The North of England Regional Back Pain and Radicular Pain Pathway

10th February 2015

Introduction

According to NICE guidance (CG 88, May 2009), low back pain is common and affects one third of the adult population each year, or which up to 20% will consult their GP[1].
Approximately 30 million days were lost from work in 2011 as a result of MSK problems[2]. Low back pain is the largest single cause of disability in the UK[6]
It has been estimated that the lifetime prevalence of low back pain is reported to be as high as 84%, and the prevalence of chronic low back pain is about 23%, with 11—12% of the population being disabled by low back pain[3].

No clearly defined pathway

In the North of England, this was no consensus as to which pathway these patient should use. Elsewhere, attempts have been made to implement a process of streamlining patient to the therapies most likely to resolve their problems. The starting point for triaging patients is the STarT Back screening tool[4], developed in 2008. This was designed to screen primary care patients for prognostic factors relevant to initial decision-making. Subsequently a randomised controlled trial demonstrated an improvement in quality of health as well as a cost benefit[5]. The fundamental principle for managing what is best described as a public health epidemic is to make the primary care services the gateway and starting point of any management process. Strict adherence to this process will prevent patients 'escaping' to therapies that have no benefit.
For this reason, as will be seen later, the thrust of this current initiative was to devise a pathway, based on validated triage methods, centred in primary care and designed to be user-friendly.

Regional discussions

The Planned Care Clinical Innovation Team (CIT) had already identified variation in spinal surgery across the region as a significant problem, but quickly appreciated to address this issue, addressing management much earlier in the patients' pathway is the most likely way to succeed. This could only be effective if the pathway in primary care was appropriate.
The Northern CCG Forum, which has both clinical and managerial representation of the North East and Cumbria CCGs, agreed to adopt the work in the early part of 2013 under the umbrella of the emerging Clinical Networks and test a potential framework for wider pathway development where it made sense to do so, with the support of the Clinical Networks and benefits of regional Commissioning Support Service.
The network held a back pain scoping event on 21st March 2013 at Newcastle Racecourse, which was attended by approximately 80-100 GPs, physios, pain management specialists, orthopaedic surgeons and neurosurgeons.
Significant progress was made on what a future pathway should look like. A small steering group was involved in finalising this pathway.

Rationale for Regional pathway

- Avoiding post code lottery and common and consistent approach strong lever with providers who may need to shift practice.
- Combined Physical and psychological program recommended by NICE will require commissioning of the program by a number of CCGs to be practical due to relatively small numbers of patients who will be eligible
- Implementation may be easier with a common commissioning support service.

Key features of the pathway

- In scope- both simple mechanical low back pain and acute radiculopathy
- Out of scope -chronic back pain management interventions and non- mechanical back pain.
- Preventative public health programme an important element of back pain strategy and "normalisation " of simple mechanical back pain
- Re-training of health professionals to "de-medicalise" simple back pain
- Agreed standardisation of patient literature.

- Use of Keele University STarT Back screening tool for patients on 2nd GP attendance with acute episode back pain to stratify risk and determine management, fast-tracking individuals most likely to become chronic. Treatment should be prioritised to moderate/severe group.
- As up to 80 % of simple mechanical back pain episodes resolve in 6 weeks and poor evidence for manual treatment during these episodes, defer simple therapies to after 6 weeks.
- For those still exhibiting significant disability/distress (criteria established by consensus) then assessment by a specialist spinal triage and treat practitioner (Appendix 1) to identify red flags, identify radicular pain and mange patients on CBT principles. The pathway will be managed in primary care by this practitioner.
- Offer one (or occasionally more) of three approved simple therapies (Manual therapy, group exercise therapy, acupuncture), with formal review by the practitioner who will maintain overall direction of the management plan.
- Offering a Combined Physical and Psychological Programme (CPPP) (100 hours over 3-8 week period, Appendix 2) to those patients failing to improve sufficiently.
- No direct referral to a spinal surgeon for chronic mechanical back pain without passage through a CPPP.
- For acute radiculopathy, improve management and rapidity of access to epidural injection or nerve root block as an option for conservative management of and rapid access to a spinal surgeon if surgery required.
- No x-rays of backs by GPs or other professionals and no direct access to MRIs by GPs unless red flags present. Urgent assessment by Spinal triage and treat practitioner should be 1st line.
- Agree intended outcomes and KPIs on the various elements of the pathway including patient feedback.

