NHS

West Midlands Regional Spine Network

Consensus guidance and standard for referral of elective adult lumbar spine disorders

December 2018

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Purpose	To provide a guidance on referral for elective adult lumbar spine disorders in the West Midlands Region
Version	1.0
Previous versions	Nil
Supporting documents	WMRSN MRI policy RSN mandatory items NICE Low back pain and sciatica pathway (2017) (NG59) NICE Spondyloarthritis in over 16s (2017) (NG65) STarT Back tool
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Sign off	WMRSN board
Related networks	MSK networks Pain clinics
Distribution	All WMRSN hospital COO and medical director All WMRSN STP / CCG Chairs / Planned care leads All WMRSN Triage services Betsi Cadwaladr health board
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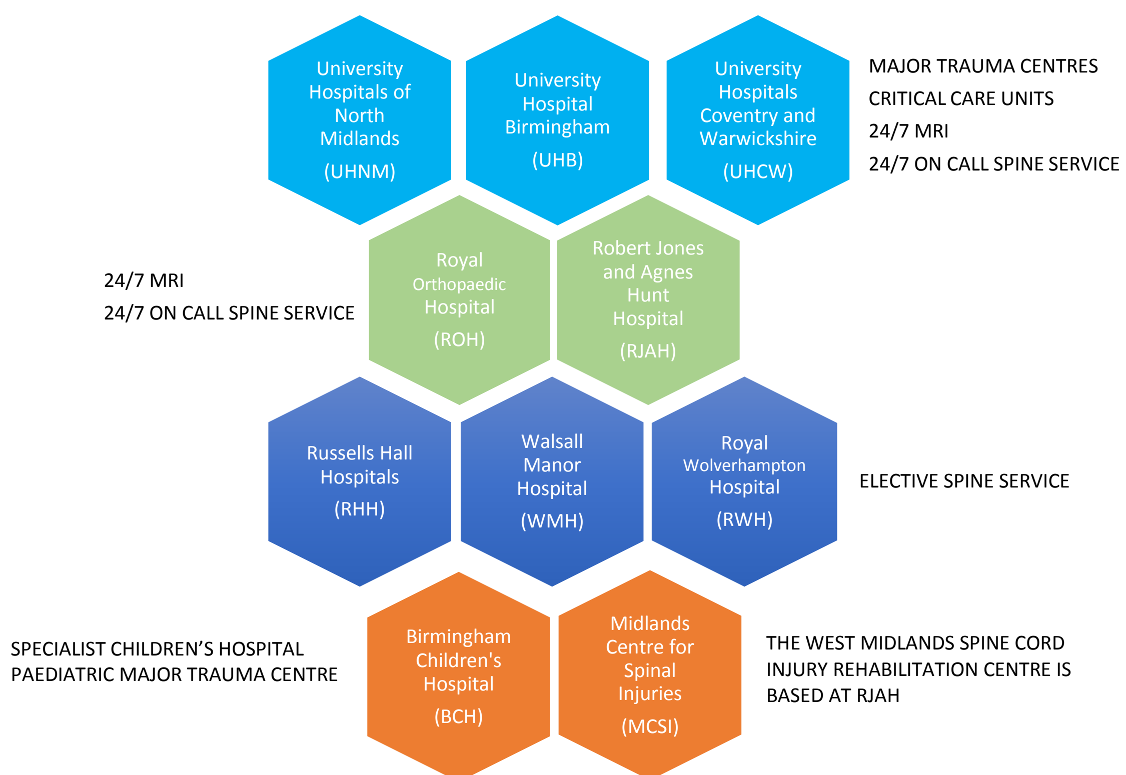
INTRODUCTION

The West Midlands Regional Spine Network (WM RSN) includes 3 major trauma centres, 2 specialist orthopaedic hospitals, 3 neuroscience centres and 3 spine partner hospitals. There is also a specialist children's hospital which provides elective and emergency spine care. There is a regional specialist spinal cord injury rehabilitation centre. Spine cord injury rehabilitation also takes place at the neurorehabilitation centres associated with the major trauma centres.

UHNM, UHB, UHCW, ROH and RJAH are known as spine hubs as they provide 24 hours spine on call cover. RWH, Walsall Manor and RHH are spine partners as they provide a spine service but without 24 hours on call cover.

