Bucks MSK

Spinal pain GP management
Mechanical Neck/Back pain
No Radicular Pain

Assessment

- Pain without paraesthesia / motor weakness / no definitive radicular symptoms
- Screen for 'Red Flags'/ severity of pain / impact on function, lifestyle, employment (see NICE guidelines, links in Appendix)
- Use StarT Back tool (LBP) for all patients to assess risk of chronicity
- If patient develops neuropathic pain or nerve root pain – follow 'Radiculopathy Pathway'
- If serious pathology is suspected e.g. Trauma, Spinal infection*, Cauda Equina Syndrome, Red Flags* Speak to on call Orthopaedic Team (same day direct referral may be needed).
- Inflammatory back pain: age <40 years, morning stiffness>30 min, better with exercise, alternating buttock pain, FH of AS, psoriasis, IBD, anterior uveitis. Consider checking CRP/ESR and HLA-B27 and direct referral to Early Arthrtiis Clinic via ERS. Treat with NSAIDs + PPI

Early management

(must be attempted prior to any referral to iMSK)

- Appropriate to recommend self-management if no history of significant trauma, no red flags, no radicular symptoms and no unsteadiness when walking and patient able to self-manage pain
- Consider self-management for low risk group according to StarT Back tool and early referral for moderate-high risk group.
- NSAID's with PPI Cover - 1st line and over the counter Co-codamol
- Advise – maintain mobility and give 'Understanding LBP' leaflet (see links below)
- Reassure patient - most settle within 6 weeks
- Explain imaging may not be indicated
- If symptoms deteriorate despite analgesia: GP to perform physical examination and exclude red flags
- Consider blood tests
- If pain significantly impacting work / mobility and no response to early management – referral to iMSK
- Give safeguarding advice re: red flags

Referral to Bucks MSK:

- On-going pain and dysfunction; failure to respond to early management intervention > 6 weeks
- Refer: GP referral, via e-RS

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Spinal pain GP management

Neck-Back Pain – Radiculopathy

Assessment

- Should always be assessed clinically face to face
- Often pain, sensory disturbance and or weakness in lower limb(s) with a dermatomal distribution.
- May only be in thigh (upper lumbar nerve roots) or buttock.
- Assess Neurology (paraesthesia, motor changes)
- Assess Severity - consider impact on lifestyle
- Red Flags: Bilateral symptoms, S&S of cord compression, Cauda Equina Syndrome (see NICE guidelines link in appendix)
    - Speak to on call Orthopaedic Team (same day direct referral maybe required)
    - Severe or progressive motor weakness may also require direct referral to Orthopaedics (urgent)

Early management

(must be attempted prior to any referral to iMSK)

- If radicular symptoms are not significant (no weakness or numbness), then the management should be similar to 'Mechanical LBP pathway' with the addition of:
    - o Consider neuropathic medication https://cks.nice.org.uk/neuropathic-pain-drug-treatment
- Advise – maintain mobility and give 'Understanding LBP' leaflet (see link below)
- Early referral to iMSK if:
    - Severe pain 2-6 weeks, foot drop
    - Non-tolerable pain>6 weeks
    - *Explain imaging may not be indicated*

Referral to Bucks MSK:

- On-going pain and dysfunction; failure to respond to early management intervention > 6 weeks
- Refer: GP referral, via e-RS

Bucks MSK

Spinal pain GP management

- NICE Guidelines – Red flags:
    - LBP no radiculopathy: https://cks.nice.org.uk/back-pain-low-without-radiculopathy
    - LBP with radiculopathy: https://cks.nice.org.uk/sciatica-lumbar-radiculopathy
    - Neck pain: https://cks.nice.org.uk/neck-pain-non-specific
    - Neck pain with radiculopathy: https://cks.nice.org.uk/neck-pain-cervical-radiculopathy
    - Myelopathy:
        - 'Red flags' that suggest compression of the spinal cord (myelopathy):
        - Insidious progression.
        - Neurological symptoms: gait disturbance, clumsy or weak hands, or loss of sexual, bladder, or bowel function.
        - Neurological signs:
        - Lhermitte's sign: flexion of the neck causes an electric shock-type sensation that radiates down the spine and into the limbs.
        - Upper motor neuron signs in the lower limbs (Babinski's sign — up-going plantar reflex, hyperreflexia, clonus, spasticity).
        - Lower motor neuron signs in the upper limbs (atrophy, hyporeflexia).
        - Sensory changes are variable, with loss of vibration and joint position sense more evident in the hands than in the feet.
- *For patients with red flag symptoms suggestive of infection or malignancy following blood tests would be helpful: FBC, CRP, LFTs, UEs, bone profile, myeloma screen , PSA in male patients

PPG0286 Nov 20 (0049)