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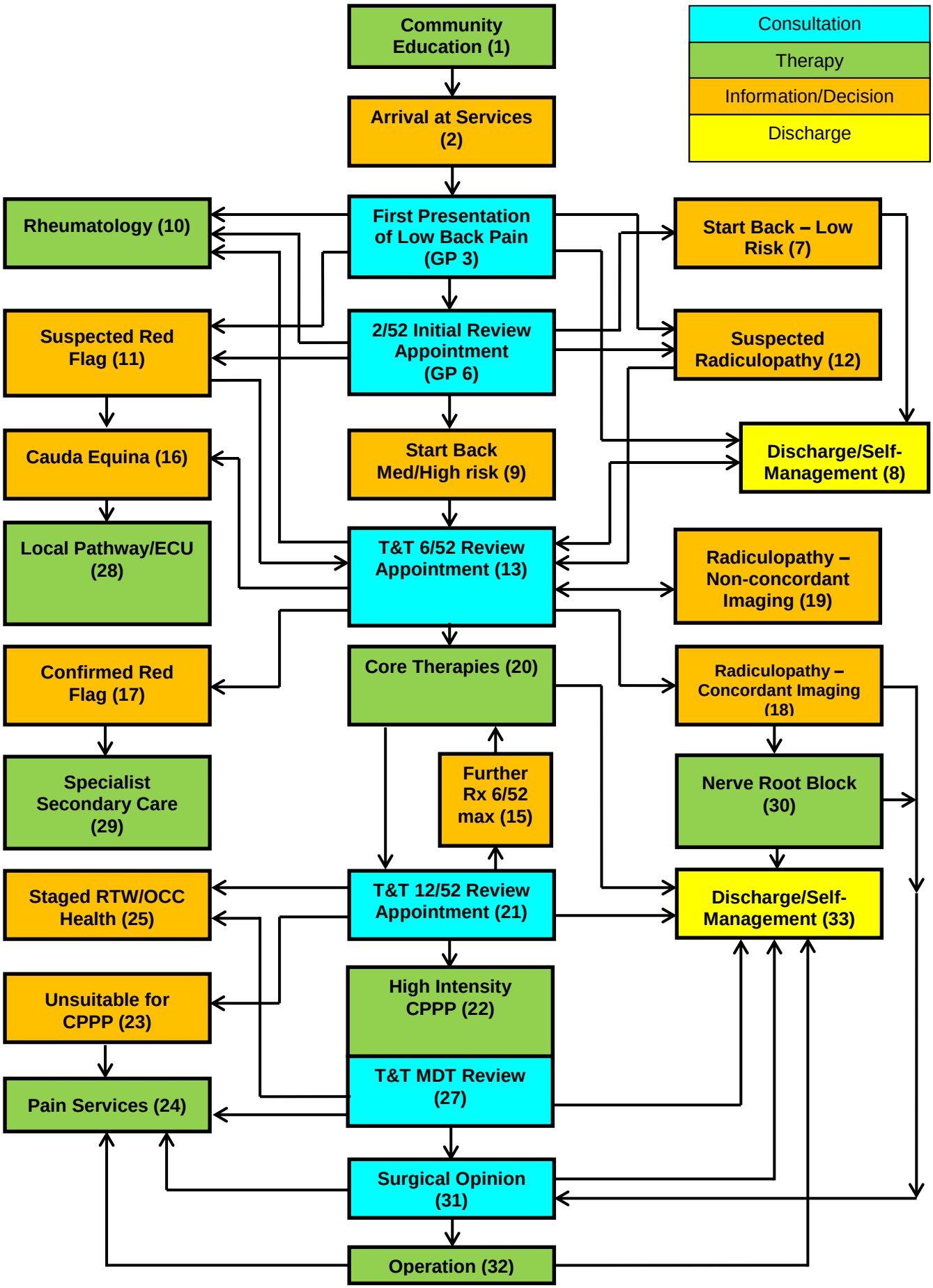
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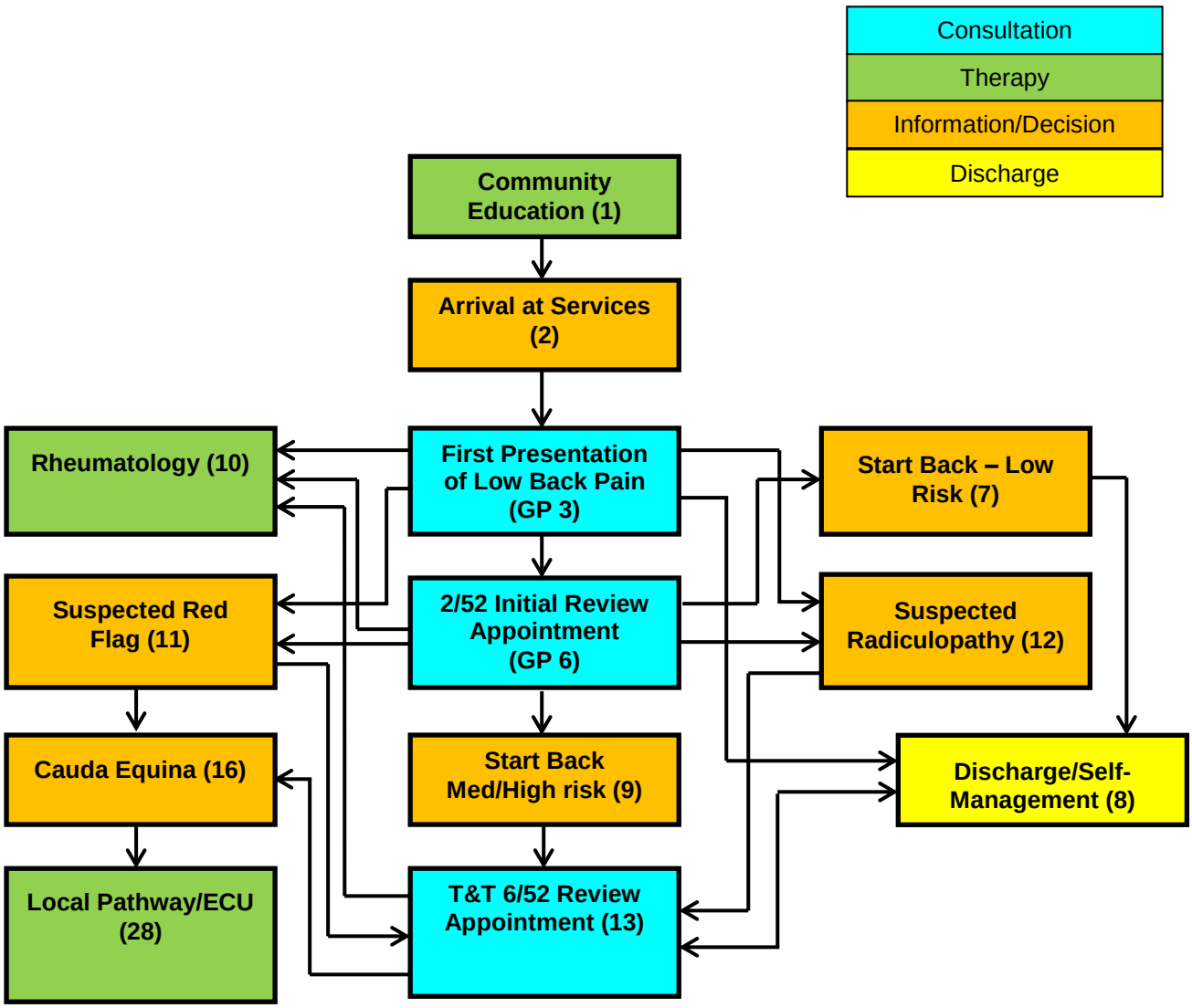
