

# Be Conservative With Neck Pain, Experts Urge

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Contributing Writer

Physicians who urged conservative treatment for neck pain—including a waiting period for imaging studies—were peppered with questions at the annual meeting of the American Academy of Orthopaedic Surgeons about how to determine whether and when neck pain stems from the disk.

“Unfortunately, we have no clear guide-

lines on how to determine whether neck pain is coming from the disk,” said Raj Rao, M.D. “If it’s worse with extension, I’m more inclined to believe that this may be [disk-related] pain. But number one is just my instinctive feel.”

Dr. Rao, director of spine surgery at the Medical College of Wisconsin, Milwaukee, and Jeffrey C. Wang, M.D., had both emphasized during a session on the cervical spine that neck pain—which 50%-70% of people experience at some point—

most often resolves with conservative measures.

“If there are no urgent findings, no history of trauma, no suspicion of neoplasm or infection, and [the patient doesn’t] have a worsening neurologic deficit, there is an appropriate period of time you can wait before obtaining any imaging studies whatsoever,” said Dr. Wang, chief of the spine service at the UCLA School of Medicine.

He recommended waiting at least 4 weeks before performing plain radiography of the cervical spine and evaluating radiographs as thoroughly as possible before considering MRI.

“The newer thinking is that [in addition to many other factors] we want to look at the amount of space available for the spinal cord and the neurologic elements,” Dr. Wang said. “And remember, the oblique views are important.”

Despite recent concerns about nonsteroidal anti-inflammatory drugs, the drugs are still a first line of treatment for patients with neck pain, Dr. Wang said. Corticosteroids “do not have a role in neck pain alone without any neurologic symptoms,” and narcotics and muscle relaxants are appropriate only for short-term use, he said.

“Physical therapy,” he emphasized, “is very, very valuable. We can now send patients in the acute phase—there are many more modalities to control pain.”

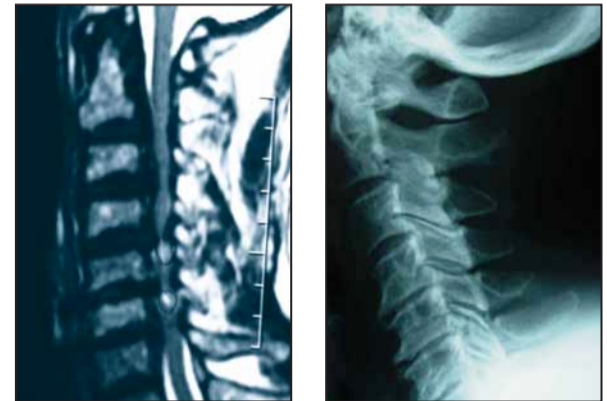
Dr. Wang and Dr. Rao responded to physicians who said they were frustrated with patients involved in legal actions who seek their opinion on whether motor vehicle accidents caused their neck pain—and specifically whether the accidents caused disk herniations.

The two physicians urged their colleagues to be cautious. “My party-line answer is that I can’t make a determination

of whether [their neck pain] is caused by the accident. ... And I rarely see patients with an acute herniated disk from a car accident,” Dr. Wang said.

“We have to remember we’re dealing with pain. There are so many inputs,” Dr. Rao said. “It’s very difficult to quantify how much of the pain is coming from the patient’s neck, the patient’s disk, and elsewhere.”

Studies show that one-third of patients who suffer whiplash in motor vehicle accidents will have symptoms for 1 year, and



MRI (left) helps identify severe narrowing of the spinal cord. An x-ray shows degenerative changes.

PHOTOS COURTESY DR. JEFFREY C. WANG

25% will have symptoms for up to 2 years, Dr. Wang said.

The physicians also responded cautiously to a question from the session moderator Jeffrey S. Fischgrund, M.D., about the role of diskograms. “I’m sure that within 2 years, cervical disk replacements will become available, and there’s no question that people will be looking at this as a treatment for neck pain. And I’m sure we’ll see a lot more diskograms. ... Will this be an option for people with neck pain?” said Dr. Fischgrund, who practices in Southfield, Mich.

