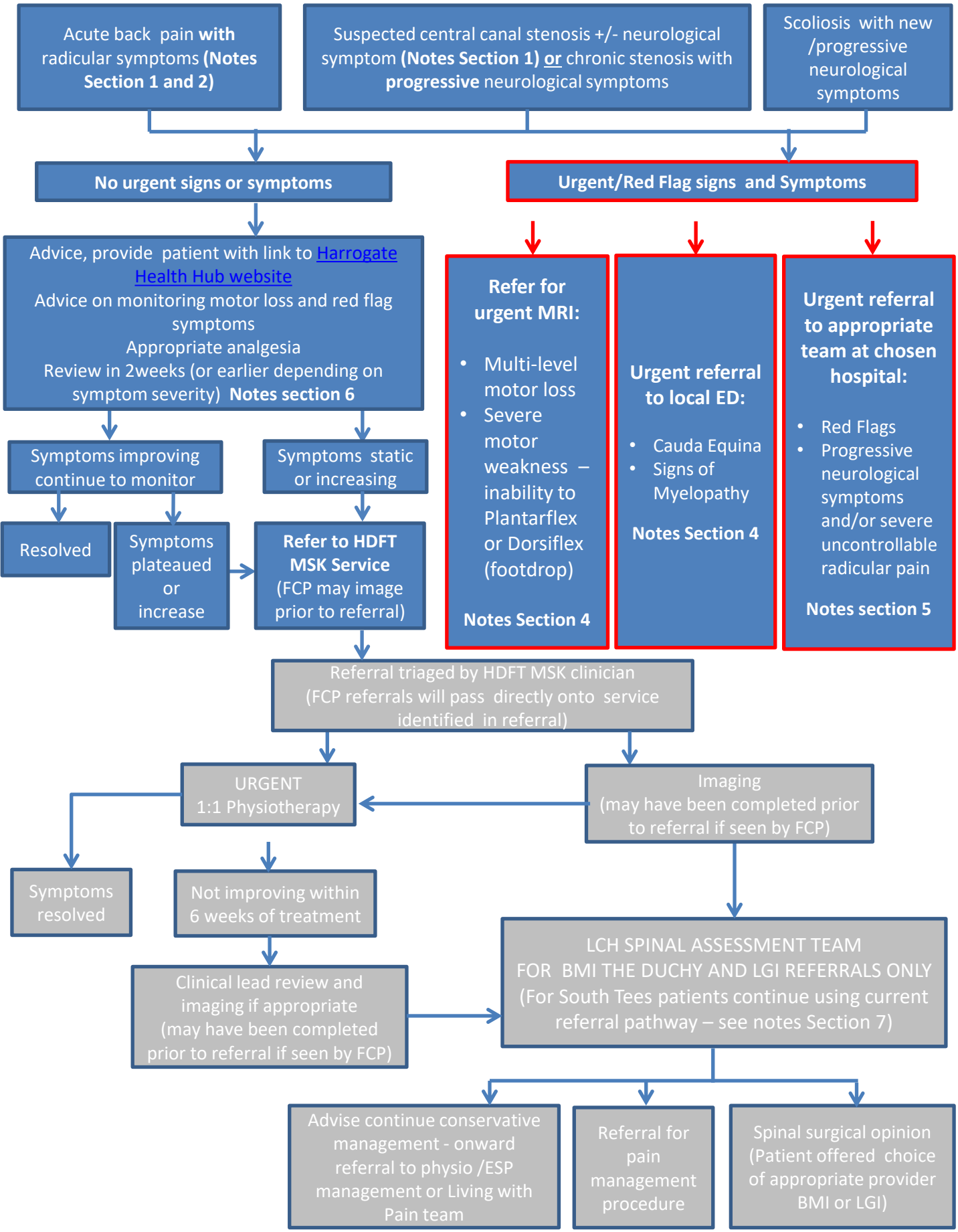
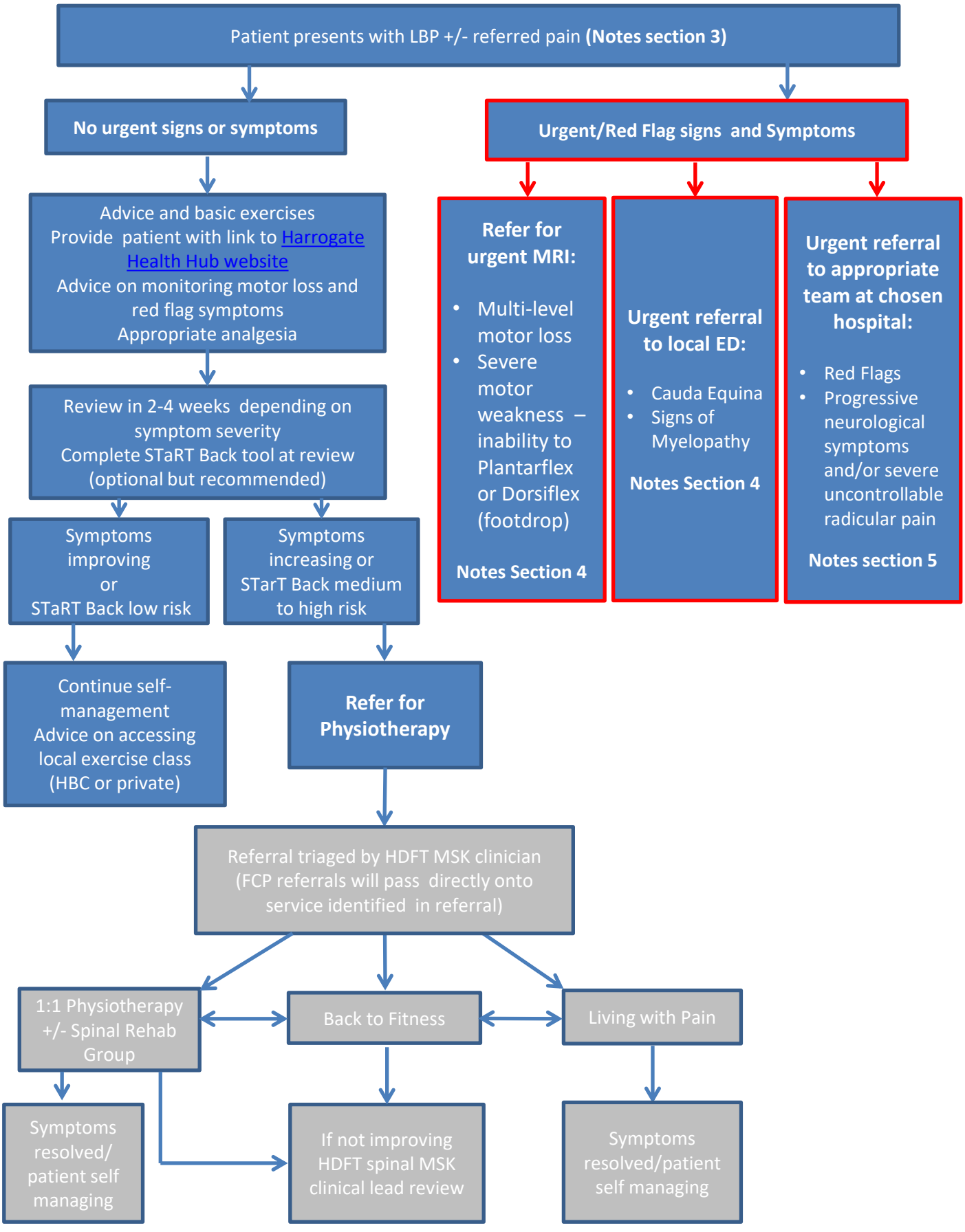
Radicular Pain Pathway – GP and FCP



