Virtual Back/Neck First Consultation

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History

What happened? (start with open-ended question)
-Trauma, occupational (litigation/disability/desk job)
How long? (duration of current episode, x/7 on y/12 on z yrs)
Previous symptoms? (similar, nature of therapy)
Other symptoms? (start open ended)
-Pain radiating (where), weakness, numbness, fever, trouble urinating or moving bowels, unintended weight loss.
What makes symptoms worse? (positional, coughing/sneezing)
What makes symptoms better or what has been tried to relieve symptoms?
-rest, medications (response to treatment)
Other relevant information?

S Site
O Onset
C Character
R Radiation
A Associated factors
T Timing
E Exacerbating factors
S Severity

Indication for Further Review
Red Flags for tumour, infection, inflammatory, fracture, or **cauda equina**[1]
Radicular symptoms (Leg/Buttock/Groin, Shoulder/Scapula/Arm/Hand)
Symptoms for 2 weeks or more

Yes → MRI Scan → Refer appropriately

No

Initial Phone Management
Presumed non-specific acute low back pain

Treatment
Medications: NSAIDS, etc.
Bedrest: No, Work: Limit any risky activities but work includes moderate exercise
Walking: if not painful as is tolerated
Gym/Running: Not until there is resolution as these are preventative strategies not treatments

Education
Reassurance/Expectations: Common problem, Expect gradual improvement over few weeks
Reasons to call back promptly: Radicular symptoms, bladder (retention), worsening pain
Call for appointment if not improving after 1-2 weeks

Case Management
Follow up phone call in 3-4 days
Recurrent episode- schedule routine visit to review preventative care
If new patient- schedule routine visit

Cauda Equina Syndrome is a rare condition which presents the following symptoms some which are very specific and warrant urgent attention including acute onset bilateral sciatica (rarely unilateral), saddle anaesthesia, insensate urination, urinary hesitancy leading to retention leading to overflow incontinence (never on an empty bladder) and non-specific symptoms including back pain and loss of anal tone.
In contrast, a disc herniation will usually cause unilateral sciatica affecting one dermatome, e.g. outside of thigh/leg (L5) or posterior thigh/leg (S1). Spinal stenosis will cause slow and episodic bilateral sciatica but rarely with urinary symptoms.

Virtual Back/Neck Review Consultation

Additional Tools depending on the direction of the conversation

History Verification including Red Flags- as per First Visit

Questionnaires (see attached)
(allows patient to vent, organises conversation, quantifies problem)
(to be emailed to patient or given in waiting room, prior to consultation)
Evaluate Pain-VAS Back/Neck and Leg/Arm
Evaluate Function -Oswestry Disability Index (Lumbar)
- Neck Disability Index (Cervical)
Evaluate Psychological -Startback

Characterisation of Pain
Articular (location specific, stiffness/ morning pain/ getting out of a chair/ provoked on extension, reduction within 6 weeks)
Myofascial (diffuse, tense, provoked on flexion & stretching, eased on rest, worse with stress, unable to maintain a corrected posture)
Neural (dermatomal pattern, getting out of a chair, sometimes provoked by cough or sneeze)
Central (disproportionate, non-mechanical, unpredictable pattern of pain provocation in response to multiple/nonspecific aggravating/easing factors)
Sensorimotor control (poor quality of movement, often at the start of flexion, persistent episodes, instability catch, spine cracks or pops)

Identify other contributing factors
-Obesity (listen to how it affects them, beware of giving advice)
-Other meds (lipids)
-Other illnesses (Viral, kidneys, duodenal ulcers, aortic aneurysm etc)

Social
-close relationships
-work
-sports team

Physiotherapy
(or other appropriate neuromuscular therapies)
-gets the patient **moving**
- helps **sell the message** to the patient, which reinforces conventional treatment and contradicts misheld beliefs
- request the patient to provide the email of that therapist so that they can provide you with **update** (and **check compliance**)
-**allows learning, builds rapport** with the physiotherapist

MRI Results
-Recognise **Placebo v Nocebo** effect
- High **sensitivity**, specificity is lower (unlikely to miss a tumour, but won't visualise facet problems, postural or dynamic abnormalities, myofascial or central causes of pain)
-Beware of the importance placed on the report

Non-Medical Measures
- Hot water bottle, massage, acupuncture, TENS machine, spinal manipulation (all low evidence)
Differentiate between treatment and prevention (swimming/cycling/Pilates/yoga)

Medications- NSAIDs, Neuropathic analgesia (significant side effects), no evidence for opioids/opiates/topical NSAIDs, diazepam only reserved for severe spasm

Online Resources
www.eurospinepatientline.org www.nhs.uk/conditions/back-pain

Referral Considerations
-Specialist Advice
-Nerve block for Radicular pain- usually effective for 8 weeks, allowing time for symptoms to settle
Facet injections for Back/Neck pain- temporary at best, helpful for arthritic symptoms
Rhizotomy- burns dorsal nerve endings, relief for max 2 years
Surgery
- Decompression for disc herniation for radicular pain- symptoms >8 weeks, spinal stenosis >12 weeks
- Restoration of lordosis and spinal fusion/disc replacement for back/neck pain- after failure of conservative options, usually requires reconstruction of anatomy.

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