Sussex MSK Partnership East

Neck Pain

NHS

History, Examination, Assessment

Suspected spinal sinister pathology - see suspected spinal sinister pathology pathway
Other suspected sinister pathology to be investigated in primary care
Refer via 2WW cancer pathway where appropriate
Inflammatory Arthritis needs urgent Rheumatology referral
Septic Arthritis, suspected myelopathy or suspected fracture needs referral to emergency acute orthopaedics via A&E

Clinical Presentation

Late Whiplash

Non specific axial neck pain without radiculopathy
(Consider Primary Care Management for the first 6 weeks)

Neck Pain - Whiplash (Acute)

Neck pain with radiculopathy – See Radicular leg or arm pain (Sciatica Brachialgia)

Primary Care Management

Diagnostics:

- None

Management:

- Patient education and information
- Encourage and facilitate a return to normal activities
- Diagnose and treat anxiety and depression where they coexist
- Analgesia in line with agreed formularies /guidance

Diagnostics:

- None

Management:

- Reassure patient that neck pain is a very common problem and that the symptoms are likely to resolve
- Encourage the patient to remain active
- Discourage:
  wearing a cervical collar
  prolonged absence from work
- Correct poor posture
- A firm pillow may provide comfort at night
- Analgesia in line with agreed formularies / guidance including trial of a low-dose tricyclic antidepressant
- Patient information
- Address any psychosocial factors i.e.:
  Fear or avoidance beliefs
  Associated anxiety and depression
  Medico-legal issues
  Family dynamics
- Consider Physiotherapy

Diagnostics:

- None

Beware if have midline cervical tenderness (as this suggests a fracture or dislocation) or other serious injuries

- Exclude spinal cord compression (myelopathy) - <u>if suspected refer to A&E</u>. Assess:
  Presence of associated stress, anxiety, or depression and poor concentration
  Look for 'yellow flags' that indicate psychosocial barriers to recovery and that suggest that the acute injury could progress to become a chronic problem

Management:

- Patient education and information
- Provide reassurance that whiplash-associated disorder is usually benign and self-limiting
- Encourage early return to usual activities and early mobilisation – explain that usual activities may initially be painful, but this is not harmful or indicative of ongoing damage
- Discourage rest, immobilisation, and the use of soft collars
- Analgesia in line with agreed formularies /guidance

See Radicular leg or arm pain (Sciatica Brachialgia) pathway

Thresholds for referral to SMSKPE

Refer to Physiotherapy in first instance

Refer to Advanced Practitioner if:

- Patient at risk of developing chronicity

To be managed in primary care

Contact MSK Service for advice if pain is uncontrolled or there is diagnostic doubt

Refer to Physiotherapy if:

- Failed primary care management

Refer to Advanced Practitioner if:

- Complex psychosocial comorbidities
- Poor response to conservative management in Primary Care
- Unsuccessful physiotherapy
- If seen previously in FRP / PMP
- Functional impairment & ongoing significant pain

Refer urgently to Advanced Practitioner if:

- Suspecting serious spinal abnormality

Manage in primary care first 6 weeks

Refer to Physiotherapy after 6 weeks

Refer to Advanced Practitioner if:

- Progressive intractable pain
- Nerve pain suspected - see brachialgia pathway