding optimising current analgesia, polypharmacy or any other concerns. Liaise as appropriate with GP. Consider sign posting to local pharmacy service. - Consider referral to other pathways as appropriate eg. MSK Spine, Rheumatology. - Consider radiofrequency denervation (RFD) following a successful medial branch block. - Consider referral for 1:1 Pain Practitioner and / or psychology support - Refer for consideration of a Pain Management Programme where all appropriate investigations and treatments have been explored. Patient must be willing to engage in a self-management approach - Consider MDT case review where appropriate
Thresholds for referral for Intervention Offer patient choice of provider	**Consider referral for radiofrequency denervation (RFD) when** - Conservative management not effective - Moderate to severe pain rated >5/10 NPRS - Symptoms suggestive of structures supplied by medial branch - Repeated RFD (Based on clinical judgement, but no sooner than 12 months)
Management pathway for Specialist In-patient care	**N/A**
Referral reason / Patient presentation	**LUMBAR RADICULOPATHY** **Radicular leg pain** **https://www.nice.org.uk/guidance/ng59**
Primary Care Management	**Please note:** **Many patients will improve within 6-12 weeks. Try to manage them in primary care.** **Be alert for new symptoms, red flags, and changes to the patient's normal presentation. Act accordingly.** **Patients presenting with Cauda equine, painful or non-painful foot drop, or quads palsy and/or weakness: See spinal pathway guidelines** **Biopsychosocial Assessment:** - History - Examination to include assessment for: Myotomal weakness, change in reflexes, change in sensation, +/- neurodynamics (SLR, PKB) - Complete Risk Stratification STarTBack Tool: https://www.keele.ac.uk/sbst/startbacktool/sbtoolonline/ **Management (If no significant motor loss of MRC grade 4 or above):** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Review analgesia in line with agreed formularies and local guidance, alongside national guidelines for managing neuropathic pain: https://www.nice.org.uk/guidance/cg173 - Promote maintenance of normal ADL's including work or supporting return to work. Consider referral to https://www.possabilitypeople.org.uk/

	- Review any previously agreed flare up plans or develop a management plan with the patient - Consider sign posting to community based physical activity and exercise programmes. https://www.possabilitypeople.org.uk/ - Consider self-referral to physiotherapy - Consider sign posting to community based counselling services e.g. time to talk / wellbeing services
Thresholds for Primary Care to initiate a referral	**Refer to Physiotherapy** if not improving with primary care management **Urgent Referral to Advanced Practitioner (ICATS)** - If significantly deteriorating symptoms or high levels of distress - Multi-level myotomal weakness and/or loss of multi-segmental sensation - MRC grade for muscle strength drops to 3/5 or below **Routine referral to Advanced Practitioner (ICATS)** - Persistent pain - If unclear presentation and/or symptoms are unresponsive to conservative management **Note: if you are concerned please follow Advice and Guidance process to contact the MSK Service. Email: Brighton.mskpartnership@nhs.net**
Management Pathway for the Integrated MSK Service	**Assessment:** - History - Examination - Pain rating score (NPRS) - Consider differential diagnosis and refer to appropriate pathway guideline **Management** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Offer local support services where appropriate for supported self-management - Consider physiotherapy - Be aware of medication options as per local guidelines. Liaise ICATS prescriber if any queries from clinician or patient regarding optimising current analgesia, polypharmacy or any other concerns. Liaise as appropriate with GP. Consider sign posting to local pharmacy service. - Consider referral to other pathways as appropriate eg. MSK Spine, Rheumatology. - Consider referral for 1:1 Pain Practitioner and / or psychology support - Refer for consideration of a Pain Management Programme where all appropriate investigations and treatments have been explored. Patient must be willing to engage in a self-management approach - Consider MDT case review where appropriate
Thresholds for referral for Intervention Offer patient choice of provider	**Consider referral for epidural injection when:** - Severe sciatica - Conservative management not effective https://sussexmskpartnershipcentral.co.uk/pain/
Management pathway for Specialist In-patient care	**Consider referral for:** - Surgery as appropriate - Spinal cord neuromodulation