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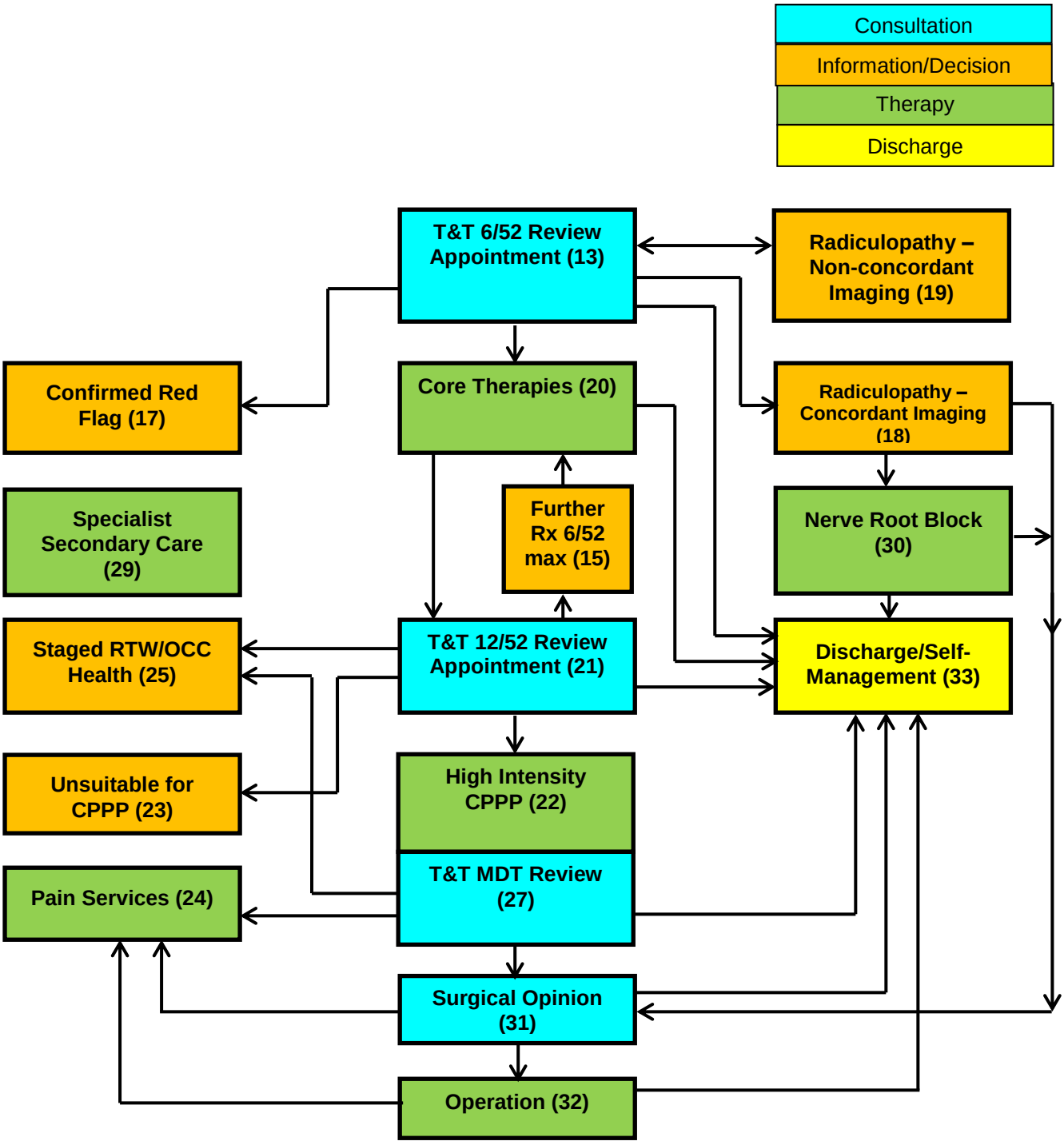
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Box 1 - Community Education

