Be Conservative With Neck Pain, Experts Urge

BY CHRISTINE KILGORE
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 guidelines 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.

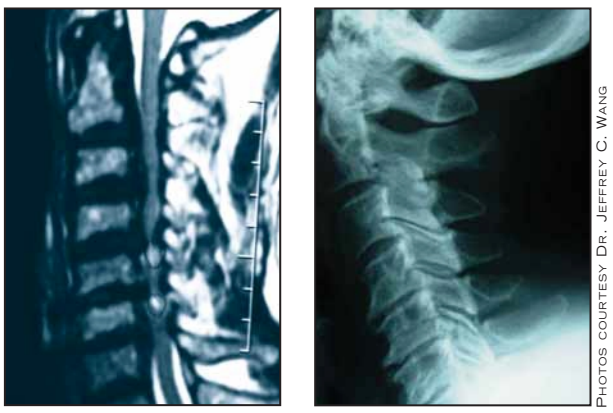
"Physical therapy," he emphasized, "is very, very valuable. We can now send patients in the acute phase—there are many more modalities to control pain."

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



PHOTOS COURTESY DR. JEFFREY C. WANG

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

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." ■

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