Dynamic Chiropractic

Task Force Results Explained to Media, Health Care Professionals

DR. SCOTT HALDEMAN HIGHLIGHTS FINDINGS OF THE NECK PAIN TASK FORCE AND ITS EFFECT ON THE HEALTH CARE LANDSCAPE.

Kathryn Feather

Dr. Scott Haldeman, DC, MD, PhD, recently shared the key points uncovered by his research with the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and its Associated Disorders in an April Webinar attended by health care professionals and the media. (Click here to watch a recording of the Webinar or click here for an overview of the findings.)

Dr. Scott Haldeman, President, Task Force on Neck Pain and its Associated Disorders.

After a brief description of the history of the task force - particularly noting its multidisciplinary and international aspects - Dr. Haldeman outlined the work of the task force, which consisted of a systematic review of scientific evidence including 31,878 citations, and 1,203 reviewed and 552 admissible papers, as well as four original research projects.

According to Dr. Haldeman and the researchers, the study results indicated two universal messages: 1) Neck pain is a widespread experience with most sufferers managing to carry on with their usual activities and one or two people out of 20 who find their pain disabling; and 2) Once an episode of neck pain happens, the majority will find it is a persistent or recurrent condition.

Researchers also concluded, "There is usually no single cause of neck pain. Many factors play a part including overall physical and mental health, work and daily activities. There are usually multiple factors that contribute to an individual's neck pain. Most neck pain is not the result of serious injury or disease. Diagnostic tests such as X-rays, CT or MRI scans are only required in a minority of cases when a thorough physical examination and patient history indicate further investigation is needed. Routine imaging will not increase understanding of causation. Degenerative changes in the neck increase with age and are common in people with and without neck pain; degenerative changes seen on X-rays are not predictive of neck pain."

The task force also recommends classifying neck pain, including WAD, into four grades, with the following definitions:

- Grade 1: Neck pain with little or no interference with daily activities.
- Grade 2: Neck pain that limits daily activities.
- Grade 3: Neck pain accompanied by radiculopathy (pinched nerve - pain, weakness and/or numbness in the arm).
- Grade 4: Neck pain with serious pathology such as tumor fracture, infection and systemic disease. It was beyond the mandate of the task force to study Grade 4 neck pain.

"Most neck pain is Grade 1 or 2, and there are a variety of treatments worth considering, including education, exercise, mobilization, manipulation, acupuncture, analgesics, massage and low-level laser therapy.

"Treatments unlikely to help Grades 1 and 2 neck pain include collars; ultrasound; electrical muscle stimulation; transcutaneous electrical nerve stimulation (TENS); most injection therapies such as corticosteroid in cervical facet joints; radiofrequency neurotomies (overheating of small nerves in the neck to suppress pain); and surgery."

Arguably two of the more important task force findings are that people with Grade 1 or 2 neck pain can play an active role in managing their pain and that there is no best treatment for neck pain that is effective for everyone. Researchers recommend "trying a variety of therapies or combination of therapies" to help patients find relief. They also state that "pain relief is often modest and short-lived. Be cautious of treatments that make 'big' claims for relief of neck pain. Short episodes of care may be helpful as lengthy treatment is not associated with greater improvements."

In terms of neck pain patients playing an active role in managing their pain, Dr. Haldeman and the task force recommend the following:

- Don't expect to find a single cause for your neck pain.
- Stay as active as you can.
- You may choose to self-manage your pain. For example, stay active, exercise, reduce mental stress or try over-the-counter pain relievers.
- If you think you need treatment, talk to your health care provider about the range of effective treatment options that make sense for you; you might need to try a variety of options.
- Have realistic expectations for relief, which is often modest and short-lived.
- Don't continue treatment that doesn't provide improvement within a reasonable period of time. You should see improvement after two to four weeks if the treatment is the right one for you.
- There is relatively little research on what does or does not prevent neck pain from occurring in the first place or from recurring. For example, ergonomics, cervical pillows, or postural improvements might not help.

Certain portions of the webinar were directed specifically to "all health care providers" as well as

emergency physicians, surgeons and public and private insurers. The longest section dealt with all health care providers and offered several recommendations in dealing with neck pain patients.

All health care providers should, "conduct a thorough patient history, physical examination and patient self-assessment questionnaire to identify or rule out Grades 3 or 4 neck pain, (e.g. radiculopathy, tumor, fracture, infection, systemic disease). Routine imaging in Grades 1 or 2 neck pain will not increase understanding of causation. Avoid unnecessary investigations for Grades 1 and 2 neck pain (e.g. X-ray, MRI, CT scan). Degenerative changes seen on X-ray are not predictive of neck pain."

"Treat based on grades of neck pain. Provide the patient with an informed choice of effective treatment options and involve the patient in decision-making/trial of different options. No one treatment works for everyone. Proceed cautiously with Grade 3 neck pain as there is little research on non-surgical interventions for Grade 3 neck pain. Consider epidural corticosteroid injections for temporary relief of radiculopathy. Consider surgery in the presence of serious pathology or persistent radiculopathy. Whiplash associated disorders (WAD) may fall into any of the 4 grades of neck pain. Assess and treat according to grade. Grade 4 patients should be treated in accordance with best practices for the diagnosed pathology."

The most important finding of the task force as related to chiropractic and its relationship with the allopathic community was the supposed risk of vertebrobasilar stroke associated with chiropractic visits. The task force found "cervical manipulation is a reasonable option for people with Grade 1 or 2 neck pain. The risk of vertebrobasilar (VBA) stroke associated with a visit for a chiropractor's office appears to be no different from the risk of stroke following a visit to an MD's office. It is likely that patients in the early stages of VBA stroke are presenting to both chiropractors and family doctors because of neck pain and headache due to pre-existing vertebral artery dissection, which is a risk factor for VBA stroke. VBA dissection and stroke is extremely rare and there is no practical way to screen neck pain and headache patients for this problem."

The task force recommends the following the emergency physicians:

- Clinical screening procedures - The Canadian Cervical Spine Rule or the National Emergency X-radiography Utilization Study (NEXUS) Low Risk Criteria - are extremely effective at identifying patients who do not require X-ray or other imaging studies.
- There is no scientifically admissible evidence to support the use of routine MRI as a screening tool in the ER.
- CT scan is more sensitive than X-ray in identifying fractures in high-risk trauma patients (e.g., intoxicated, unconscious and/or obtunded).
- Five-view X-rays are no more effective than three views in identifying fractures.

For surgeons, the task force made two specific points. "There is no evidence for surgical intervention in Grade 1 or Grade 2 neck pain. For surgery that is meant to take the pressure off a compressed nerve root, there is no evidence that one type of decompression or fusion surgery is superior to other types of decompression and fusion surgeries (e.g. plates, cages, type of graft taken)."

For public and private insurers, the task force made four recommendations:

- Adopt universal (multi-provider/multi-modality) evidence-based treatment guidelines when paying for services.
- Create health care provider incentives which reward doing the "right thing" (e.g. thorough examination and history; effective treatment options, education and monitoring).
- Recognize the role that compensation policies have on patient outcomes; ensure that

insurance policies don't inadvertently promote disability.
- The risks associated with effective, non-surgical treatments are about the same - all are low risk.

In summary, Dr. Haldeman and the task force said, "Members of the Neck Pain Task Force feel that the most productive use of this review is to inform and empower the public - more specifically, people with neck pain or who are at risk of developing neck pain. The most valuable outcome and contribution will be a change of attitudes and beliefs about neck pain and its prevention, diagnosis, treatment and management."

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