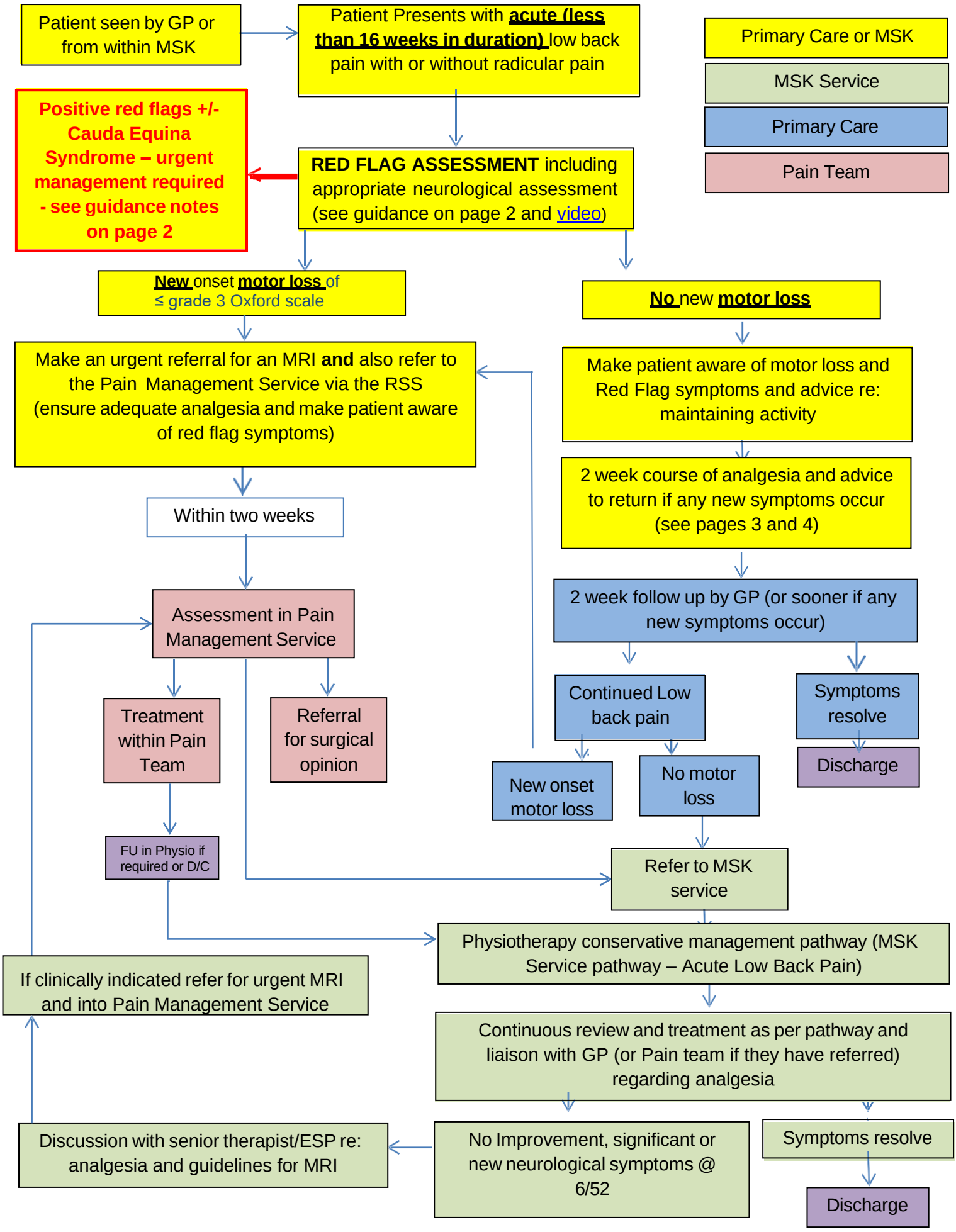
Pathway for patients presenting with new onset motor loss in the presence of acute low back and radicular pain