Quick info:

All first contact providers should be made aware of pathway and have appropriate education of salient points.

Material in public domain to emphasise common condition, vast majority no serious cause, most get better within 6 weeks. Maintain normal life including work, keeping active, and limit resting. Simple pain killers.

Box 2 - Arrival at services 111/GP/ECU/Self refer

Flowchart Contents

Quick info:

All first contact providers should be made aware of pathway and have appropriate education of salient points.

Box 3 - First Presentation Initial Management

Flowchart Contents

Quick info:

This care map is intended for acute/persistent spinal pain, including radicular pain.
Screen for: cauda equina, red flags.
First contact clinician should have telephone access to advice from spinal Triage and Treat Practitioner (specialist nurse /physiotherapist) as locally configured (13) to help clinician decide appropriate pathway.
Take a history - ask about local /referred leg pain, radicular pain, bladder/bowel/sexual dysfunction, systemic symptoms, yellow flags, impact on family, social and work ability
Perform physical examination - Observation of spine, lower limbs, gait, and pain behaviour.
Neurological examination looking for neurological signs.

Try to identify:

- Cauda equina- current or imminent compression of the Lumbo-sacral nerve roots resulting in neurogenic bladder and bowel dysfunction (details box 16). Immediate (same day) secondary care referral.
- Significant **new** neurological deficit - new/progressive neurological deficit (details box 11). Immediate (same day) secondary care referral.
- Spinal infection (details box 11). Immediate (same day) secondary care referral.
- Spinal metastases (details box 11). Refer to secondary care under two week rule or Triage and Treat Practitioner within 5 days.
- Osteoporotic fracture (details box 11). Refer to secondary care urgently (2 weeks) or Triage and Treat Practitioner within 5 days.
- Nerve root pain (details box 12). Refer to Triage and Treat Practitioner, urgently if appropriate.
- Inflammatory Disorders (box 10). Refer to Rheumatology
- Vascular pain

Do not request plain x-rays or MRI- Fast track Red flags (see Box 11) for appropriate opinion/ specialist care.

Mechanical Back Pain

Quick info:
Management:

- Reassurance
- Stay active
- Avoid medicalising patient
- Return to work ASAP
- Offer analgesics NSAI or topical agents, weak opiods such as Codeine. Stronger opiods only for short planned courses, and not for longer term.
- Patient information - back book/ on-line info (Sheffield online advice?)
- Review 2/52 (6) if symptoms not making sufficient improvement.

Self-Management: Patient information (Box 1), GP or over the counter medication, Self-directed exercise programme, Self-directed relaxation techniques, Self-directed return to normal social and activities

Box 6 – 2/52 Review Appointment Complete STarT Back

Flowchart Contents

Quick info:

- Patient reviewed at 2/52 by initial clinician.
- Repeat history, examination and assessment from initial assessment ((box 3).
- Review red flags.
- Review radicular symptoms or signs.
- Mechanical back pain use STarT Back tool http://www.keele.ac.uk/sbst/
    - Low risk (7) - single biopsychosocial CBT based advice session by GP or clinician of first contact.
    - Advice to return if not settled to Spinal Triage and Treat Practitioner (13).
- Medium /high risk- refer to approved Triage and Treat Practitioner (13) for management using biopsychosocial approach.
    - If > 6 weeks from onset may be referred for one of three approved therapies (manual therapy (max 8-10 sessions over 6 weeks), exercise therapy, acupuncture) and then reviewed at (21).
    - If less than 4 weeks to be reviewed at (13 (6/52)).
- Do not request plain x-rays or MRI- Fast track Red flags (see Box 11) for appropriate opinion/ specialist care.

Triage and Treat Practitioner should be able to refer for secondary care opinion at any stage if there is a deterioration/change in patient symptoms

Box 7 – STarT Back - Low Risk

Flowchart Contents

Quick info:

Low risk - single biopsychosocial CBT based advice session by GP or clinician of first contact.

Management:

- Reassurance - Improvement is likely, explanation of signs and symptoms, distinction between hurt and harm
- Avoid medicalising patient
- Advice about continuation of normal activities, including work, or return to normal activities using graded steady increases, Stay active including work return to work ASAP
- Offer analgesics NSAI or topical agents, weak opiods such as Codeine. Stronger opiods only for short planned courses, and not for longer term.
- Information that recurrence is often seen, and can be managed by the patient
- Self-Management - Self-directed exercise programme, Self-directed relaxation techniques, and Self-directed return to normal social and occupational activities
- Indications for early clinical review and emergency attendance
- Patient information - back book/ on-line info
- Advice to return if not settled to Spinal Triage and Treat Practitioner

Box 8 – Discharge/Self-management (also 33)

Flowchart Contents

Quick info:

- Reassurance - Improvement is likely, explanation of signs and symptoms, distinction between hurt and harm
- Avoid medicalising patient
- Advice about continuation of normal activities, including work, or return to normal activities using graded steady increases, Stay active including work return to work ASAP
- Information that recurrence is often seen, and can be managed by the patient
- Self-Management - Self-directed exercise programme, Self-directed relaxation techniques, and Self-directed return to normal social and occupational activities
- Indications for emergency attendance
- Patient information - back book/ on-line info/ARUK leaflets, exercises

Box 9 – STarT Back - Medium/High Risk

Flowchart Contents

Quick info:

- The Keele Start Back Tool is a tool to stratify care/intervention dependant on the patient's risk of developing chronic symptoms (high risk = high risk of chronicity).
- Patients with medium/or high risk on STarT back tool should be referred for specialist opinion from Triage and Treat clinician who will decide appropriate intervention dependant on patient individual requirements and situation using a biopsychosocial approach.