Referral reason / Patient presentation	**NECK PAIN** The term 'neck pain' is used to include any non-specific neck pain which is not due to cancer, fracture, infection or an inflammatory disease process. https://cks.nice.org.uk/neck-pain-non-specific#!scenario
Primary Care Management	**Please note:** - **Many patients with neck pain will experience flare ups. These usually resolve within 6-12 weeks.** - **Be alert for new symptoms, red flags, and changes to the patient's normal presentation. Act accordingly.** **Biopsychosocial Assessment:** - History - Examination - Consider appropriate investigations as indicated **Management:** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Promote maintenance of normal ADL's including work or supporting return to work. Consider referral to https://www.possabilitypeople.org.uk/ if additional support is required. - Review any previously agreed flare up plans or develop a management plan with the patient - Consider sign posting to community based physical activity and exercise programmes. https://www.possabilitypeople.org.uk/ - Consider self-referral to physiotherapy - Consider sign posting to community based counselling services e.g. time to talk / wellbeing services - Review analgesia in line with agreed formularies and local guidance
Thresholds for Primary Care to initiate a referral	**Refer to Physiotherapy** if not improving with primary care management **Refer to Appropriate Speciality** if investigations are outside normal limits **Refer to Advanced Practitioner (ICATS)** if unclear presentation and / or neck pain is unresponsive to conservative management **Urgent Referral to Advanced Practitioner (ICATS)** if significantly deteriorating symptoms or high levels of distress
Management Pathway for the Integrated MSK Service	**Assessment:** - History - Examination - Pain rating score (NPRS) - Consider differential diagnosis and refer to appropriate pathway guideline **Management:** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Offer local support services where appropriate for supported self-management - Consider physiotherapy - Be aware of medication options as per local guidelines. Liaise with ICATS prescriber if any queries from clinician or patient regarding optimising current analgesia, polypharmacy or any other concerns. Liaise as appropriate with GP. Consider sign posting to local pharmacy service. - Consider referral to other pathways as appropriate eg. MSK Spine, Rheumatology. - Consider radiofrequency denervation (RFD) following a successful medial branch block.

	- Consider myofascial trigger point injections - Consider referral for 1:1 Pain Practitioner and / or psychology support - Refer for consideration of a Pain Management Programme where all appropriate investigations and treatments have been explored. Patient must be willing to engage in a self-management approach - Consider MDT case review where appropriate
Thresholds for referral for Intervention	**Consider referral for radiofrequency denervation (RFD) when:** - Conservative management not effective - Moderate to severe pain rated >5/10 NPRS - Symptoms suggestive of structures supplied by medial branch - Repeated RFD (not to be offered sooner than 16 months) https://sussexmskpartnershipcentral.co.uk/pain/ *****Cervical MBB and RFD need to be discussed with the lead consultant prior to referral **Consider referral for myofascial trigger point injections when:** - Conservative management not effective - When symptoms are thought to be of localised myogenic origin
Management pathway for Specialist In-patient care	**N/A**
Referral reason / Patient presentation	**THORACIC BACK PAIN** The term 'thoracic back pain' is used to include any non-specific thoracic back pain which is not due to cancer, fracture, infection or an inflammatory disease process
Primary Care Management	**Please note:** *** Many patients with thoracic back pain will experience flare ups. These usually resolve within 6-12 weeks.** *** Be alert for new symptoms, red flags, and changes to the patient's normal presentation. Act accordingly.** **Biopsychosocial Assessment:** - History - Examination - Consider appropriate investigations as indicated **Management:** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Promote maintenance of normal ADL's including work or supporting return to work. Consider referral to https://www.possabilitypeople.org.uk/ - Review any previously agreed flare up plans or develop a management plan with the patient - Consider sign posting to community based physical activity and exercise programmes. https://www.possabilitypeople.org.uk/ - Consider self-referral to physiotherapy - Consider sign posting to community based counselling services e.g. time to talk / wellbeing services - Review analgesia in line with agreed formularies and local guidance
Thresholds for Primary Care to initiate a referral	**Refer to Physiotherapy** if not improving with primary care management **Refer to Appropriate Speciality** if investigations are outside normal limits **Refer to Advanced Practitioner (ICATS)** if unclear presentation and / or low back pain is unresponsive to conservative management