WM RSN SPINE SURGICAL SERVICE OUTLINE



All hospitals accept adult patients for outpatient and inpatient management.
BCH, UHNM, ROH and RJAH accept 16 – 18 year olds for outpatient and inpatient management.
BCH and UHNM accept <16 year olds for outpatient and inpatient management. RJAH manages patients <14 years old as inpatients through Alder Hey Hospital, Liverpool.

In addition, the RSN also includes the triage services, pain management and rehabilitation services. Private provider hospitals carrying out spine surgery are also part of the RSN.

TYPES OF ELECTIVE SPINE SURGERY BY HOSPITAL

Hospital	Degenerative lumbar	Degenerative cervical	Adult deformity	Paediatric disorders	MSCC	Intradural pathology
UHNM	✓	✓	✓	✓	✓	✓
UHB	✓	✓	✓		✓	✓
UHCW	✓	✓	✓		✓	✓
ROH	✓	✓	✓	✓*	✓	✓
RJAH	✓	✓	✓	✓*	✓	
RHH	✓					
WMH	✓					
RWH	✓	✓				
BCH				✓		

*16 – 18 year old on site; for ROH < 16 y are managed at BCH; RJAH < 14 y at Alder Hey

PRIVATE PROVIDERS OF ELECTIVE SPINE SURGERY

BMI Meriden Hospital
BMI South Cheshire
BMI Priory

Nuffield North Staffordshire
Nuffield Shrewsbury
Nuffield Warwickshire
Nuffield Wolverhampton

Ramsay Rowley Hall
Ramsay West Midlands Hospital

Spire Little Aston
Spire Parkway
Spire Little Aston
Spire Droitwich

Executive Summary

- The aim of this document is to provide guidance on referrals for adult elective lumbar spine disorders to spine surgical services in NHS and private sector providers in the West Midlands Regional Spine Network.
- Paediatric and emergency/red flag conditions are not covered by this document.
- This document aligns with the National low back pain and sciatica (over 16s) NICE guidance (NG59).
- All adult elective referrals should be referred to a triage and treat service which is a primary/secondary care interface service. The triage service should assess the need for and carry out an MRI scan. MRI scans should be relevant to the presenting symptoms and be at least within 6-12 months of the current episode.
- All patients with back pain and or radicular pain should have a period of conservative management including exercise, medication and education before referral to a triage service. Only those with immobilising radicular pain not responding to treatment, or a major or progressive neurological deficit should be referred for a direct urgent secondary care opinion.
- Patients with radicular pain not responding to conservative methods should ideally be referred to a spine surgical service at 8 to 12 weeks after onset (depending on patient choice) by the triage services.
- Patients with neurogenic claudication symptoms should be referred to a spine surgical service within 6 months by the triage services.
- Patients with pure 'non-specific' back pain should not be referred to a spine surgical service. Only patients with back pain associated with radicular pain, spondylolisthesis or spondylolysis, adult deformity or post-surgical (e.g. post discectomy) should be referred to a spine surgical service after 6 to 8 months of conservative treatment.
- Injections for pure back pain other than medial branch blocks and facet denervation should not be considered. Lumbar facet joint injections should not be performed by any service.
- All injections for radicular pain can be performed (e.g. lumbar epidural, caudal epidural, transforaminal epidural, root block).
- Lumbar total disc replacement should not be performed.
- Lumbar fusion for patients with back pain associated with radicular pain, spondylolisthesis or spondylolysis, adult deformity or post-surgical (e.g. post discectomy) can be considered.
- Lumbar fusion for pure 'non-specific' back pain should not be performed outside of a RCT.

Who does this policy affect?

Patient group

This policy affects adult elective patients with lumbar spine disorders that are referred from a primary care setting via a triage service (primary/secondary care interface service) to a secondary or tertiary care setting for spine surgical opinion.

It does not relate emergency or red flag conditions.
It does not relate to paediatric patients.

Clinical staff

General practitioners, triage services, spine surgical services, pain clinic services and therapists involved with spinal disorders should be aware of and acting on this policy.

