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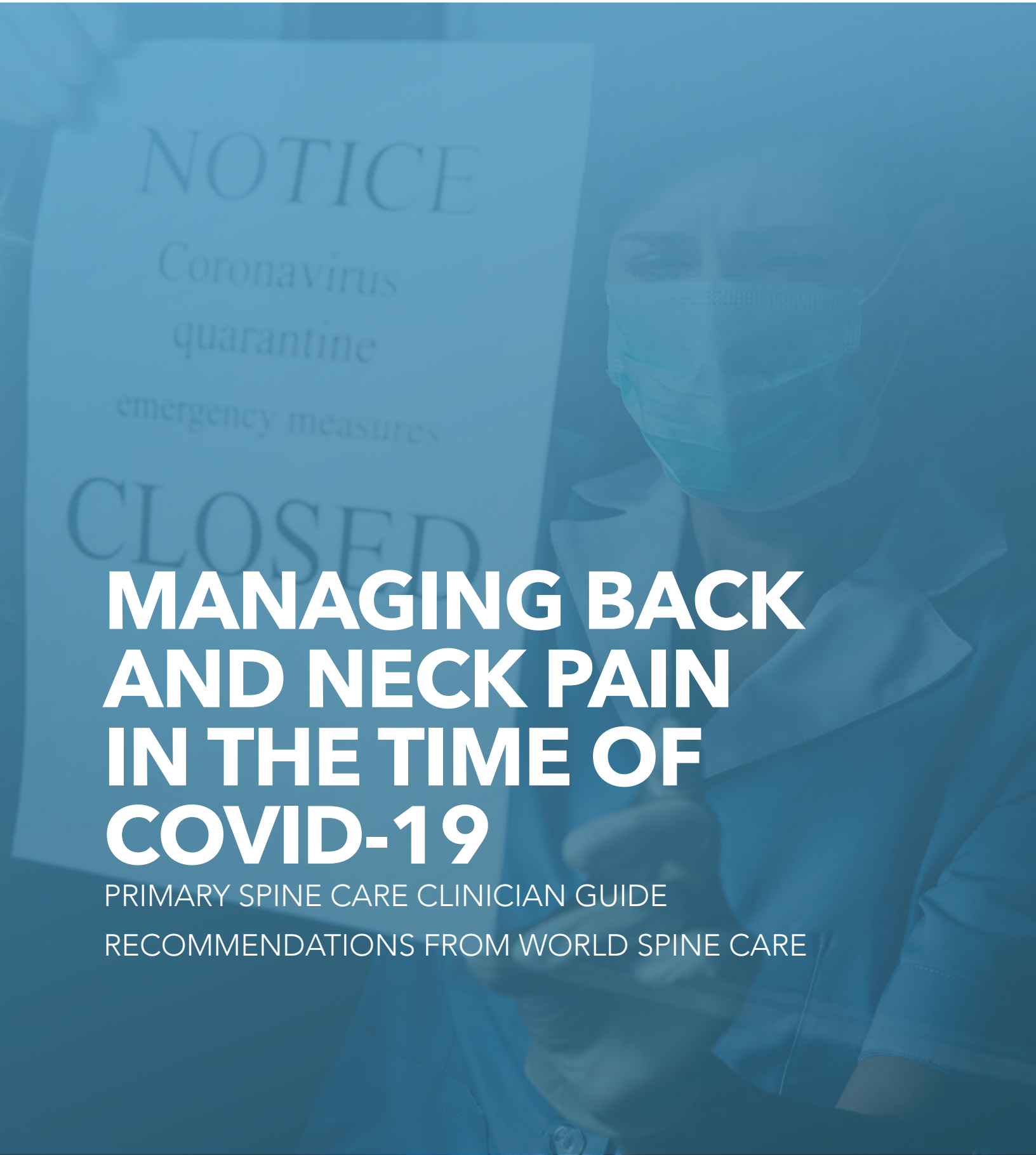

MANAGING BACK AND NECK PAIN IN THE TIME OF COVID-19

PRIMARY SPINE CARE CLINICIAN GUIDE

RECOMMENDATIONS FROM WORLD SPINE CARE

ADAPTED FROM THE GLOBAL SPINE CARE INITIATIVE

Recommendations from World Spine Care

As a result of the current COVID-19 pandemic, most healthcare providers who commonly treat or advise patients who are experiencing spinal pain (low back, middle back and neck pain) are unable to see patients. These Primary Spine Care Clinicians include chiropractors, physical therapists, osteopaths, and family/general physicians.

