Be Conservative With Neck Pain, Experts Urge

No history of trauma, suspicion of neoplasm or infection? Wait a while before taking images.

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 originates 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 who have neck pain, Dr. Wang said.

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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.

The physicians also responded cautiously to a question from the session moderator Jeffrey S. Fischgrund, M.D., about the role of diskograms in evaluating neck pain.

"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 who practice at UCLA order diskograms of the cervical spine as they do of the lumbar spine, but "I tend not to get diskograms," Dr. Wang observed. "I'm not quite sure what to make of them." ■

MRI helps identify severe narrowing of the spinal cord. The circles highlight swelling.

A lateral x-ray shows degenerative changes of the cervical spine.

PHOTOS COURTESY DR. JEFFREY C. WANG

Low-Dose Combos Top High-Dose Monotherapy for Sciatica

BY TIMOTHY F. KIRN
Sacramento Bureau

SNOWMASS, COLO. — Sciatica and low back pain respond best to low doses of medications used in combination as opposed to high-dose monotherapy, David G. Borenstein, M.D., said at a symposium sponsored by the American College of Rheumatology.

There are no magic bullets. Instead, "it's trial and error and seeing what works with a patient," said Dr. Borenstein, a textbook author and researcher who practices in a rheumatology group in Washington.

According to prescribing patterns, it appears that muscle relaxants are among the most effective medications for back pain, but they are more effective when used in combination with other medications, Dr. Borenstein said.

In a telephone survey of patients with acute low back pain who were contacted 1 week after an office visit, the best outcomes appeared to be associated with a combination treatment using a muscle relaxant and an NSAID together.

Other respondents were taking no medication, or opioids, acetaminophen, and muscle relaxants alone (Spine 1998; 23:607-14).

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Dr. Borenstein said the survey findings are consistent with his own clinical experience using combination regimens, which he said can minimize side effects and have a synergistic effect.

He added that providers could use a lot more guidance on how to use drugs in combination; more dose-finding studies are needed.

In a report on two combined studies involving 1,405 patients with low back or neck pain, participants were randomly assigned to take the muscle relaxant cyclobenzaprine or placebo.

Dr. Borenstein noted that the cyclobenzaprine outperformed placebo in three primary, patient-rated end points. They were relief from pain at the start of the day, assessment of medication helpfulness, and clinical global impression of change.

Interestingly, when the researchers looked at three doses—2.5 mg, 5 mg, and 10 mg—each taken three times daily, they found that all the doses were more effective than placebo.

The 5-mg dose was no less effective than the 10-mg dose and was less likely to cause sedation, Dr. Borenstein said (Clin. Ther. 2003;25:1056-73).

Future strategies for treating low back pain may involve biologics such as infliximab, Dr. Borenstein said.

Several studies using animal models suggest that back pain, and the radicular pain that frequently accompanies it, is not caused by direct compression so much as by processes occurring in the nucleus pulposus, perhaps mediated by tumor necrosis factor.

Yet to be published open-label trials of infliximab that were conducted in Finland have shown significant efficacy within hours of patients' receiving a single injection, compared with controls that were given sham injections of saline.

However, the only double-blinded, controlled trial reported to date found no benefit relative to placebo.

The lack of efficacy seen in this unpublished trial may have been due to the high placebo response, Dr. Borenstein commented.

Another trial is underway. "[We need to] find out who the appropriate patients are," he said. "Then I suspect we will be able to show this is a good therapy." ■