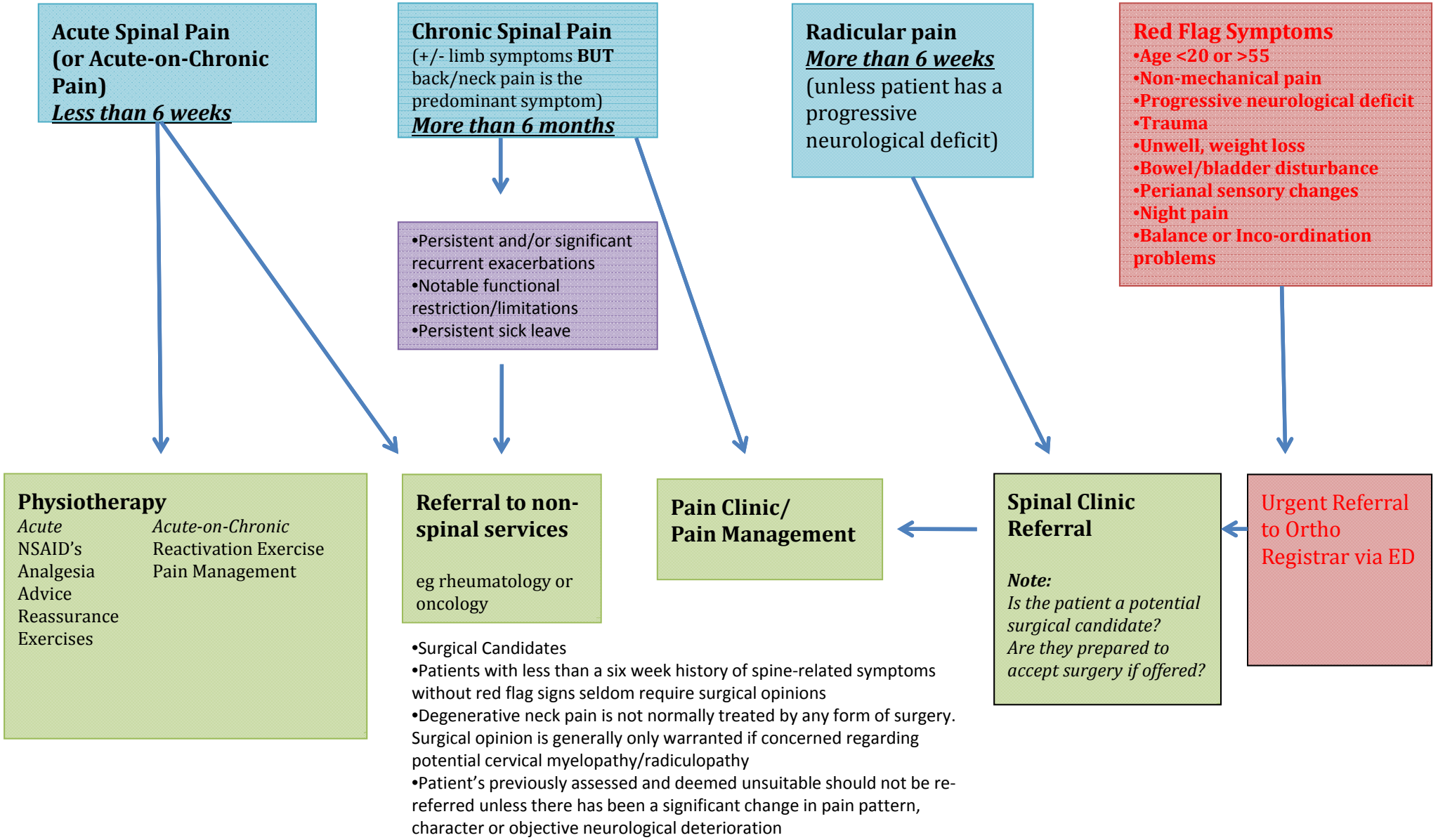
Algorithm for Cervical Spinal Patients



•Surgical Candidates
•Patients with less than a six week history of spine-related symptoms without red flag signs seldom require surgical opinions
•Degenerative neck pain is not normally treated by any form of surgery. Surgical opinion is generally only warranted if concerned regarding potential cervical myelopathy/radiculopathy
•Patient's previously assessed and deemed unsuitable should not be re-referred unless there has been a significant change in pain pattern, character or objective neurological deterioration

Explanatory Notes

•The flow chart is designed to give clinicians (GPs and Physiotherapists) an 'at a glance' look at the referral and management pathway for patients with low back/neck pain and referred leg/arm pain to Out Patient Services. The chart is designed to follow the four scenarios of acute back/neck pain, chronic back/neck pain (both of which can include referred leg/arm pain) and where leg/arm pain predominates the symptomatology (radicular or stenotic pain) and Red Flags. This then allows clinicians to 'signpost' to the appropriate pathway. Please note that back/neck pain whether acute or chronic can present with somatic referred leg/arm pain and unless a trial of conservative physiotherapy has been made, then these patients should first be referred to physiotherapy. If this has failed or the back/neck or leg/arm pain 'picture' is too severe then refer to the Out Patient Services.

•It is important to note that triage and assessment for spinal pain is a multi-dimensional problem, involving both physical and psychosocial characteristics, so the chart is a guide and no substitute for sound clinical reasoning and flexibility in each individual patient case. Also onward referral to the surgical team is only appropriate if the patient is willing to consider surgery. Referral on to the surgical team for discussion on surgery is appropriate in cases where the patient is undecided, but there are clear clinical reasons for surgery.

•It is important for clinicians to be able to differentiate between true radicular pain from probable disc protrusion (and more likely to respond to surgical input) and somatic referred pain that can arise from many other pain generating structures within the spine. Although both states can combine in a patient, differentiation is important. The following chart for identifying symptomatic disc herniation with nerve root involvement may be useful.

Radicular Symptoms/Signs

•Unilateral leg/arm pain in a typical sciatic root distribution below the knee (severe and shooting often felt along a narrow strip)
•Specific limitation of straight leg raising by at least 50% of normal, with reproduction of leg pain
•Segmental motor deficit
•Segmental sensory change
•Hyporeflexia
•Acute kyphotic/and or scoliotic deformity
•Imaging evidence of a disc protrusion at the relevant level

Somatic Symptoms

•Vague, deep, dull aching, difficult to localise the source
•Felt more closely related to the myotomes rather than dermatomes
•Straight leg raise normal
•No segmental motor deficit
•No segmental sensory deficit
•Normal reflexes
•No acute deformity