In most jurisdictions, secondary and tertiary medical specialists and surgeons including orthopedic surgeons, neurosurgeons, rheumatologists, pain management physicians, and neurologists have been forced to limit their practices to emergency or critical patients.

However, spinal pain and other spinal disorders have not gone away. People are still experiencing back and neck pain and are having to cope with the discomfort, disability and disruption of life that these conditions can cause.

Patients can become very anxious when they experience back or neck pain and feel neglected when they are unsure how to deal with these symptoms and unable to see their chiropractor, physical therapist, acupuncturist, osteopath, family/general physician, or specialist for advice on what to do.

World Spine Care (WSC), in conjunction with the Global Spine Care Initiative (GSCI), has developed an evidence-based model of care that can be modified so that patients can still help themselves or be helped by their licensed clinicians while at the same time avoiding or markedly restricting the degree of direct contact.

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DISCLAIMER

This Guide should only be considered in situations where social isolation is required or where clinicians or patients have elected to reduce contact, due to COVID-19, to those who require urgent or emergency care. It is expected that patients and providers will continue regular care as soon as any restrictions are lifted.

This Guide is provided as a public education service. WSC assumes no responsibility for any legal issues that may arise. Note that the GSCI Classification and Care Pathway has not yet been scientifically validated.

This Guide was developed by a multidisciplinary panel of 28 spine care authorities and clinicians from 10 countries on 4 continents.

References

Haldeman, S., Nordin, M., Chou, R., Côté, P., Hurwitz, E. L., Johnson, C. D., et al. (2018). The Global Spine Care Initiative: World Spine Care executive summary on reducing spine-related disability in low- and middle-income communities. European Spine Journal, 24(6), 1–10.

Haldeman, S., Johnson, C. D., Chou, R., Nordin, M., Côté, P., Hurwitz, E. L., et al. (2018). The Global Spine Care Initiative: classification system for spine-related concerns. European Spine Journal, 20(8 Suppl), 1–12.

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CLINICIAN GUIDE

MANAGING BACK AND NECK PAIN IN THE TIME OF COVID-19

CLINICIAN GUIDE

STEP 1

PATIENT DEMOGRAPHICS AND PSYCHOSOCIAL SITUATION

First contact by a patient

A patient has contacted me for spine pain and asks what they can do and whether they need to see someone. What can I do to help my patient without placing them at risk of COVID-19 infection?

This Guide can be used to review the symptoms experienced by a patient that may impact recommendations for patient management. The form below can be found in Appendix 1 and printed separately or incorporated into an EMR.

PATIENT DEMOGRAPHICS AND PSYCHOSOCIAL SITUATION

Patient Name: Date:

Age: Sex:

Normal Occupation:

Current work situation:

- Working:
- Unemployed:
- Laid off due to COVID-19:
- Worker's compensation:

Location of primary complaint:

- Low back:
- Mid back:
- Neck:

Co-morbidities:

Level of anxiety and concern about their condition:

Psychiatric history:

Other:

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STEP 2

COMPLAINT SEVERITY AND TRIAGE

Questions 1-5 are included in the WSC Patient COVID-19 Guide. These questions can be completed by the patient before seeking care or advice. If completed they should be reviewed with the patient.