Lower Back Pain (LBP) Pathway – GP and FCP



Notes Section 1: Referral into radicular pain pathway

- Patients presenting with acute back pain with radicular symptoms that may present as:
  - leg pain that can spread below the knee
  - +/- numbness and tingling and/or muscular weakness in a nerve root distribution .
- Patients presenting with suspected central canal stenosis that may present with the following:
  - Back pain and bilateral leg pain +/- neurological symptoms - i.e. radiating leg pain/paraesthesia/numbness
  - Symptoms come on with walking and are distance-limiting
  - Pain progression is normally from buttocks to the periphery
  - Relief is gained by rest /sitting and bending forwards.
  - Peripheral pulses are normal. i.e. not vascular in nature
- Patients presenting with chronic stenosis with progressive neurological symptoms
- Patients with Scoliosis with new /progressive neurological symptoms

Notes Section 2: Exclusion Criteria from Radicular Pain Pathway

- Patients with referred pain. For the purposes of differential diagnosis, referred arm, leg or neck pain is more generalised in distribution and does not follow a specific nerve root distribution. Pain does not generally spread below the elbow or knee. Patients should be managed with analgesia, advice and physiotherapy as per the LBP pathway
- Patients with degenerative back pain generally have no surgically remedial cause and so should not be referred. Patients should be managed with analgesia, advice and physiotherapy.
- Patients with non-specific neurological symptoms/somatisation disorder - Such patients should be referred to a neurologist or to the pain clinic.
- Where radicular pain is significantly improving or resolved.
- Where there is residual dermatomal numbness following a previous radicular pain episode.

Notes Section 3: Referral into LBP pathway

- Patient presents with either acute or chronic back pain +/- referred pain (pain in a generalised distribution usually not below the knee i.e. not in a nerve root distribution) and no neurological signs and symptoms
- These patients rarely have a surgically remedial problem. Such patients need a clear and informative explanation of why neurosurgical intervention will not be of benefit.
- They are then best managed in primary care through a combination of advice, appropriate medication and access to exercise services, physiotherapy and chronic pain specialists where required.