Managerial staff

Practice managers, STP / CCG leads, responsible directorate managers, divisional managers, associate directors and Chief Operating Officer for each Trust in the WM RSN (spinal hub, spinal

partner and non-spine partner hospitals) must be aware of this policy and be involved in acting on this policy.

What is the policy trying to achieve?

The policy aims to improve 3 important aspects of elective adult lumbar spine care for the WM RSN:

1. Ensuring a patient has timely access to the right facility at the right time.
2. Ensuring patients are not referred for procedures with low clinical value.
3. Ensuring patients are referred for procedures with high clinical value.

The policy is a written consensus statement from the WM RSN in support of implementation of the NICE guidance on Low Back Pain and Sciatica in the over 16s (NG59).

Clarifying the terms used.

Lumbar spine and low back are synonymous terms in this document.

Sciatica pain refers to radicular (or nerve root related) pain secondary to nerve root compression in the lumbar spine at any level causing buttock, groin or leg pain concordant with concordant compression identified on an MRI scan (or equivalent imaging).

Neurogenic claudication refers to the clumsiness and or pain in the legs on activity due to nerve root compression secondary to lumbar spinal stenosis.

GP refers to a general practitioner or equivalent in a primary care setting.

Triage service refers to a primary/secondary care interface triage service. It often takes the form of a musculoskeletal integrated service.

Secondary care refers to spine surgical services, pain clinic services and rheumatology services (even if based in primary care).

Referral responsibilities.

Details can be found in NICE Guidance Low back pain and sciatica in the over 16s NG59.
This guidance excludes paediatric and red flag or emergency referrals.

General Practitioner (GP)

1. Elective adult lumbar spine disorders should be referred by the GP to their local primary/secondary care interface triage service.
2. The GP should not have to initiate any MRI investigations for non-red flag disorders before referral to the triage service.
3. The GP should initiate initial conservative management as per NG59 before referral to the triage service. This includes education, physiotherapy and medication.
4. The GP should use the STarT Back Tool as per NG59 to guide timing for referral to community physiotherapy services.
5. Otherwise failure of improvement with conservative means should result in referral to the triage service within 4 - 6 weeks. For severe pain earlier referral and or request for an urgent assessment can be considered.
6. The GP should assess for red flags including cauda equina syndrome, MSCC, major or progressive neurological deficit and refer emergently to the spine surgical service if present (see WM RSN Emergency disorders policy).

7. The GP should assess for inflammatory conditions for pure low back pain presentations as per NICE guidance “Spondyloarthritis in over 16s” (NG65) and refer as appropriate.

Triage services

1. Triage services should ideally be triage *and treat* services with the specification as outlined in NG59.
2. Triage services should be provided in the community or primary care setting as a primary/secondary care interface service and resourced by STP / CCG.
3. Triage services must be fully cognisant of the local spine service provision and have a working and educational relationship with both primary care and secondary care clinicians.
4. The triage service must interact with primary care, physiotherapy services, rheumatology services, pain services and spine surgical services.
5. The triage service should have the ability to seek advice with members of any of these services as necessary.
6. On receipt of referral a patient should be seen within 2 - 4 weeks. An urgent referral should be seen within 72 hours.
7. The patient should be assessed by a triage practitioner competent in assessing spinal disorders.
8. The triage practitioner should refer for or continue conservative management where appropriate. This will include education, exercise, medication and combined psychological and physical interventions or equivalent as appropriate.
9. If required, the triage service should request MRI imaging in line with NG59 and WM RSN MRI policy.
10. The MRI required for most lumbar spine degenerative disorders is a T1 and T2 sagittal sequence of the lumbar spine with T2 axials of the areas of interest and abnormal areas.
11. If a patient is referred to a secondary care service the minimum information required is:
    a. Demographics.
    b. Clinical symptoms including pain pattern and predominance (leg or back), onset and duration, neurological symptoms, effect on function (recreational, professional, activities of daily life).
    c. Clinical signs including presence or absence of neurology.
    d. MRI report.
    e. MRI must be digitally transferrable to the secondary care service.
12. The triage service should assess for red flags including cauda equina syndrome, MSCC, major or progressive neurological deficit and refer urgently to the spine surgical service if present. The secondary care service will direct the need for outpatient MRI before being seen.
13. The triage service should assess for inflammatory conditions for pure low back pain presentations as per NICE guidance “Spondyloarthritis in over 16s” (NG65) and refer to Rheumatology as appropriate.