1. **What are the patient's problems/ symptoms? (VAS scale: 0-10)**
   a. minimal discomfort (pain 0-1/10)
   b. mild (pain 2-4/10)
   c. moderate (pain 5-7/10)
   d. severe (pain 8-10/10)
   e. Numbness or tingling
   f. Muscle weakness
   g. Loss of balance
   h. Onset of bladder or bowel problems like loss of control

   Recent onset:

   Pre-existing and not changing:

2. **Does the pain radiate beyond the spine?**
   a. No
   b. Down both legs
   c. Down one leg
   d. Down both arms
   e. Down one arm
   f. New or different headaches
   g. Chest pain

3. **Are the symptoms stopping the patient from doing normal activities?** (NIH CIC scale: 0-50)
   a. No. The patient can do everything (NIH PCIC Score: 8–27)
   b. Yes, a little. The patient can do most activities (NIH PCIC Score: 27-35)
   c. Yes, a lot. The patient has difficulty doing anything (NIH PCIC score: >=35)

4. **Has the patient experienced a recent fall or accident?**
   a. No
   b. Yes

5. **Is there any history consistent with red flags for spinal pathology?**
   a. No
   b. Cancer
   c. Infection such as Tuberculosis or HIV
   d. Osteoporosis, steroid use, age over 60
   e. Inflammation of my joints or rheumatoid disease
   f. Serious neurological disease

Note: The VAS scores and NIH Pain Consortium Impact Classification Score (NIH PCIC) are not in the patient guide. Any valid disability scale can be used instead of the NIH PCIC score.

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STEP 3

GLOBAL SPINE CARE INITIATIVE (GSCI) CLASSIFICATION

What Class of back or neck pain best represents the patient symptoms?

CLASS 0 – MINIMAL OR NO DISCOMFORT BUT NO OTHER SYMPTOMS

Yes, on 1a and No on all other questions.

CLASS I – MILD SPINE PAIN

Yes, on 1b and No to all other questions.

CLASS II – MODERATE SPINE PAIN

Yes, on 1c and 3b.

CLASS II – SEVERE SPINE PAIN

Yes, on 1d and 3c and No on all other questions.

CLASS III – SYMPTOMS CONSISTENT WITH NERVE PROBLEM

Pain, numbness or tingling in arms or legs, new onset marked muscle weakness, new onset of bowel or bladder problems (Yes to 1d and/or 1e, and/or 1f and/or 1g and/or 1H).

Severe new onset of headaches or chest pain (yes to questions 2b and/or 2c and/or 2d and/or 2e).

Consider additional questions on gait difficulty, loss of balance, loss of hand function including clumsiness, dexterity that may represent symptoms of myelopathy.

CLASS IV – POSSIBLE SPINE/BONE FRACTURE

Severe fall or accident with severe spine pain (Yes on 1c and 4b).

CLASS V – POSSIBLE COMPLICATION OF A SERIOUS PROBLEM THAT IS AFFECTING THE SPINE

Yes, on any of the conditions noted in questions 5.

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STEP 4

DETERMINATION OF GSCI SPINAL DISORDER SUBCLASSIFICATION

Questions to ask to determine subclassification

1. Duration of symptoms?
2. Are symptoms progressive or stable?
3. What risk factors for spine pain and co-morbidities are present?

CLASS 0 – NO OR MINIMAL SYMPTOMS

SUBCLASS CONSIDERATIONS

- Class 0a = no history of risk factors
- Class 0b = history of risk factors

It is not necessary to see a clinician in his or her office. Telehealth may be considered.

CLASS 1 – MILD SPINE PAIN

SUBCLASS CONSIDERATIONS

- Class Ia = *acute* (duration < 3 months)
- Class Ib = *chronic* (duration > 3 months)

Office-based treatment by a clinician is not usually necessary. Telehealth may be necessary. Advice and reassurance may be helpful.

CLASS II – MODERATE AND SEVERE SPINE PAIN

SUBCLASS CONSIDERATIONS

- Class IIa = *acute* (duration < 3 months) *moderate* pain and disability
- Class IIb = *chronic* (duration > 3 months) *moderate* pain and disability
- Class IIc = *acute*, *severe* pain
- Class IId = *chronic*, *severe* pain and disability

IIa & IIb: Office-based treatment by a clinician is not always necessary. Telehealth is important. Advise and reassure. Regular Telehealth follow-up may be necessary.

IIc: Office-based treatment by a clinician may be necessary. In many cases acute symptoms can be managed through Telehealth in the absence of red flags.