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Guidance notes

Cauda Equina Syndrome:

Symptoms **which are present on the day of attendance and are less than 3 months in duration** requiring urgent action:

- Altered sensation in the saddle area
- Bladder dysfunction – incontinence or retention
- Faecal incontinence

These patients should be **immediately** sent to the **Emergency Department**

Red flags where further investigation in primary or secondary care should be considered before referral to MSK:

- Significant motor weakness e.g. Isolated foot drop
- Progressive neurological deficit in lower extremities
- Saddle area numbness, urinary incontinence/retention or faecal incontinence that is **not** present on day of attendance or are greater than 3 months in duration
- Bilateral true sciatica
- Sexual dysfunction
- Paresis (gait disturbance)
- Thoracic pain
- Weight Loss
- Fever
- Previous malignancy
- Age < 20 or >55
- Systemic illness
- HIV
- IV drug user
- Frequent or long term steroid use
- Structural deformity

Please note there should be no requirement for non-urgent MRI requests from primary care. Such patients should be referred into the MSK service for full assessment and management of chronic back pain.

Referral criteria for MRI For MSK physiotherapists:

- Discuss with senior therapist/ESP re: analgesia ladder and patient history (if referring from within MSK)
- The MRI scan will be used to aid decision making for further treatment interventions (either in the Pain team or Orthopaedic surgery)
- Clear neurological deficit (motor loss) in the presence of back pain with radicular symptoms
- It is essential that the MRI request states whether there has been previous back surgery, including the level operated on and when the surgery was. If the patient has had a previous scan of the same area we need to know when and where.
- Check MRI is not contraindicated (no pacemakers, no aneurysm clips, no inner ear implants, no implanted spinal cord stimulators, no metal fragments in the eye).

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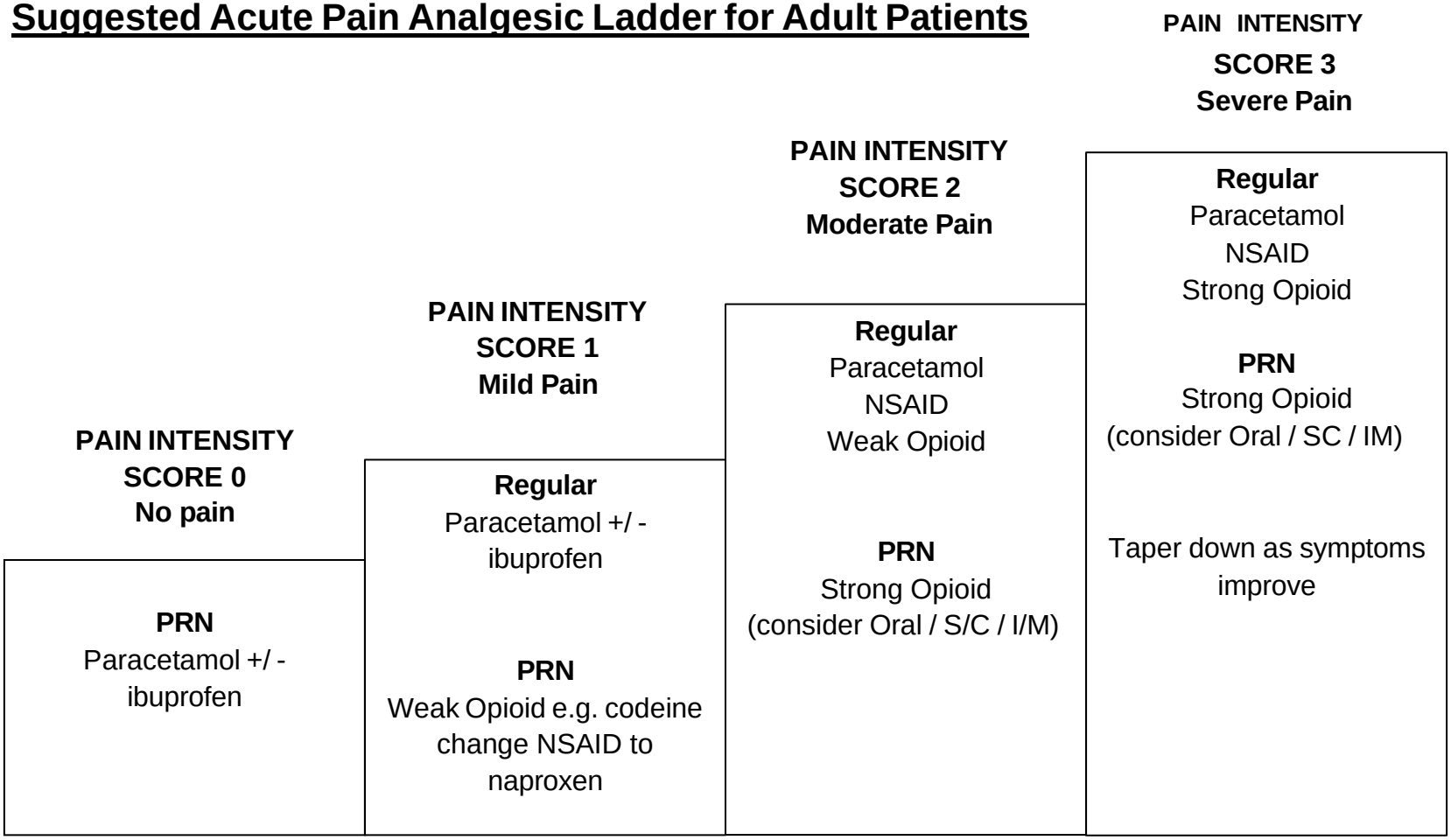
Suggested Acute Pain Analgesic Ladder for Adult Patients