Secondary care services

1. The secondary care service (and rheumatology service if primary care based) must have an educational and working relationship with the triage services.
2. There must be easy access (electronic preferably) for the triage practitioners to request and receive advice.
3. Secondary care should not invest in a secondary care based triage service. The use of secondary care staff to triage should be unnecessary and such resources are best served to improve capacity and quality in secondary care and support the primary/secondary care interface triage service. Continuing education, dialogue and skill sharing will serve to enhance the pathway and maintain competence and trust.

4. The secondary care service must provide access for urgent referrals to be seen within 2 weeks if requested by the triage service.
5. The secondary care service should work to national access times for treatment.
6. The secondary care service must still give advice to GPs as required.
7. The secondary care service must still see and assess emergent, urgent or red flag referrals directly from the GP using appropriate emergency portals. If emergent referrals are assessed and not requiring emergent or urgent intervention, the patient should be discharged to the triage and treat service if the time line of symptoms is short and not requiring surgical intervention. If the patient will require intervention then an appointment should be arranged in the elective secondary care service.
8. Any routine GP referrals that are mistakenly referred directly to secondary care should be redirected by secondary care to the triage service (do not reject to GP).

What to refer to secondary care services?

Details can be found in NICE Guidance Low back pain and sciatica in the over 16s NG59.
This guidance excludes paediatric and red flag or emergency referrals.

Radicular pain with or without back pain

1. All urgent, emergency and red flag referrals should be referred and accepted by secondary care services through appropriate portals as normal.
2. Patients with radicular AND back pain (especially if radicular predominant) or radicular pain only are considered here.
3. Radicular pain does not have to radiate below the knee to be related to nerve root compression. This should not be a prerequisite of referral as it is not based on evidence or neuroanatomical reality.
8. GP should refer to triage services within 4 - 6 weeks of onset if no improvement after initial conservative management including community physiotherapy. For severe pain earlier referral and or request for an urgent assessment can be considered.
4. Triage services should request an MRI if not improving.
5. Radicular pain must be clinically correlated with compression identified on an MRI scan or equivalent before referral to secondary care.
6. Patients with radicular pain should be referred to a spine surgical service by the triage team within 2 -3 weeks if severe and not responding. Otherwise radicular pain patients should be referred within 6 – 8 weeks if not responding to conservative methods (in keeping with patient choice).
7. Radicular pain patients should not be asked to persist with conservative measures beyond this time frame unless the patient chooses not to be referred.
8. Surgical intervention for radicular pain has a good success rate and low complication rate.
9. Spine surgical services can offer both injections and surgical interventions for radicular pain.

Neurogenic claudication secondary to spinal stenosis

1. All urgent, emergency and red flag referrals should be referred and accepted by secondary care services through appropriate portals as normal.
2. This category of patients may have a feeling of clumsiness on walking or standing with or without radicular pain with an MRI (or equivalent imaging) demonstrating clinically correlated spinal stenosis.
1. The absence of root tension (or other clinical signs) does not exclude this diagnosis.
2. Peripheral pulses should be assessed and be normal.
3. GP should refer to triage services within 6 – 8 weeks if not improving after an initial trial of conservative management including community physiotherapy.

4. Triage service should request an MRI if not improving.
5. Patients should be referred to a spine surgical service by the triage team no later than 6 months after onset of symptoms and a conservative trial including education, exercise and medication.
6. Earlier referral should be made if the patient's mobility or function is significantly impaired.
7. Surgical intervention for stenotic pain has a good success rate and low complication rate.
8. Spine surgical services can offer surgical interventions for spinal stenosis. The evidence for the use of injections in spinal stenosis is poor.