IId: Office-based treatment by a clinician may not be necessary unless there is a flareup of incapacitating symptoms. Consider Telehealth consultation first.

CLINICIAN GUIDE

STEP 4
(CONTINUED)

CLASS III – NEUROLOGICAL SYMPTOMS OR DEFICITS

SUBCLASS CONSIDERATIONS

- Class IIIa = *minor or non-progressive*
- Class IIIb = *acute, major or progressive*
- Class IIIc = *chronic and stable*

Office or emergency room treatment by appropriate clinician is necessary if the symptoms are acute or progressive.

CLASS IV – SEVERE STRUCTURAL SPINE PATHOLOGY -POSSIBLE FRACTURE

SUBCLASS CONSIDERATIONS

- Class IVa = *stable* spine structural pathology with no serious symptoms or red flags
- Class IVb = *acute* (e.g. fracture) or *chronic* (e.g. instability) spine *structural pathology* which correlates with symptoms

IVa: Office based treatment is not necessary. Telehealth may be considered for advice and reassurance.

IVb: Emergency treatment is necessary.

CLASS V – SPINE RELATED SYMPTOMS DUE TO SERIOUS SYSTEMIC PATHOLOGY

SUBCLASS CONSIDERATIONS

- Class Va = *severe acute spine pathology*. **Requires immediate attention (emergency).**
- Class Vb = *slowly progressive spinal pathology*. **Requires intervention (non-emergency).**
- Class Vc = *symptoms originating from non-spinal pathology*. **Requires immediate attention (emergency).**

Referral to patient's medical family/general physician or specialist to determine whether serious disease is causing the patient's spine-related symptoms. Advise patient if emergency attention is required.

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STEP 5

TREATMENT CONSIDERATIONS

On completion of the questionnaire and determining the Class and Subclass of spinal disorder, consider the following:

1. Follow WHO, CDC, NHS, and other national government agency guidelines for the current status and recommendations regarding the prevention and management of COVID-19.

2. Consult national evidence-based treatment guidelines for evidence-based treatment options for each subclass of spinal disorder. Consider the Global Spine Care Initiative flashcards for a review of these guidelines and interventions recommended for each class and subclass of spinal disorder.

   Other Resources

   - NHS - Back Pain
   - American College of Physicians Clinical Practice Guideline
   - Canadian Chiropractic Guideline Initiative
     - Neck Pain
     - Low Back Pain
     - Self Management Resources
     - Exercise Videos
   - American Physical Therapy Association Clinical Practice Guidelines
   - Task Force on Neck Pain Executive Summary

