SHIP8 Clinical Commissioning Groups Priorities Committee

Policy title Number/version	**Policy 60: Interventions for Spinal Pain** **Version 2.0**
Policy position:	Varied – see individual statements
Date of Committee Recommendation	**January 2021**
Update	**This policy will be updated as per 3 year cycle or in light of a substantial body of new evidence or new national guidance (e.g. NICE)**

This policy does not apply to patients presenting with "red flag symptoms" such as deterioration in neurological function (e.g. objective weakness, sexual dysfunction, cauda equina syndrome). These patients require an urgent referral to an acute spinal centre for further evaluation and imaging, as non-surgical treatment may lead to irreversible harm.

General recommendations:

- Assessment should include the biopsychosocial impact on the individual such as with EQ-5D or STarT back tool for low back pain.
- Conservative therapies, including a course of structured physiotherapy and exercise with or without psychological therapy, should be offered as first line treatment.
- Interventions are undertaken using a multi-disciplinary team approach.
- Steroid and local anaesthetic spinal injections as a therapeutic intervention are not normally funded and only considered where the conservative management have been recorded as either undertaken and unsuccessful or considered unsuitable.
- Acupuncture is a low priority and is not normally funded.
- 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.

Cervical (neck) pain

Cervical radiculopathy

Cervical radiculopathy is characterised by sensory or motor symptoms in one or both of the upper extremities caused by nerve root compression in the cervical spine, with symptoms of occipital headache, neck pain which may radiate to shoulders, and arm pain, weakness, finger/ thumb numbness/ tinging. Conservative management should be offered for 6 weeks initially before other interventions are considered.

Epidural/ nerve root injections:

- A single epidural/ nerve root injection for cervical radiculopathy 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.

- Repeat epidural/ nerve root injections for cervical radiculopathy 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.

Non-specific neck pain

Non-specific neck pain is pain or discomfort in the neck and/or shoulder girdle without pain referred to the arms — in most cases no specific cause can be found. Symptoms vary with physical activity and over time. The cause is usually multifactorial and includes poor posture, neck strain, sporting and occupational activities, anxiety, and depression. Most cases of acute neck pain resolve within 8 weeks.

Conservative management should be undertaken for up to 12 weeks before a referral for specialist assessment is made.

- Spinal injections, including facet joint injections, medial branch blocks and epidural/ nerve root injections, are **not normally funded** in non-specific neck pain.

Lumbar (low back) pain

Imaging

- **Do not routinely offer imaging in a non-specialist setting** for patients with low back pain with or without sciatica, where there are no red flags or suspected serious underlying pathology following evaluation of medical history and examination.
- Imaging in low back pain **should be offered** if serious underlying pathology is suspected. Serious underlying pathology includes but is not limited to: cancer, infection, trauma, spinal cord injury (full or partial loss of sensation and/or movement of part(s) of the body) or inflammatory disease.

Sciatica

Sciatica or radicular pain is pain caused by irritation or compression of the sciatic nerve. Conservative therapies should be offered as first line treatment before a referral for specialist assessment is made.

Epidural/ nerve root injections:

- A single epidural/ nerve root 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.
- Repeat epidural/ nerve root 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.
- Epidural injections for neurogenic claudication in patients who have central spinal canal stenosis are **not normally funded**.

Surgery:

- Spinal decompression with or without fusion can be considered when all non-operative options have been tried or are contraindicated.
- In the presence of concordant MRI changes, lumbar discectomy may be offered to patients with compressive nerve root signs and symptoms lasting 3 months (except in severe cases) despite best efforts with non-operative management.

Non-specific low back pain

Non-specific low back pain can be defined as low back pain which cannot be attributed to recognisable, known specific pathology (such as cancer, fracture, infection or an inflammatory disease process); It can also be described as mechanical axial pain. Non-specific low-back pain is common, often multifactorial and responds well to non-operative treatment such as lifestyle modifications, weight loss, analgesia, manual therapy, exercise.

The following procedures are **not normally funded** in non-specific low back pain:

- Disc replacement
- Spinal fusion and/or discectomy
- All local anaesthetic and steroid spinal injections including
  - Facet joint injections
  - Therapeutic medial branch blocks
  - Intradiscal therapy
  - Prolotherapy
  - Trigger point injections with any agent, including botulinum toxin
  - Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis
  - Any other spinal injections not specifically covered above.

Facet joint pain

The facet joints are pairs of joints that stabilise and guide motion in the lumbar spine. Facet joint pain is considered to arise from degeneration of the joints. Manual therapy, with appropriate psychological therapies where necessary, should be considered as an early intervention.

Medial branch blocks:

- A single medial branch nerve block for diagnostic purposes is supported as part of potential radiofrequency denervation (destroys the nerves that supply the painful facet joint in the spine) for facetogenic low back pain.
- Therapeutic medial branch blocks are **not normally funded**.

Radiofrequency denervation:

- Radiofrequency denervation can be offered if **all** the following criteria are met:
  - The main source of pain is thought to come from structures supplied by the medial branch nerve; **and**
  - All non-surgical and alternative treatments have been tried and failed; **and**
  - There are no radicular symptoms; **and**
  - There is moderate to severe chronic pain that has improved in response to diagnostic medial branch block.
- Imaging in patients with low back pain with specific facet joint pain as a prerequisite for radiofrequency denervation is **not normally funded**.
- Repeat radiofrequency denervation should not be performed within a 12 month period.

Sacroiliac Joint (SIJ) pain

The diagnosis of SIJ 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. Rheumatological advice should be sought if sacroiliitis is suspected.

- Steroid and local anaesthetic injections of the SIJ may assist in the diagnosis as well as allowing physiotherapy.
- Radiofrequency denervation of the SIJ is supported after diagnostic injections.
- The use of iFuse devices is supported if all other treatments fail.
- Prolotherapy is **not normally funded** due to a lack of evidence on clinical and cost effectiveness.

This policy is based on:

1. NHS England Evidence-Based Interventions (EBI): Guidance for CCGs (2020)
2. NHS England Evidence-Based Interventions (EBI): Guidance for CCGs (2019)
3. Spinal Services GIRFT Programme (2019) National Specialty Report
4. NICE Clinical Knowledge Summary (2018) Neck pain - cervical radiculopathy
5. NICE Clinical Knowledge Summary (2018) Neck pain - non-specific
6. NHS England (2017) National Low Back and Radicular Pain Pathway
7. NICE guideline NG59 (November 2016, updated 2020) Low back pain and sciatica in over 16s: assessment and management

Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status

Clinical coding:

Pending