Clinical Guidelines: Spine

To be used on the overwhelming majority of spine (cervical / thoracic / lumbar) patients.

After H and P, there are "red flags" that should stand out.

Red flag concerns:

1. Neuro injury: weakness, bladder / bowel changes, saddle anesthesia
2. Myelopathy: hand dexterity issues, spastic gait, hyperreflexia, Hoffman' sign, clonus, Babinski
3. Infection: fever, wound drainage, pain out of proportion, immunosuppressed host
4. Tumor: personal history CA (recent / distant), weight loss, severe pain
5. Fracture: history of trauma (fall / MVA)

Depending on the specific red flag concern, the recommended action may be immediate referral to ED (cauda equina vs. acute imaging / lab work, to next day follow-up). For a surgeon, communication is key early in the process.

For the 95% of patients that do not present any red flags, initial treatment for axial / mechanical symptoms is the same as treatment for radicular symptoms.

1. Acute (1-6 weeks): patient education / reassurance, short rest, NSAID's/Tylenol, possible PO steroids (diabetes), physical therapy evaluation / home exercise program, no heavy-duty narcotics.
    a. No scheduled follow-up is necessary for the majority of patients, as long as they improve steadily (patient education / reassurance).
    b. If no improvement is seen in 2-4 weeks or if symptoms change or get worse, offer them a follow-up (with mid-levels /PA's / Dr. Balog)
2. Subacute / Chronic (6-12+ weeks): formal therapy evaluation and treatment (if they did not do the therapy), consider script NSAID's, no narcotics, consider gabapentin (radicular), interventional pain evaluation and treatment offered (for radicular complaints)
    a. Consider imaging at this time or the next visit (offer a follow-up)
    b. If you are planning to send them to a surgeon (a decision you can make with the patient), make sure the patient understands that surgery may not be necessary. The MRI may help determine its necessity.
    c. If symptoms are purely mechanical / axial (low back / cervical), few consider that a surgical issue (regardless of the MRI's findings). Consider a chronic pain management referral. In the beginning, you may be uncomfortable with this decision, but sending a proper patient to pain management instead of a surgeon saves everyone time and effort.