SHIP8 Clinical Commissioning Groups Priorities Committee

No. 60

Policy Recommendation: Spinal Pain

Date of issue: February 2020

The Priorities Committee considered the evidence for the treatment of pain arising from the spine and updated the recommendations into this single policy. This **updates and replaces** policy number 20 issued in April 2017 and draft policy number 59 from Nov 2019

This review does not cover “red flag symptoms” which should still be managed urgently in the clinically appropriate manner

Common recommendations.

The management of pain will be affected by the type of pain which can broadly be described as axial or radicular (neuropathic). Axial symptoms tend to be less responsive to surgical interventions and timescales are greater. Acute axial pain can often last for 3 months and can be considered chronic after 6 months. Radicular or neuropathic symptoms tend to be quicker to resolve and those complicated and severe cases are generally more amenable to surgical interventions but manual therapy is still indicated in the initial management.

Interventions are only performed in conjunction with a multi-disciplinary team approach and with conservative therapies as first line including a course of structured physiotherapy and exercises with or without psychological therapy.

Assessment should include the biopsychosocial impact on the individual such as with EQ-5D or STarT back tool

- Acupuncture remains not routinely commissioned
- Spinal injections as a therapeutic intervention are not routinely commissioned and only considered where the above recommendations have been recorded as either undertaken and unsuccessful or considered unsuitable.
- Spinal fusion and/or discectomy for non-specific back pain is not routinely commissioned.
- Spinal decompression, with or without fusion, can be considered when all conservative options have been tried or are contraindicated.
- In cases of radicular pain caused by central canal stenosis and/or neurogenic claudication found on MRI epidural injections are not routinely indicated but can be an effective first line treatment or used in those unfit for surgery. Use is therefore not mandated but should be considered on a case by case basis.

Patients receiving any surgical intervention should be registered on the British Spine Registry and the providers are expected to participate in the Regional Spinal Network.

Site specific recommendations.

Lumbar Spine

Use of the STarT back tool should be undertaken as early on in the illness as possible to identify those at risk of chronicity.

- Disc replacement for low back pain is not routinely commissioned
- A single epidural injection for sciatica not responding to conservative therapy can be considered as part of a rehabilitation pathway or as a one-off diagnostic intervention to inform surgical management
- A single medial branch nerve block for diagnostic purposes is supported as part of potential radio frequency denervation for facetogenic low back pain
- Radiofrequency denervation (to destroy the nerves that supply the painful facet joint in the spine) can be offered if:
    - ❖ The main source of pain is thought to come from structures supplied by the medial branch nerve
    - ❖ All non-surgical and alternative treatments have been tried
    - ❖ There are no radicular symptoms
    - ❖ There is moderate to severe chronic pain that has improved in response to diagnostic medial branch block

- Repeat radio frequency denervation should not be performed within a 12 month period.
- Therapeutic as opposed to diagnostic medial branch blocks are not routinely commissioned.
- Repeat epidural injections for sciatica may be offered where co-morbidities exclude surgery or where less invasive treatment is not possible, and the previous injection has offered at least a 70% improvement in pain sustained for at least 6 months.

Sacroiliac Joint

The diagnosis of sacroiliac joint pain can be difficult and is often misdiagnosed as back or hip pain. It is recommended that the four tests, Gillet, standing forward flexion, sitting forward flexion, and supine-to-sit tests, are used initially. If sacroiliitis is suspected, then Rheumatological advice should be sought.

- Injection of the sacroiliac joint may assist in the diagnosis as well as allowing physiotherapy.
- Sacroiliac joint denervation using radio frequency denervation is supported after diagnostic injections.
- The use of iFuse devices is supported if all other treatments fail.