Notes Section 4: For Urgent referral to local ED and Urgent MRI

- Cauda Equina Syndrome: Symptoms include - Bladder disturbance (difficulty controlling urination or retention, loss of sensation), Bowel disturbance (inability to control bowel movements , loss of sensation), reduced perianal sensation and perineal numbness, sexual dysfunction (inability to maintain erection or ejaculate, loss of sensation during intercourse) – Urgent referral to local ED who will arrange scan as required
- Progressive motor weakness affecting more than one nerve root and/or gait disturbances – Urgent MRI and urgent referral to spinal surgery if appropriate
- Severe motor weakness accompanying an acute onset lumbosacral radicular pain syndrome, i.e., inability to plantar flex (S1) or inability to dorsiflex ('foot drop', L5) – Urgent MRI and urgent referral to spinal surgery.
- Patients with signs of myelopathy. All patients should be referred to ED, whether asymptomatic or not, with positive long tract signs (* see below) or when an MRI has been done and where, even in the absence of long tract signs, there is cord signal change at a stenotic spinal level. Symptoms include numb, clumsy hands, jumping, stiff legs, falls, poor balance and urinary frequency.

N.B. ED will assess and arrange a scan in a suitable time scale (not always same day)

*Long tract signs (also known as upper motor neuron or pyramidal signs)
1.Should be done/commented on for all patients with cervicovertebral or cervical radicular pain as a screen for an underlying myelopathy.
2.Signs to look for include: hyper-reflexia, Babinski, clonus, crossed-adductor reflexes, Hoffman's, and loss of fine finger movements.

Notes Section 5: For Urgent referral to appropriate team at patients chosen hospital with urgent MRI (both direct referral by GP) or ED where specified

Serious spinal pathology is rare about 1% of all cases LBP. Investigate these patients urgently:

Patient with Moderate / Severe back pain plus:	
Signs/Symptoms	**Investigations**
Previous cancer, especially breast, lung, prostate, kidney, and thyroid	MRI, Bloods FBC, CRP, Bone Profile, PSA
Systemic symptoms, weight loss, underlying malignancy	MRI, Bloods FBC, CRP, Bone Profile, PSA
Patients who have lost height / use of long-term steroids Osteoporotic vertebral collapse, Other Vertebral Collapse	X-ray, consider MRI (+DEXA), consider Myeloma Screen
Possible infection Discitis, Tuberculosis, IV Drug users	Consider MRI, Bloods FBC, CRP
Widespread Neurological signs, progressive myelopathy	Referral to local Emergency Department for assessment with a view to an urgent MRI to be performed locally
Widespread Neurological signs, Cauda Equina syndrome	Referral to local Emergency Department for assessment with a view to an urgent MRI to be performed locally
Trauma – low velocity - Fracture / Osteoporotic collapse / other vertebral collapse	X-ray, consider MRI
Severe back pain under the age of 20 should raise suspicions especially if non sport or injury related. Underlying malignancy, investigate early	FBC, CRP, Bone Profile, MRI
Thoracic pain if severe – Underlying malignancy, Osteoporotic vertebral collapse. Look for pointers from the history, e.g. steroid use, night pain, severe spinal tenderness take a good history of previous medical problems	MRI, FBC, CRP, Bone Profile, PSA

Notes Section 6: Routine referral for a consultant spinal opinion must be referred via the specified pathway and will be assessed via the appropriate Spinal Assessment Team (Leeds Community Health (LCH) Spinal Assessment Team based at HDFT for LGI and BMI The Duchy referrals and South Tees Spinal Assessment Team at the Friarage for STT referrals) prior to the decision to refer on for consultant review. The referral process for STT patients remains unchanged.

- Acute severe radicular leg pain usually spreading below the knee, not showing any improvement with conservative measures should be referred through the radicular pathway. Most cases will respond well to a course of physiotherapy and some improvement is likely to imply eventual resolution without requirement for surgery. Pain will be in a nerve root distribution. Neurological symptoms (paraesthesia, numbness and/or muscular weakness) will be in a nerve root distribution and normally exacerbated by cough and/or movement. **Please detail these symptoms and results of neurological assessment in the referral letter.**
- Refractive longer term radicular pain (i.e. greater than three months) significantly interfering with lifestyle, disturbing sleep, or causing extended periods off work and not responding to conservative treatment should be referred through the radicular pathway.
- **If a patient is not appropriate for a course of physiotherapy please clearly state this and the reason in the referral letter**

Notes Section 7: Referral Procedure

- **Urgent Referrals to ED:**
  Refer to local ED immediately

- **Urgent Referral:**
  GP direct referral through e-RS to appropriate service (Oncology, Orthopaedics, Rheumatology, spinal services) clearly mark referral as urgent and select urgent priority on e-RS

- **Routine Referrals:**
  No direct routine referrals to LGI or the BMI, patient must follow the agreed pathway via HDFT MSK/physio service first, please refer through e-RS.
  If a spinal surgical opinion is required the appropriate spinal assessment team will forward on referral for consultant opinion
  The referral process for South Tees patients remains unchanged.