

Neck pain task force collars best treatments

February 05, 2008 | Andrew Skelly

LOS ANGELES | An international task force with major Canadian involvement has developed a new system of classifying neck pain; analyzed the literature to determine which treatments may work and which ones don't; and conducted original research showing patients are no more likely to suffer a stroke after visiting a chiropractor than they are after visiting a family doctor.

The findings of the Bone and Joint Decade Task Force on Neck Pain and Its Associated Disorders were released here at the World Congress on Neck Pain last month and posted on the website of the journal Spine. The report will appear in print as a supplement to the journal's February 15 issue.

Dr. Scott Haldeman, the task force president and a neurologist and clinical professor at the University of California at Irvine, discussed the report's key messages with the Medical Post in advance of the congress.

"Most people develop neck pain, and 5% to 10% of the population actually find the pain disabling. We're talking about a huge problem, and so far we don't treat it very well," said Dr. Haldeman, a

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The task force categorized neck pain into four grades:

- Grade 1: Little or no interference with daily activities;
- Grade 2: Limits daily activities;
- Grade 3: Accompanied by radiculopathy;
- Grade 4: Serious pathology such as tumour, fracture, infection, systemic disease.

The task force, whose members represented 19 clinical and scientific disciplines, screened nearly 32,000 citations, finding 1,203 relevant articles and deeming 552 scientifically acceptable for a synthesis of the best evidence.

They concluded that treatments worth considering for Grades 1 and 2 neck pain, which account for most cases, include: education, exercise, mobilization, manipulation, acupuncture, analgesics, massage and low-level laser therapy. But there was no evidence that any one treatment was better than any other.

Treatments found unlikely to help Grades 1 and 2 neck pain were collars, ultrasound, electrical muscle stimulation, transcutaneous electrical nerve stimulation, most injection therapies, including corticosteroid injections in cervical facet joints, radiofrequency neurotomies and surgery.

“Most people who know the literature will not find this a surprise,” Dr. Haldeman said. “But those who . . . make their living with one particular technique are likely to become quite upset.”

Patients considering chiropractic treatment may be reassured by the task force’s Ontario-based study suggesting earlier reports of an increased risk of vertebrobasilar artery (VBA) stroke following visits to a chiropractor were instances of “confounding by indication.”

“The increased risks of VBA stroke associated with chiropractic and (primary-care physician) visits is likely due to patients with headache and neck pain from VBA dissection seeking care before their stroke. We found no evidence of excess risk of VBA stroke associated with chiropractic care compared to primary care,” concluded a team led by Dr. J. David Cassidy (DC, PhD), a senior scientist in the Division of Health Care and Outcomes Research at the Toronto Western Research Institute.

An earlier analysis of Ontario administrative data by the Institute for Clinical Evaluative Sciences in Toronto, published in *Stroke* in October 2001, showed people under age 45 years who had suffered a VBA stroke were five times more likely than controls with no stroke history to have visited a chiropractor within one week of the stroke. Unlike that

report, the new study also looked at stroke incidence after visits to primary-care physicians.

The researchers found 818 cases of VBA stroke admitted to Ontario hospitals from April 1, 1993 to March 31, 2002 (more than 100 million person-years of observation). Four controls were age- and gender-matched to each case; and case and control exposures to chiropractors and primary-care physicians were determined from health billing records.

In those younger than 45 years, cases were about three times more likely to have seen a chiropractor or a primary-care physician in the month before their stroke than controls. There was no increased association between chiropractic visits and VBA stroke in those older than 45, however the association remained for primary-care visits.

“It should put the controversy to rest,” said Dr. Haldeman. “Dissections appear to be an issue, but . . . all the concerns about this being a chiropractic issue probably are not valid.”

Other key messages from the task force report:

- Conduct a thorough patient history, physical examination and patient self-assessment questionnaire to identify or rule out Grades 3 or 4 neck pain.
- Routine imaging in Grades 1 or 2 neck pain will not increase understanding of causation.
- Patients with Grades 1 or 2 neck pain should be advised to stay as active as they can. A variety of therapies or combinations of therapies may be needed to find pain relief, which is often modest and short-lived.
- Be cautious of treatments that make impressive claims for relief of neck pain, and discontinue treatments that don't provide improvement within two to four weeks.
- Epidural corticosteroid injections may provide temporary relief of radiculopathy in Grade 3 neck pain. Consider surgery in the presence of serious pathology or persistent radiculopathy.
- In the case of emergency department visits involving neck pain, the Canadian Cervical Spine Rule and the NEXUS Low Risk Criteria are effective at identifying patients who do not require imaging.
- Use of MRI as a screening tool in the emergency setting is not supported by evidence; CT scan is more sensitive than X-ray in high-risk patients (e.g. intoxicated, unconscious and/or obtunded); and five-view X-rays are no more effective than three in identifying fractures

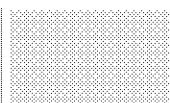
- In Grade 3 neck pain, there is no evidence that any one type of decompression or fusion surgery is superior to the others.

Payment recommendations

The task force also called on public and private insurers to adopt evidence-based treatment guidelines when paying for services.

“A physician who does multiple procedures, rightly or wrongly, is going to be paid considerably higher than a person who sits down and talks to the patient and examines the patient,” Dr. Haldeman said. “And the feeling is that since the evidence suggests that sitting down and examining and talking to the patient is more likely to improve patient outcomes than these invasive procedures, then the payers should encourage it.”

The Task Force on Neck Pain and Its Associated Disorders was established in 2000 and was given official status by the steering committee of the United Nations/World Health Organization Bone and Joint Decade project in 2002.



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