Low back pain with no radicular pain

1. All urgent, emergency and red flag referrals should be referred and accepted by secondary care services through the appropriate portals as normal.
2. Inflammatory conditions for low back pain presentations should be assessed and referred to the appropriate service as per NICE guidance "Spondyloarthritis in over 16s" (NG65).
3. GPs should use the STarT Back tool to guide timing for referral to physiotherapy services. Otherwise refer to interface triage if no improvement after 6 weeks of onset.
4. Triage services should refer for conservative management as/if appropriate, including referral to services able to provide physical and psychological interventions in a multidisciplinary setting, and/or pain clinics.
5. For patients with low back pain not responding to conservative management and still seeking care, referral to secondary care should be considered after 6 – 8 months of conservative management.
6. Patients with low back pain (without radicular pain) due to "non-specific" causes should be referred to pain services rather than surgical services.
7. Only patients with back pain associated with spondylolisthesis or spondylolysis, adult deformity, radicular pain or post-surgical (e.g. post discectomy) should be referred to a spine surgical service after appropriate but unsuccessful conservative treatment. Imaging should be completed by triage services before referral.
8. No patient should be referred for facet joint injections according to NICE guidance.
9. Triage practitioners can refer to secondary care pain clinics for consideration of medial branch blocks and facet rhizolysis if conservative treatment has failed. The secondary care service that will assess suitability for these injections.

Adult spine deformity

1. Adult spine deformity (scoliosis or kyphosis) can present as deformity, difficult maintaining an upright posture, back pain, radicular pain or neurogenic claudication.
2. Patients with predominant back pain, should follow the pathway for low back pain patients. They can be referred for a surgical opinion for fusion if they do not improve after 6 – 8 months.
3. Patients with predominant radicular pain should follow the radicular pain pathway and be referred for a surgical opinion if they do not improve after 8 – 12 weeks.
4. Patients with predominant neurogenic claudication should follow the neurogenic claudication pathway and be referred for a surgical opinion if they do not improve after 6 months.
5. Patients with predominant deformity or posture related problems along with pain should be referred to your local spine deformity service after ensuring that they are fit enough for major surgery and are willing to have major surgery. The need for surgery will be assessed by the spine deformity service.

What secondary care treatment options are there?

Lumbar epidural Injections

1. Epidural (lumbar or caudal), transforaminal epidural and root blocks can be offered for radicular pain predominant patients.
2. They should not be used as a treatment for low back pain only.
3. The efficacy is not proven in neurogenic claudication.
4. They can be offered in interface, spine surgical services or pain services.

Lumbar facet joint injections

1. These should not be offered or carried out for low back pain or radicular pain as per NICE guidance.

Medial branch blocks and facet rhizolysis

1. These could be offered for low back pain after failure of conservative treatment.

Decompression / discectomy with or without fusion

1. Patients with radicular pain secondary to disc prolapse or stenosis should be offered decompressive surgery.
2. Patients with neurogenic claudication secondary to stenosis should be offered decompressive surgery.
3. Decompression with fusion (instrumented or uninstrumented) for elective radicular pain could be offered in the following conditions:
    a. Revisional surgery
    b. Predominant foraminal stenosis
    c. Evidence of instability
    d. Spondylolisthesis (grade 2 or above)
    e. Scoliosis or kyphosis
4. Current evidence does not either support or preclude the use of interbody cages in most radicular pain procedures requiring fusion. The use of interbody cages lies with the surgeon performing the procedure.

Fusion (instrumented or uninstrumented) for low back pain

1. Fusion for non-specific low back pain should only be offered as part of an RCT according to NICE guidance.
2. Fusion for low back pain predominant patients can be offered after a conservative trial of 6 – 8 months in the following conditions:
    a. Back pain with some radicular pain
    b. Spondylolisthesis
    c. Spondylolysis
    d. Adult deformity
    e. Post-surgical (e.g. post discectomy)
3. Current evidence does not support or preclude the use of interbody cages in most fusion procedures. The use of interbody cages lies with the surgeon performing the procedure.

Lumbar total disc replacement for low back pain

1. Lumbar total disc replacement should not be offered or carried out for low back pain unless part of a RCT according to NICE guidance.

And finally…

This document is a guideline that summarises the main responsibilities and key points of the National Low Back Pain and Sciatica pathway (NG59). This is a document that represents consensus of the West Midlands Regional Spine Network Board.

It is important for primary care, interface services and secondary care spine surgical services to work closely and maintain open channels for dialogue and exchange of information and knowledge. This will ensure the pathway achieves its aims and improves care for patients.

Useful Links

NICE low back pain and sciatica in over 16s NG59

NICE spondyloarthritis in over 16s NG65

STarT Back Tool

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