Some physicians at UCLA order diskograms of the cervical spine, but “I tend not to get diskograms,” Dr. Wang said. “I’m not quite sure what to make of them.” ■

**Men**

In two placebo-controlled, double-blind, multicenter studies in men (a two-year study of FOSAMAX 10 mg/day and a one-year study of once weekly FOSAMAX [alendronate sodium] 70 mg) the rates of discontinuation of therapy due to any clinical adverse experience were 2.7% for FOSAMAX 10 mg/day vs. 10.5% for placebo, and 6.4% for once weekly FOSAMAX 70 mg vs. 8.6% for placebo. The adverse experiences considered by the investigators as possibly, probably, or definitely drug related in ≥2% of patients treated with either FOSAMAX or placebo are presented in the following table.

	Osteoporosis Studies in Men Adverse Experiences Considered Possibly, Probably, or Definitely Drug Related by the Investigators and Reported in ≥2% of Patients			
	Two-year Study		One-year Study	
	FOSAMAX 10 mg/day % (n=146)	Placebo % (n=95)	Once Weekly FOSAMAX 70 mg % (n=109)	Placebo % (n=58)
<b>Gastrointestinal</b>				
acid regurgitation	4.1	3.2	0.0	0.0
flatulence	4.1	1.1	0.0	0.0
gastroesophageal reflux disease	0.7	3.2	2.8	0.0
dyspepsia	3.4	0.0	2.8	1.7
diarrhea	1.4	1.1	2.8	0.0
abdominal pain	2.1	1.1	0.9	3.4
nausea	2.1	0.0	0.0	0.0

**Prevention of osteoporosis in postmenopausal women**

The safety of FOSAMAX 5 mg/day in postmenopausal women 40-60 years of age has been evaluated in three double-blind, placebo-controlled studies involving over 1,400 patients randomized to receive FOSAMAX for either two or three years. In these studies the overall safety profiles of FOSAMAX 5 mg/day and placebo were similar. Discontinuation of therapy due to any clinical adverse experience occurred in 7.5% of 642 patients treated with FOSAMAX 5 mg/day and 5.7% of 648 patients treated with placebo.

In a one-year, double-blind, multicenter study, the overall safety and tolerability profiles of once weekly FOSAMAX 35 mg and FOSAMAX 5 mg daily were similar.

The adverse experiences from these studies considered by the investigators as possibly, probably, or definitely drug related in ≥1% of patients treated with either once weekly FOSAMAX 35 mg, FOSAMAX 5 mg/day or placebo are presented in the following table.

	Osteoporosis Prevention Studies in Postmenopausal Women Adverse Experiences Considered Possibly, Probably, or Definitely Drug Related by the Investigators and Reported in ≥1% of Patients			
	Two/Three-Year Studies		One-Year Study	
	FOSAMAX 5 mg/day % (n=642)	Placebo % (n=648)	FOSAMAX 5 mg/day % (n=381)	Once Weekly FOSAMAX 35 mg % (n=382)
<b>Gastrointestinal</b>				
dyspepsia	1.9	1.4	2.2	1.7
abdominal pain	1.7	3.4	4.2	2.2
acid regurgitation	1.4	2.5	4.2	4.7
nausea	1.4	1.4	2.5	1.4
diarrhea	1.1	1.7	1.1	0.6
constipation	0.9	0.5	1.7	0.3
abdominal distention	0.2	0.3	1.4	1.1
<b>Musculoskeletal</b>				
musculoskeletal (bone, muscle or joint) pain	0.8	0.9	1.9	2.2

**Concomitant use with estrogen/hormone replacement therapy**

In two studies (of one and two years' duration) of postmenopausal osteoporotic women (total: n=853), the safety and tolerability profile of combined treatment with FOSAMAX 10 mg once daily and estrogen ± progestin (n=354) was consistent with those of the individual treatments.

**Treatment of glucocorticoid-induced osteoporosis**

In two, one-year, placebo-controlled, double-blind, multicenter studies in patients receiving glucocorticoid treatment, the overall safety and tolerability profiles of FOSAMAX 5 and 10 mg/day were generally similar to that of placebo. The adverse experiences considered by the investigators as possibly, probably, or definitely drug related in ≥1% of patients treated with either FOSAMAX 10 mg/day (n=157), FOSAMAX 5 mg/day (n=161), or placebo (n=159), respectively, were: *Gastrointestinal*: abdominal pain (3.2%; 1.9%; 0.0%), acid regurgitation (2.5%; 1.9%; 1.3%), constipation (1.3%; 0.6%; 0.0%), melena (1.3%; 0.0%; 0.0%), nausea (0.6%; 1.2%; 0.6%), diarrhea (0.0%; 0.0%; 1.3%); *Nervous System/Psychiatric*: headache (0.6%; 0.6%; 0.0%; 1.3%).