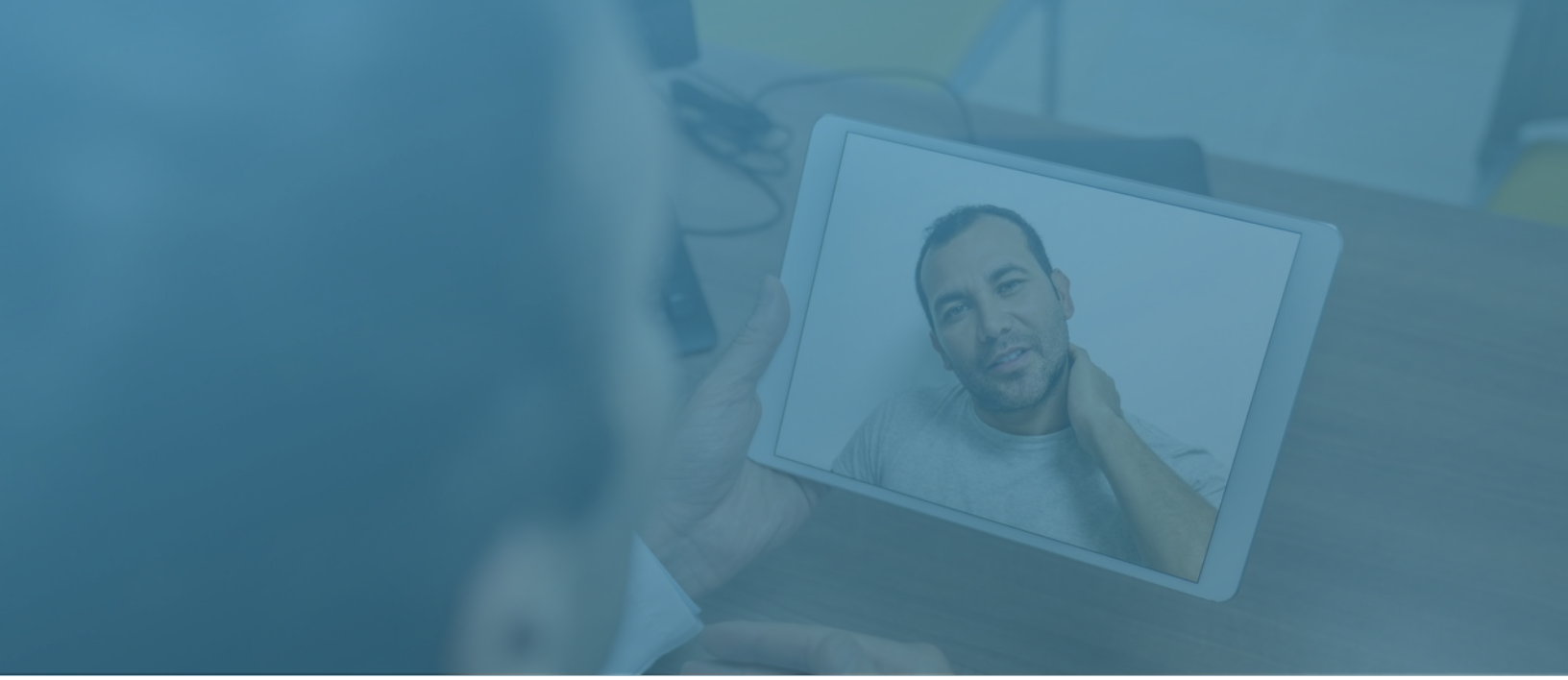
3. Advise patients over the phone, provide video consultations (in some/regions partially or fully reimbursed by the health insurance), use social media including Facebook to educate patients. Considerations:
   - Research existing on-line educational media that satisfies the requirements for each individual patient.
   - Consider leading online educational classes with patients.
   - Consider leading or referring to on-line yoga, including the World Spine Care Yoga Project, Tai-Chi, Pilates, or rehabilitative exercise group classes with patients.

4. For Class 0, Class I, and moderate Class II, reinforce that the current research suggests that self-care is usually enough to control symptoms. Provide advice and reassurance that may relieve the pain and aid recovery.

CLINICIAN GUIDE

STEP 5
(CONTINUED)

5. The taking of over the counter medication including paracetamol and non-steroidal anti-inflammatory drugs (NSAIDs), including Ibuprofen and Naproxen is recommended for short term relief of back and neck pain by most evidence-based guidelines. Patients should be aware of the potential adverse events including gastrointestinal bleeding and ulcers, cardiovascular and renal disorders. The possibility that NSAIDs may negatively impact COVID-19 pulmonary symptoms has been raised but not confirmed at the time of publication. (*Non-steroidal anti-inflammatory drugs and covid-19. BMJ 2020; 368:m1185.*) Clinicians should be able to advise patients or refer patients to a reliable source of information when asked by patients about taking these medications. Click here for additional details.
6. Reinforce that testing such as X-ray and MRI rarely help in the decision on which treatment to consider. Referral to a surgeon is not necessary unless the patient is incapacitated, has had a significant injury, or has red flags that result in Class III, IV or V assessment.
7. Be available for regular follow up contact with the patient (virtually).
8. Recognize that patient symptoms on rare occasions can get worse, so that they could eventually fall into a different Class or Subclass and require different or more immediate care than originally recommended.
9. Patients should be empowered to embrace self-management but still feel they are being cared for.



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TELEHEALTH CONSIDERATIONS

WORLD SPINE CARE SUPPORTS MAKING TELEHEALTH FOR SPINE CARE MORE AVAILABLE AS WELL AS REIMBURSABLE.