	Urgent Referral to Advanced Practitioner (ICATS) if significantly deteriorating symptoms or high levels of distress
Management Pathway for the Integrated MSK Service	**Assessment:** - History - Examination - Pain rating score (NPRS) - Consider differential diagnosis and refer to appropriate pathway guideline **Management:** - Offer reassurance and direct patient to SMSKP website: https://sussexmskpartnershipcentral.co.uk/ - Offer local support services where appropriate for supported self-management - Consider physiotherapy - Be aware of medication options as per local guidelines. Liaise ICATS prescriber if any queries from clinician or patient regarding optimising current analgesia, polypharmacy or any other concerns. Liaise as appropriate with GP. Consider sign posting to local pharmacy service. - Consider referral to other pathways as appropriate eg. MSK Spine, Rheumatology. - Consider radiofrequency denervation (RFD) following a successful medial branch block. - Consider referral for 1:1 Pain Practitioner and / or psychology support - Refer for consideration of a Pain Management Programme where all appropriate investigations and treatments have been explored. Patient must be willing to engage in a self-management approach - Consider MDT case review where appropriate
Thresholds for referral for Intervention Offer patient choice of provider	**Consider referral for radiofrequency denervation (RFD) when** - Conservative management not effective - Moderate to severe pain rated >5/10 NPRS - Symptoms suggestive of structures supplied by medial branch - Repeated RFD (Based on clinical judgement, but no sooner than 12 months) https://sussexmskpartnershipcentral.co.uk/pain/
Management pathway for Specialist In-patient care	**N/A**

Appendix One

Budapest diagnostic criteria. Adapted from Harden et al (2007).	
All of the following statements must be met: • The patient has continuing pain which is disproportionate to any inciting event • The patient has at least one sign in two or more of the categories below • The patient reports at least one symptom in three or more of the categories below • No other diagnosis can better explain the signs and symptoms	
Category	**Sign/Symptom**
1- 'Sensory'	Allodynia (pain to light touch and/or deep somatic pressure and/or joint movements) and/or hyperalgesia (to pinprick)
2- 'Vasomotor'	Temperature asymmetry and/or skin colour changes and/or skin colour asymmetry
3- 'Sudomotor/oedema'	Oedema and/or sweating changes and/or sweating asymmetry
4- 'Motor/trophic'	Decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail skin)

Appendix Two

Differential diagnosis of complex regional pain syndrome (CRPS). Adapted from: https://www.rcplondon.ac.uk/guidelines-policy/complex-regional-pain-syndrome-adults

- Infection (bone, soft tissue, joint or skin)
- Orthopaedic mal-fixation
- Joint instability
- Arthritis or arthrosis
- Bone or soft tissue injury (including stress fracture, instability or liganment)
- Compartment syndrome
- Neural injury (peripheral nerve damage, including compression or entrapment, or central nervous system or spinal lesion)
- Thoracic outlet syndrome
- Arterial insufficiency (usually after preceding trauma, atherosclerosis in older people or thrombangitis obliterans (Burger's disease)
- Raynaud's disease
- Lymphatic or venous obstruction
- Gardener-Diamond syndrome
- Brachial neuritis or plexus (parsonage-Turner syndrome or neuralgic amyotrophy)
- Erythromelalgia (may include all limbs
- Self-harm