

**GP Review Appointment Guidelines**

**Assessment T&T Practitioner**

**Rheumatology**

**Suspected Red Flag**

**STarT Back Med/High Risk**

**STarT Back Low Risk**

**2/52 Review**

**Discharge/Self-Management**

**Suspected Radiculopathy**

**2/52 Review Appointment Complete STarT Back**

* Patient reviewed at 2/52 by initial clinician
* Repeat history, examination and assessment from initial assessment (*see “First Presentation Initial Management” document*)
* Review red flags
* Review radicular symptoms or signs
* Mechanical back pain use STarT Back tool http://www.keele.ac.uk/sbst/
	+ Low risk (*see “STarT Back – Low Risk”*) - single biopsychosocial CBT based advice session by GP or clinician of first contact.
	+ Advice to return if not settled to Spinal Triage and Treat Practitioner (*Review Appointment 6/52*).
* Medium /high risk- refer to approved Triage and Treat Practitioner (*Review Appointment 6/52*) for management using biopsychosocial approach.
	+ If > 6 weeks from onset refer to the Triage & Treat Practitioner.
* Do not request plain x-rays or MRI- except in the case of suspected Red Flag (see ’suspected red flag’ pathway for appropriate action)

***Triage and Treat Practitioner should be able to refer for secondary care opinion at any stage if there is a deterioration/change in patient symptoms.***

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**STarT Back Low Risk**

 **STarT Back - Low Risk**

*Low risk - Single biopsychosocial CBT based advice session by GP or clinician of first contact.*

Management:

* Reassurance - Improvement is likely, explanation of signs and symptoms, distinction between hurt and harm
* Avoid medicalising patient
* Advice about continuation of normal activities, including work, or return to normal activities using graded steady increases, Stay active including work return to work ASAP
* Offer analgesics NSAI or topical agents, weak opioids such as Codeine. Stronger opioids only for short planned courses, and not for longer term.
* Information that recurrence is often seen, and can be managed by the patient
* Self-Management - Self-directed exercise programme, Self-directed relaxation techniques, and Self-directed return to normal social and occupational activities
* Indications for early clinical review and emergency attendance
* Patient information - back book/ on-line **www.cmbackpainhelp.nhs.uk**
* Advice to return if not settled to Spinal Triage and Treat Practitioner





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**STarT Back - Medium/High Risk**

* The Keele Start Back Tool is a tool to stratify care/intervention dependant on the patient’s risk of developing chronic symptoms (high risk = high risk of chronicity).
* Patients with medium/or high risk on STarT back tool should be referred for specialist opinion from Triage and Treat clinician who will decide appropriate intervention dependant on patient individual requirements and situation using a biopsychosocial approach.



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**STarT Back Low Risk**

**Suspected Red Flag**

The red flags were introduced in 1994 in the CSAG report. They comprise a number of symptoms and signs which have been associated with increased risk of underlying serious conditions. Recently some doubt has been cast on the sensitivity and specificity of the flags but they remain useful shorthand for clinicians to maintain awareness of possible serious pathology.

|  |  |
| --- | --- |
| * Age <16 or >60 with new onset back pain
* Unrelieved pain – continuous night pain
* History of Cancer
* Recent Unexplained weight loss
* Prolonged steroid use
* Objectively unwell with spinal pain
* Infection - fevers/rigors
 | * Immunosuppression with new spinal pain
* Raised inflammatory markers
* Urinary incontinence /retention faecal incontinence
* Altered perianal sensation, (reduced anal tone and squeeze – if circumstances permit)
* Change in sexual function
* Limb weakness
 |

***Assessment by Spinal Triage and Treat Practitioner (same practitioner as Review Appt 6/52)***

Significant **new** neurological deficit - new/progressive neurological deficit, (*also see “Cauda Equina”*):

|  |  |
| --- | --- |
| * + Multilevel weakness in the arms/legs
	+ Gait disturbance
	+ Hyper-reflexia
	+ Clonus
	+ Positive Babinski (up-going plantar response)
	+ Bilateral sciatica
 | * + Acute urinary disturbance
	+ Saddle anaesthesia/ paraesthesia
	+ Reduced/absent anal tone
	+ Reduced/absent anal contraction
	+ New /progressive spinal deformity
	+ Urinary retention
 |

***Then same day referral to secondary care specialist***

Spinal infection:

|  |  |
| --- | --- |
| * + Objectively unwell - fever
	+ IV drug use
	+ Recent infection
 | * + Immunocompromised patient (steroids, diabetes, biologics, transplant)
	+ Raised inflammatory markers
 |

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***Then same day referral to secondary care specialist***

Spinal metastases:

|  |  |
| --- | --- |
| * + History of Cancer
	+ Unexplained weight loss
	+ Progressive non mechanical pain
 | * + Thoracic spine pain
	+ Progressive night pain
 |

Suspected unstable fracture:

* + Severe low back pain following significant trauma

Osteoporotic fracture

|  |  |
| --- | --- |
| * + Sudden onset
	+ Minor trauma
	+ Age
 | * + Osteoporosis
	+ Recent deformity
 |

***If Triage and Treat Practitioner suspects serious destructive pathology, urgent investigation (protocol led MRI/bloods) and referral (5 days) should be made to appropriate secondary care spinal specialist / surgeon / oncologist.***

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**Discharge/Self-management**

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* Avoid medicalising patient
* Advice about continuation of normal activities, including work, or return to normal activities using graded steady increases, Stay active including work return to work ASAP
* Information that recurrence is often seen, and can be managed by the patient
* Self-Management - Self-directed exercise programme, Self-directed relaxation techniques, and Self-directed return to normal social and occupational activities
* Indications for emergency attendance give telephone number of the Triage & Treat Practitioner if patient deteriorates
* Patient information - back book/ on-line info/Arthritis Research UK leaflets, exercises

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***Routine referral to secondary care 4-6 weeks***

***If inflammatory disorder is not found, rheumatologist to refer back to Triage and Treat Practitioner***

**Rheumatology**

*Suspected Rheumatology Spondyloarthropathy*

|  |  |
| --- | --- |
| * Younger patient
* Thoracolumbar or sacroiliac pain
* Prolonged early morning stiffness
* Waking early hours, pain in second half of night
 | * Persisting limitation spinal movements in all directions
* Peripheral joint involvement
* Symptoms improve with exercise
* Systemic symptoms - uveitis, IBS, psoriasis, enthesopathies
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**Suspected Radiculopathy**

Radicular /nerve root pain:

|  |  |
| --- | --- |
| * Pain radiating down the leg, most frequently below knee often to foot /toes with approx. dermatomal distribution
* Shooting/electric shock, paraesthesia, numbness
* Restricted straight leg raise
* Muscle weakness
 | * **Neurological deficit for example**:
* Tingling
* Loss/altered reflexes
* Numbness
 |

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***Assessment by Spinal Triage and Treat Practitioner (same practitioner as Review Appointment 6/52)***

* Severe pain with unilateral neurology not responding to conservative treatment
* Consider Imaging for Severe radicular pain at 2-6 weeks depending on severity and improvement, or for non-tolerable radicular pain at 6 weeks
* If imaging concordant and symptoms progressive or persist, fast track to nerve root block / spinal surgical opinion within 8 weeks of onset
* Progressive motor deficit (e.g. foot drop) - ***urgent referral to Spinal Surgery Service or urgent MRI***