1. Find out if Telehealth communication is allowed in your jurisdiction.
2. In many countries and regional jurisdictions, including the United States, be careful about providing Telehealth sessions to patients who live outside of your jurisdiction. You may be sanctioned for practicing without a license. Follow all the legal recommendations for Telehealth.
3. Check with your malpractice carrier to make sure there are no restrictions for coverage while conducting Telehealth sessions.
4. Also make sure to obtain a verbal consent from the patient in which they acknowledge there are limitations to a Telehealth session, which is not the same as a physical examination (not possible to do a detailed neurological examination on the phone, etc.).
5. Be careful not to violate any patient privacy rules. Use a video program or platform that provides an appropriate level of patient confidentiality to satisfy regional or national laws.
6. Find out if compensation is allowed, including billing requirements that may necessitate mandatory documentation regarding Telehealth sessions with your patients.
7. Keep records of your consultation.
8. Make sure to get the address of the physical location of the patient. This may be necessary in case of an emergency arises during the Telehealth session.

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OUTPATIENT CONSIDERATIONS

AFTER TELEHEALTH ASSESSMENT, THE PATIENT MUST BE SEEN AND EXAMINED IN MY OFFICE OR AT ANOTHER CLINICAL FACILITY.

During this period of social and physical distancing what precautions must I consider when seeing a patient while protecting both the patient, me, and my staff from infection?

1. Follow World Health Organization (WHO), Centre for Disease Control (CDC), the National Health Service (NHS), and other government agency guidelines based on your geographical area of practice. Note that these guidelines are fluid, so be sure to keep yourself informed of best practices and requirements.
2. Be sure that all office equipment is sanitized after every patient contact.
3. Always wear a clean mask and gloves and wash hands before and after every patient contact.
4. Patients with severe incapacitating pain or radiculopathy, especially if acute, should be seen in an outpatient office. The goal is to determine if they need referral. If referral is not necessary, provide reassurance and relief. Try, as much as possible, to keep them away from emergency departments where they are at higher risk of infection of COVID-19.
5. Create a list of the surgeons, medical specialists and emergency facilities in your community who will accept patients who require specialist level or immediate care.
6. Prioritize front line workers (doctors, nurses, ambulance, police, military and law enforcement personnel and others) who are treating and supporting COVID-19 patients and

CLINICIAN GUIDE

OUTPATIENT CONSIDERATIONS
(CONTINUED)

services, to help them stay at work despite non-serious spine pain.

7. Check with your jurisdiction rules about their definition of "essential services". In certain jurisdictions, primary care clinicians are legally permitted to see patients in an out-patient setting, if they are providing "essential services". This has usually been interpreted to mean patients in acute pain or distress, who would otherwise go to an emergency department. It does not mean maintenance or preventive services.

8. For those primary care clinicians who work within integrative settings, the rules about outpatient services vary greatly. In certain jurisdictions seeing a patient in an out-patient setting with sciatic radiculopathy is considered a "non-essential" service. In other jurisdictions this would be considered an "essential" service.

9. One of the emerging findings in patients with severe COVID-19 is blood clotting disorders. Research into this phenomena is being conducted in various places around the world but little has been published to date, therefore, chiropractors and other manual therapists should ensure they follow the latest research on this topic because of the possible impact on the treatment of patients who have had COVID-19.

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THANK YOU.

On behalf of World Spine Care and the Global Spine Care Initiative, we wish to thank the multidisciplinary panel of 28 spine care authorities and clinicians from 10 countries on 4 continents who provided their time and expertise into the development of this Guide.

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Learn more about World Spine Care: www.worldspinecare.org

APPENDIX A

PATIENT DEMOGRAPHICS AND PSYCHOSOCIAL SITUATION

Patient Name: _____ Date: _____

Age: _____ Sex: _____

Normal Occupation: _____

Current work situation: _____

Working: _____

Unemployed: _____

Laid off due to COVID-19: _____

Worker's compensation: _____

Location of primary complaint: _____

Low back: _____

Mid back: _____

Neck: _____

Co-morbidities: _____

Level of anxiety and concern about their condition: _____

Psychiatric history: _____

Other: _____

_____

_____

_____