Box 10 – Rheumatology

Flowchart Contents

Quick info:

Suspected Rheumatology Spondyloarthropathy

- Younger patient
- Thoracolumbar or sacroiliac pain
- Prolonged early morning stiffness
- Waking early hours, pain in second half of night
- Persisting limitation spinal movements in all directions
- Peripheral joint involvement
- Symptoms improve with exercise
- Systemic symptoms - uveitis, IBS, psoriasis, enthesopathies

Routine referral to secondary care 4-6 weeks

If inflammatory disorder is not found, Rheumatologist to refer back to Triage and Treat Practitioner.

Box 11 – Suspected Red Flag

Flowchart Contents

Quick info:

Red flags:
The red flags were introduced in 1994 in the CSAG report. They comprise a number of symptoms and signs which have been associated with increased risk of underlying serious conditions. Recently some doubt has been cast on the sensitivity and specificity of the flags but they remain useful shorthand for clinicians to maintain awareness of possible serious pathology.

- Age <16 or >60 with new onset back pain
- Unrelieved pain – continuous night pain
- History of Cancer
- Recent Unexplained weight loss
- Prolonged steroid use
- Objectively unwell with spinal pain
- Infection - fevers/rigors
- Immunosupression with new spinal pain
- Raised inflammatory markers
- Urinary incontinence /retention faecal incontinence
- Altered perianal sensation, (reduced anal tone and squeeze – if circumstances permit)
- •Change in sexual function
- •Limb weakness

Assessment by Spinal Triage and Treat Practitioner (Same Practitioner as Box 13).

Significant **new** neurological deficit - new/progressive neurological deficit,
(Cauda Equina see box 16):

- Multilevel weakness in the arms/legs
- Gait disturbance
- Hyper-reflexia
- Clonus
- Positive Babinski (up-going plantar response)
- Bilateral sciatica
- Acute urinary disturbance
- Saddle anaesthesia
- Reduced/absent anal tone
- Reduced/absent anal contraction
- New /progressive spinal deformity
- Urinary retention

Then same day referral to secondary care specialist.

Spinal infection:

- Objectively unwell - fever
- IV drug use
- Recent infection
- Immunocompromised patient (steroids, diabetes, biologics, transplant)
- Raised inflammatory markers

Then same day referral to secondary care specialist.

Spinal metastases:

- History of Cancer
- Unexplained weight loss
- Progressive non mechanical pain
- Thoracic spine pain
- Progressive night pain

Suspected unstable fracture:

- Severe low back pain following significant trauma

Osteoporotic fracture:

- Sudden onset
- Minor trauma
- Age
- Osteoporosis
- Recent deformity

If Triage and Treat Practitioner suspects serious destructive pathology, urgent investigation (protocol led MRI/bloods) and referral (5 days) should be made to appropriate secondary care spinal specialist / surgeon / oncologist.

Box 12 – Suspected Radiculopathy

Flowchart Contents

Quick info:

Radicular /nerve root pain:

- Pain radiating below knee often to foot /toes with approx dermatomal distribution
- Shooting/electric shock, paraesthesia, numbness
- Neurological deficit
- Muscle weakness
- Numbness
- Tingling
- Loss/altered reflexes
- Restricted straight leg raise

Assessment by Spinal Triage and Treat Practitioner (Same Practitioner as Box 13).

- Severe pain with unilateral neurology not responding to conservative treatment.
- Consider Imaging for Severe radicular pain at 2-6 weeks depending on severity and improvement, or for non-tolerable radicular pain at 6 weeks
- If imaging concordant and symptoms progressive or persist, fast track to nerve root block / spinal surgical opinion within 8 weeks of onset.
- Progressive motor deficit (e.g. foot drop) - urgent referral to Spinal Surgery Service or urgent MRI

Box 13 – Spinal Triage & Treat Practitioner Review – 6/52

Flowchart Contents

Quick info:

Review at 6 weeks by Triage and Treat Practitioner for mechanical back pain.
Review earlier for radicular pain, suspected red flags as appropriate
The function of the triage and treat practitioner is to direct the pathway of care and provide continuity of care across the pathway. It is important that this will be the same clinician as box 12, 21 and 27.

This clinician is highly trained and has significant skills, competencies and high autonomy. They have a major role in the:

- Identification and referral of emergency spinal presentations
- Identification, investigation and referral of urgent spinal presentations.
- Identification and discharge of patients who can self manage
- Identification, investigation and referral of radicular pain,
- Identification and referral of inflammatory disorders.
- Identification and referral of back pain related disability
- Identification, investigation and referral of potential surgical candidates with severe radicular pain or axial back pain (who have optimised non-surgical options).

In some instances the triage practitioner might be bypassed but it is to this practitioner that the pathway will return to if there is insufficient response to treatment or concerns are raised about diagnosis or any other matter.

Practitioner should be trained in biopsychosocial approach and be able to incorporate this into clinical practice. The Biopsychosocial approach includes knowledge of: anatomy, biomechanics, tissue pathology, pain mechanisms (input, processing and output dominant mechanisms), representation, evolutionary biology, psychosocial issues, and fear avoidance.

Therapist can use any modality or treatment technique which they feel appropriate to help facilitate more normal function and movement whilst also addressing the patient's pain experience. Patient should be treated with an activity based scientific approach, challenging myths and avoiding medicalising the patient.