The overall safety and tolerability profile in the glucocorticoid-induced osteoporosis population that continued therapy for the second year of the studies (FOSAMAX: n=147) was consistent with that observed in the first year.

**Paget's disease of bone**

In clinical studies (osteoporosis and Paget's disease), adverse experiences reported in 175 patients taking FOSAMAX 40 mg/day for 3-12 months were similar to those in postmenopausal women treated with FOSAMAX 10 mg/day. However, there was an apparent increased incidence of upper gastrointestinal adverse experiences in patients taking FOSAMAX 40 mg/day (17.7% FOSAMAX vs. 10.2% placebo). One case of esophagitis and two cases of gastritis resulted in discontinuation of treatment.

Additionally, musculoskeletal (bone, muscle or joint) pain, which has been described in patients with Paget's disease treated with other bisphosphonates, was considered by the investigators as possibly, probably, or definitely drug related in approximately 6% of patients treated with FOSAMAX 40 mg/day versus approximately 1% of patients treated with placebo, but rarely resulted in discontinuation of therapy. Discontinuation of therapy due to any clinical adverse experience occurred in 6.4% of patients with Paget's disease treated with FOSAMAX 40 mg/day and 2.4% of patients treated with placebo.

**Laboratory Test Findings**

In double-blind, multicenter, controlled studies, asymptomatic, mild, and transient decreases in serum calcium and phosphate were observed in approximately 18% and 10%, respectively, of patients taking FOSAMAX versus approximately 12% and 3% of those taking placebo. However, the incidences of decreases in serum calcium to <8.0 mg/dL (2.0 mM) and serum phosphate to <2.0 mg/dL (0.65 mM) were similar in both treatment groups.

**Post-Marketing Experience**

The following adverse reactions have been reported in post-marketing use:

**Body as a Whole**: hypersensitivity reactions including urticaria and rarely angioedema. Transient symptoms of myalgia, malaise and fever, fever have been reported with FOSAMAX, typically in association with initiation of treatment. Rarely, symptomatic hypocalcemia has occurred, generally in association with predisposing conditions.

**Gastrointestinal**: esophagitis, esophageal erosions, esophageal ulcers, rarely esophageal stricture or perforation, and oropharyngeal ulceration. Gastric or duodenal ulcers, some severe and with complications have also been reported (see WARNINGS, PRECAUTIONS, Information for Patients, and DOSAGE AND ADMINISTRATION).

**Musculoskeletal**: bone, joint, and/or muscle pain, occasionally severe, and rarely incapacitating (see PRECAUTIONS, Musculoskeletal Pain).

**Skin**: rash (occasionally with photosensitivity), pruritus, rarely severe skin reactions, including Stevens-Johnson syndrome and toxic epidermal necrolysis.

**Special Senses**: rarely uveitis, scleritis or episcleritis.

For more detailed information, please read the Prescribing Information.

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## Microfracture's Success for Cartilage Defect Repair Tied to BMI, Fill Grade

Microfracture significantly improved knee function in patients with isolated full-thickness cartilage defects of the femur, Kai Mithoefer, M.D., reported at the annual meeting of the American Academy of Orthopaedic Surgeons.

His prospective evaluation of the common technique, which involves clearing out defective cartilage and creating a series of holes in the subchondral bone to stimulate growth of fibrocartilaginous repair tissue, showed that best results were obtained in patients who had good repair tissue fill (as opposed to moderate or poor fill), low body mass index (BMI), and symptom duration less than 12 months.

In the study, 48 patients were evaluated, with a minimum 2-year follow-up, using a combination of validated outcomes scores—including the SF-36 and Activities of Daily Living scores—cartilage-sensitive MRI, and a subjective rating. Most patients

were male; they averaged 21 years of age.

Patients with good fill grade “had significantly more improvement in all the scores than patients with moderate fill grade,” reported Dr. Mithoefer, of Massachusetts General Hospital, Cambridge. Lower BMI was associated with better functional outcomes. Poor fill grade was associated with limited improvement and decreasing functional scores after 24 months. Patients with poor fill grade also had higher BMI and a longer duration of symptoms, he reported.

In another study of osteoarticular transplantation surgery for large full-thickness cartilage defects of the knee, investigators found that 80% of 58 patients who underwent the procedure demonstrated significant improvement at an average of 36 months, reported Albert W. Pearsall IV, M.D., of the University of South Alabama Knollwood Park Hospital in Mobile.

—Christine Kilgore