Cautions: Use the BNF for guidance and cautions. In addition

- Be cautious combining weak and strong opiates
- Anti emetics may need to be prescribed with opioids if there are concerns about opioid induced nausea
- Aperients should also be considered with opioids if there are concerns about opioid induced constipation
- Codeine is contraindicated breast feeding mothers
- Check renal function is not impaired when prescribing NSAIDs
- Consider gastric protection when prescribing NSAID's

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Acute Pain Analgesic Ladder for Adult Patients

	Drug	Dose	Frequency	Recommended Routes	Notes
Non-opioid	Paracetamol	1g	PRN 4-6 hours OR regular 4 times per day	Oral, rectal	Max dose 4g / 24hours. See cautions on BNF,
NSAIDs (select one NSAID only)	Ibuprofen	400mg	6-8 hourly	Oral	Max 1200mg / day. See cautions in BNF
	Naproxen	500mg	500 mg initially, then 250 mg every 6–8 hours as required	Oral	Max 1.25g / day. See cautions in BNF
Weak Opioid (select one weak opioid only)	Dihydrocodeine	30mg	4-6 hourly	Oral	Max 240mg / day. See cautions in BNF
	Codeine	30mg or 60mg	4-6 hourly	Oral, IM	Max 240mg / day. See cautions in BNF
	Tramadol	50mg or 100mg	4-6 hourly	Oral, IV	Max 400mg / day. See cautions in BNF
1st Line Strong Opioids	Oral Morphine	10mg	Maximum hourly as per algorithm	Oral	Follow oral morphine algorithm. See cautions in BNF
	SC / IM Morphine	10mg	Maximum hourly as per algorithm	IM, SC	Follow IM / SC morphine algorithm. See cautions in BNF

Slow release opioids are not routinely used for acute pain, for individual cases please discuss with the Pain Management Service.

(Guidance adapted with thanks from Leeds Teaching Hospital NHS Trust)