They should have comprehensive access to request and review all appropriate investigations including blood tests, X-ray, U/S, MRI, CAT scans and have the appropriate skills to interpret all findings and help the patient choose the most appropriate course of action.
To facilitate emergency /urgent/routine referrals to secondary care they should have a close professional relationship with primary care services, radiology and spinal/neuro surgery services allowing streamlined and comprehensive care of all back pain patients.

Patients may be directed:

- Self management (Box 8)
- Inflammatory Diseases (Box 10)
- Core therapies including low intensity CPP (Box 20)
- Radicular pain pathway (Box 12)
- Specialist Pain Service (Box 24)

Reviewed as necessary at box 21.

Box 15 – Further Rx Core Therapies

Flowchart Contents

Quick info:

- It may be considered that trial of a second of the core therapies would be appropriate in some patients
- This should not exceed 6 weeks of additional therapy
- Further information available in Box 20

Box 16 – Cauda Equina

Flowchart Contents

Quick info:

Emergency referral to secondary care to access urgent investigations and spinal/neuro surgeon opinion (same day). Local pathway agreement via emergency care or direct access to spinal specialist.

- Bilateral leg pain,
- Bilateral sensory or motor changes in the legs,
- Perineal sensory alteration,
- Reduced/absent anal tone
- Reduced/absent anal contraction
- Difficulty or inability to initiate micturition/urinary retention/change in sexual function,
- Urinary incontinence without awareness,
- Inability to move bowels and alteration of sensation.

Box 17 – Confirmed Red Flag

Quick info:

As box 11

Box 18 – Radiculopathy – Concordant Imaging

Flowchart Contents

Quick info:

If imaging concordant and symptoms progressive or persist, and patient wishes to consider therapy, fast track to nerve root block / spinal surgical opinion within 8 weeks of onset.

Box 19 – Radiculopathy – Non-concordant Imaging

Flowchart Contents

Quick info:

If radicular / nerve root pain is found following appropriate examination and investigation by Spinal Triage and Treat Practitioner, but neurological symptoms are not found to have concordant imaging results then the MRI and clinical details should be reviewed at the Spinal MDT.
Patients should be managed conservatively under the supervision of the Spinal Triage and Treat Practitioner.

Box 20 – Core Therapies

Flowchart Contents

Quick info:

Referral for one of three approved therapies (manual therapy (8-10 sessions over 6 weeks), exercise therapy, acupuncture).
Practitioner should be trained in Biopsychosocial approach and be able to incorporate this into clinical practice. Patient educational material, formal or informal, should reinforce the pathway message.

The Biopsychosocial approach includes knowledge of: anatomy, biomechanics, tissue pathology, pain mechanisms (input, processing and output dominant mechanisms), representation, evolutionary biology, psychosocial issues, and fear avoidance.

A package of care tailored to the individual in terms of treatment options and frequency of treatment delivery will be considered taking account of patient expectations and preferences. Low back pain related distress, anxiety, fears, beliefs and expectations should be addressed as an integral part of the package of care.

It is anticipated that the number of treatment consultations will vary between patients with many needing short periods of care. If necessary, core treatments may be used up to the limit indicated below. After this dedicated review should take place e.g. Triage investigation and Treatment practitioner or referral to specific services relevant as indicated in the pathway. Potential treatment options with indicative suggestions of frequency and duration are listed below:

- Acupuncture: Up to 10 sessions over a period of up to 12 weeks
- Manual therapy: Including mobilisation, massage and spinal manipulation up to 9 sessions over a period of up to 12 weeks.
- Exercise: Structured exercise group programme up to 8 sessions over 12 weeks: aerobic activity, movement instructions, muscle strengthening postural control and stretching.

One to one if group is not available or appropriate
Discharge on satisfactory response (box 8) including ability for patient to return to GP or triage practitioner if persistent concerns exist.

Referral to RTW / Occ. Health (box 25), triage service for review (box 21)
Physical practitioner should have close relationship with Spinal Triage and Treat Practitioner and be able to refer for an opinion at any stage if there is any deterioration/change in the patient's symptoms.

For standard referrals patients should be seen within 2 weeks subject to patient choice (patients with intermittent pain, mild to moderate reduction in function and activities of daily living).
For urgent referrals patients should be seen within 72 hours subject to patient choice (patients dependent on strong analgesics, severe sleep disturbance, condition likely to deteriorate without therapy, severe impairment of activities of daily living, pregnant women under 35 weeks).

Box 21 - Spinal Triage & Treat Practitioner Review - 12/52

Flowchart Contents

Quick info:

Please note that to provide continuity of care across the pathway **this will be the same clinician as Box 13**

Full triage will be repeated, and patients Triaged appropriately:

- Discharge / self management (Box 8)
- Core therapies including low intensity CPP (Box 20)
- Radicular pain pathway (Box 12)
- High intensity CPPTP (Box 22) Decision based on
  - Significant disability from Low Back Pain with insufficient response to Core Therapies
  - Expectation of continuing improvement
  - Expected outcome work ability
  - No physical co-morbidity which would preclude exercise
  - Working age group
  - Suitable for group format
  - Psychological approach (CBT principles, goal setting, problem solving) with
  - Intensive physical exercise component

- Specialist Pain Service (Box 24). Decision based on diagnosis of pain as a primary condition or where there are specific interventions or significant psychological issues that can't be addressed by a CPPTP
  - Multiple pain sites rather than focused in the back
  - Patients are taking large prescribed doses of opioids (>120mg daily morphine equivalents) and/or additional medication
  - Patients are exhibiting disabling levels of distress, depression or anxiety
  - Patients are using alcohol or other prescribed drugs inappropriately to relieve symptoms of pain and distress
  - Patients are using recreational drugs to relieve their pain
  - Significant fatigue
  - Poor prognosis for recovery
  - Co-morbidities precluding exercise
  - Severe disability (wheelchair, house bound)
  - Under 16 or over 50 with new onset low back pain.
  - Patients are significantly functionally impaired and other interventions have failed
  - Patients are referred for consideration of spinal cord stimulation
- Senior clinical review

Box 22 – High Intensity CPPP

Flowchart Contents

Quick info:

This is appropriate at this stage in the pathway for people with disabling back pain that has been refractory to optimal treatment including the core therapies and the less intensive (uni-disciplinary) programmes. These are typically multidisciplinary and high intensity. The exact duration will depend upon patient needs. In CG88, NICE found the best evidence was for programmes of at least 100 hours of exposure. The economic evaluation recommended that CPPTP should be made available to those who continued to report high levels of disability and /or distress after one or more core therapies.

The Intensive physical and psychological rehabilitation programme comprises:

Up to100 contact hours in up to 8 weeks (NICE CG88)
May be delivered on a full time basis
Work and occupation related activities
On CBT Principles
Outwith heath care setting
De-medicalisation of condition, Group sessions
Self reliance, coping strategies and goal setting/problem solving
Pain self management skills
Advice and information
Improvement is likely
Pharmacy advice available

This type of intensive programme may be delivered over a period of up to 8 weeks but often are delivered on a full time basis over a three week period. Suitable referrals for this programme are those patients where recovery, and for example return to work, is anticipated or where in the event of insufficient improvement surgery may be an option. Some patients may be more suitable for pain services (box 24).

The high intensity CPPP should be delivered 12 - 18 weeks from initial presentation and management may be delivered in large rehabilitation centres or leisure centres (NICE CG88). Successful treatment followed by Discharge / Self management (Box 8)

If further review required box 27

Box 23 – Unsuitable for CPPP

Quick info:

See Criteria in Box 21

Box 24 – Pain Services

Flowchart Contents

Quick info:

Provide physical, psychological and behavioural interventions that support patients and their carers in managing their pain, enabling patients to lead more normal lives with reduced disability.

Provide individual care for patients with low back pain

Treatments involving complex manipulations of medications, including opioids

Physical interventions such as SCS, nerve root blocks, or epidurals, medial branch nerve blocks and denervation

Specific Interventions

1. Pain Management Programmes (PMP)

The general aim of a PMP is to improve participation in daily activities, increase functionality and enhance quality of life for those with persistent pain and disability.

2. Nerve Root Block / Epidural

See Box 30

3. Facet joint injections and denervation

NICE Guidance for non-specific low back pain of duration from 6 weeks to 52 weeks did not show evidence of benefit from facet joint injection steroid during that time period.
The probability of lumbar facet joint involvement in back pain can be identified by diagnostic medial branch blocks of facet nerves and prolonged effect (up to one year) can be obtained by denervation.

- Radiofrequency denervation of the medial branch nerves produces a more prolonged analgesic effect but this must be balanced against the potential for more significant complications.
- Diagnostic medial branch of the posterior primary ramus nerve blocks with very small quantities of local anaesthetic are recommended as a diagnostic test before any destructive lesioning.

4. Spinal Cord Stimulation

Chronic radicular or neuropathic pain or chronic mixed back/spinal and radicular pain.
Recurrence of pain or a failure of pain relief from anatomically successful spinal surgery.
Pain persistent for more than 6 months.
Patient accepts that has long-term chronic condition.
Patient has cognitive ability to manage the therapy long term

5. Intrathecal drug delivery

A few patients who have severe refractory back and leg pain may still be improved long term by the application of Intrathecal drug delivery (ITDD). Typically these patients will have been fully assessed as above but failed all other therapies including a trial of spinal cord stimulation.

Box 25 – Staged Return to Work/Occ. Health

Flowchart Contents

Quick info:

- Assisting patients with low back pain (LBP) to continue working or facilitating an early return to work
- Emphasis on returning to work as rapidly as possible, before pain free
- Modifying work programmes i.e. negotiating
  - Modified duties in more severe cases
  - Graded/ pacing full return to work with time targets
- Facilitating work organisation
  - Work place adaptations,
  - Pace,
  - Rotation of work modified duties etc
- Communication between LBP health practitioners/services and the work place
- Early intervention (2-4 weeks), case- management and direct involvement approaches
- Provision of health messages consistent with those delivered by health professionals involved in the patients care

Box 27 - Spinal Triage & Treat Practitioner MDT Review

Flowchart Contents

Quick info:

This will be the same clinician as Box 13 and 21

This review will take place at the end of the high intensity CPPP without the need for a separate appointment.

- Discharge and self management (Box 8)
- If patient fails to respond to CPP programme consideration should be made for referral to chronic pain management Practitioner (box 24) or specialist surgical opinion (box 31) as appropriate.

Box 28–Local Emergency Pathway

Flowchart Contents

Quick info:

Referral for cauda equina or new or progressive neurological deficit.

- Telephone referral to secondary care specialist spinal surgeon

Box 29– Specialist Secondary Care

Flowchart Contents

Quick info:

Referral for confirmed Red Flag, spinal infection.

- Reserved slots with MRI same day
- Secondary care specialist spinal Surgeon
- Oncologist

Box 30–Nerve root block/epidural

Flowchart Contents

Quick info:

Injection of depot preparations of steroid usually with local anaesthetic has an established value in a variety of acute and chronic pain problems associated with inflammatory, compressive or post-surgical pathology in the lumbosacral spine, where leg pain is the predominant symptom.

- Clinician and patient agreement for therapeutic injection for moderate or severe intensity lumbosacral radicular pain (compressive or inflammatory).
- Lack of suitability of alternative treatments e.g.
  Patient unfit for surgery/poorly defined surgical target
  Patient unable to tolerate neuropathic pain medications – especially elderly.
- Informed consent
- Interlaminar, transforaminal or caudal epidural
- Nerve root injection image guided using Non-ionic, water soluble contrast

Box 31 – Specialist Spinal Surgical opinion

Flowchart Contents

Quick info:

Specialist spinal surgeon for consideration of spinal fusion.
4 – 6 months from initial presentation and management.
Must have completed CPPP prior to referral.
Careful biopsychosocial assessment, appropriate imaging. Understanding of patient objectives.

- Self management (Box 8)
- Specialist Pain Service (Box 24)
- Spinal surgery (Box 32)

Box 32 - Operation

Flowchart Contents

Quick info:

Surgery for Axial Pain

- 6 months from initial presentation and management
- This is a specialist Spinal Surgeon.
- Informed Consent
- Fusion surgery
  - Anterior
  - Posterior
  - PLIF/ TLIF
- Total disc replacement

Surgery for Radicular Pain

- Very severe radicular pain which is not controllable with analgesia or nerve root injection may require early surgery likely to be at the 1-3 week stage
- Early surgery for major radicular weakness
- 8-12 weeks if non-tolerable radicular pain
- Neurogenic claudication may be six months
- Informed Consent
- Decompression / Discectomy
- Decompression / Discectomy + Instrumented fusion may be required if:
  Instability e.g. spondylolisthesis, spinal deformity

Box 33 – Discharge/Self-Management

Quick info:

See box 8

Bibliography

Flowchart Contents

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Appendix 1. Triage and Treat Practitioner

Flowchart Contents

This functionality appears in boxes 13, 21 and 27 in the low back pain pathway. They will also be making the decisions in suspected radiculopathy(box 12) and concerning concordant and non-concordant images in boxes 18 and 19.

The individual with this functionality will be highly trained, with skills including;

- History and examination
- diagnostic triage (red flags, Radicular pain, Mechanical back pain, Inflammatory disorders etc)
- Ability to request scan
- Ability to interpret scan alongside the radiologists report
- Ability to direct treatment
- Understanding and employment of CBT principals
- Psychosocial assessment
- Assessment of medication
- Shared decision making
- Communication
- Expectation management

It is clearly a highly trained individual with some seniority and will be an expensive and limited resource. They will normally have a specialist nurse or extended scope physiotherapist background.

The function of this individual is to direct the pathway of care and to provide the continuity that patients have clearly voiced that they would like to see. In some instances the practitioner might be bypassed but it is to this practitioner that the pathway will return if response is insufficient or concerns are raised about diagnosis or any other matter.

Appendix 2. Combined Physical and Psychological Programme

Flowchart Contents

These are typically multidisciplinary and high intensity. In CG88, NICE found the best evidence was for programmes of at least 100 hours of exposure. The economic evaluation recommended that CPPTP should be made available to those who continued to report high levels of disability and /or distress after one or more core therapies. Suitable referrals for this programme are those patients where recovery, and for example return to work, is anticipated or where in the event of insufficient improvement surgery may be an option. This goal orientated programme focuses on ability and restoration of function.

A CPP is an intensive multidisciplinary programme based principally on group exercise therapy with a strong input of cognitive behavioural therapy and some input from other specialities. This guide is intended for use by commissioners and is a synthesis of the treatment programmes delivered in the randomised controlled trials cited in the NICE Guidance. Based on a careful evidence review, the NICE Guidance recommended approximately 100 contact hours.

Delivery

The programme is intensive, most commonly delivered on a full time basis over a three-week period. Some patients may be residential.

Content

The graduated physical training typically includes aerobic training, periods of resistance training by the use of gym equipment or similar and stretching exercises. Some programmes include occupational training such as lifting, pulling and simulated work postures.

Psychological content includes cognitive behavioural therapy, counselling and pain management skills. This places an emphasis on self-reliance, coping strategies and goal setting/problem solving. Treatment is predominantly delivered in group settings.
Physical training forms the majority of the content of the programme.

Specialist sessional input is provided from psychologist, specialist pain practitioner, specialist spine practitioner, pharmacist, occupational therapist, and dietician.

Venue

Programmes can be delivered in large rehabilitation centres. It has been suggested that delivery outside health care premises may improve focus on increasing ability. The availability of a pool and gym is helpful.

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On behalf of the Clinical Group

Date 10th Feb 2015

Change Control

17 Nov 2015 (Ver 1.2)

Merged box 22 & 27 on large flowchart and the smaller version.
Added clickable links to corresponding box page on the main flowchart only
Added clickable link back to main flowchart on all box pages
Changed version to 1.2
Added change control on final page
Corrected page order on Table on Contents.