



**ALGORITHM FOR ASSESSMENT AND
TREATMENT OF BACK OR NECK PAIN –
*Indications for Spinal Epidural Injection***

SUMMARY

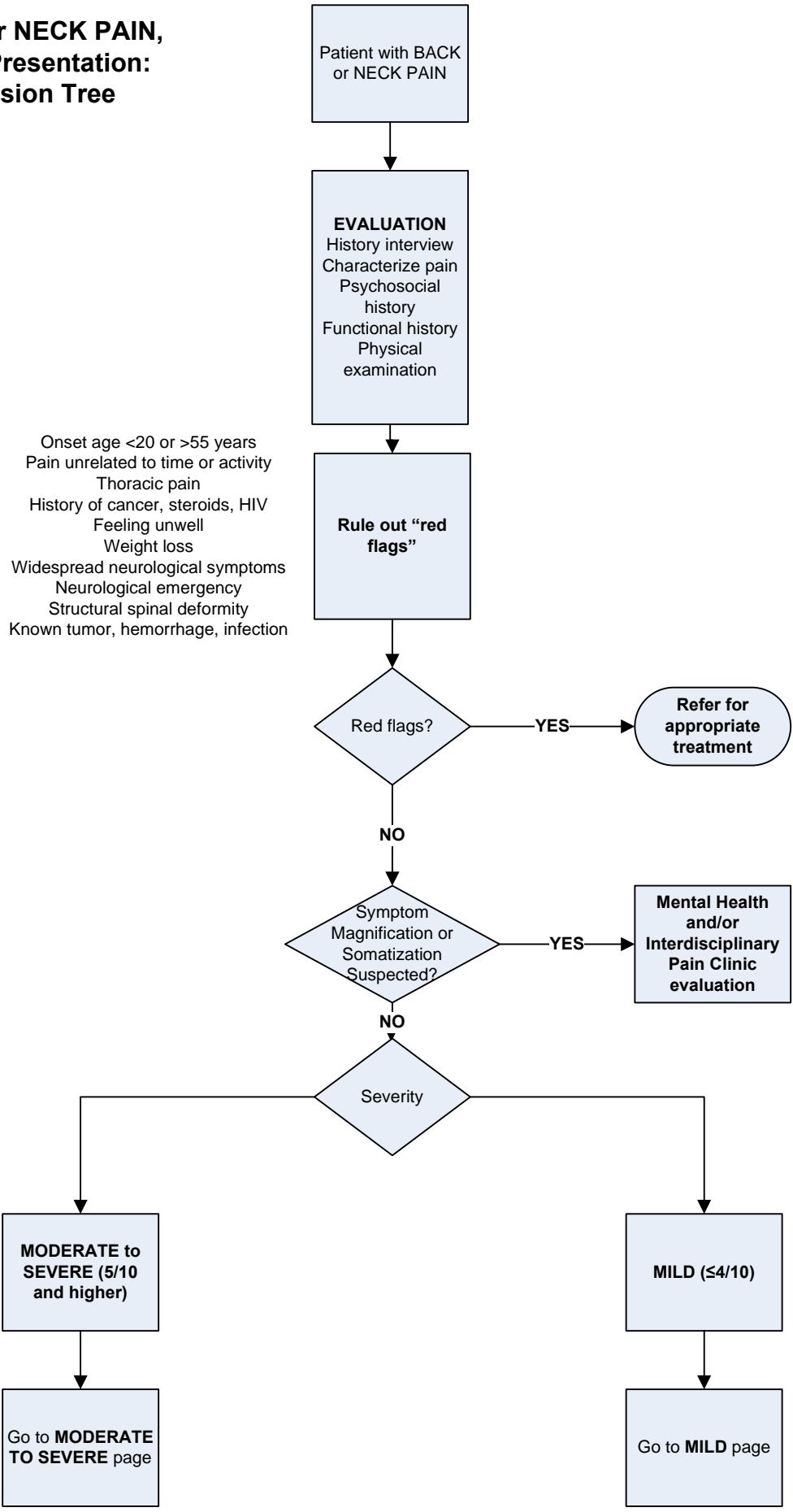
The attached algorithm is designed to facilitate the effective management of patients with back or neck pain, and to assist in decision-making for epidural injection. Key points include:

1. Upon patient presentation, check for “red flags” (see decision tree), and refer patients with “red flags” for appropriate specialty care.
2. Mild pain ($\leq 4/10$) should be managed conservatively and noninvasively. If this is unsuccessful, refer to specialty care.
3. Pursue a trial of noninvasive management before ordering a spinal epidural injection for pain treatment. Exceptions are patients with severe pain and/or severe pain-related functional limitation.
4. The most appropriate candidates for spinal epidural injection are patients whose pain is concordant with findings on exam and diagnostic tests (MRI, CT and/or EMG/NCS), *and* who have:
 - a. Radicular pain (involving limb *or* trunk and limb), *or*
 - b. Lumbar spinal stenosis.
5. If these criteria are not met, consider referral to specialty care to ascertain the best treatment.
6. The literature does not support the routine use of a rapid series of 3 epidural steroid injections at the same site.
7. If epidural steroid injections are helpful, periodic repetition may be helpful as symptoms return. If epidural injections are not helpful, refer the patient to specialty care. Number of injections is determined by examining outcome, risk-benefit ratio, and pertinent health insurer policy.
8. All patients should be educated in *pain self-management* and empowered to use these skills every day.

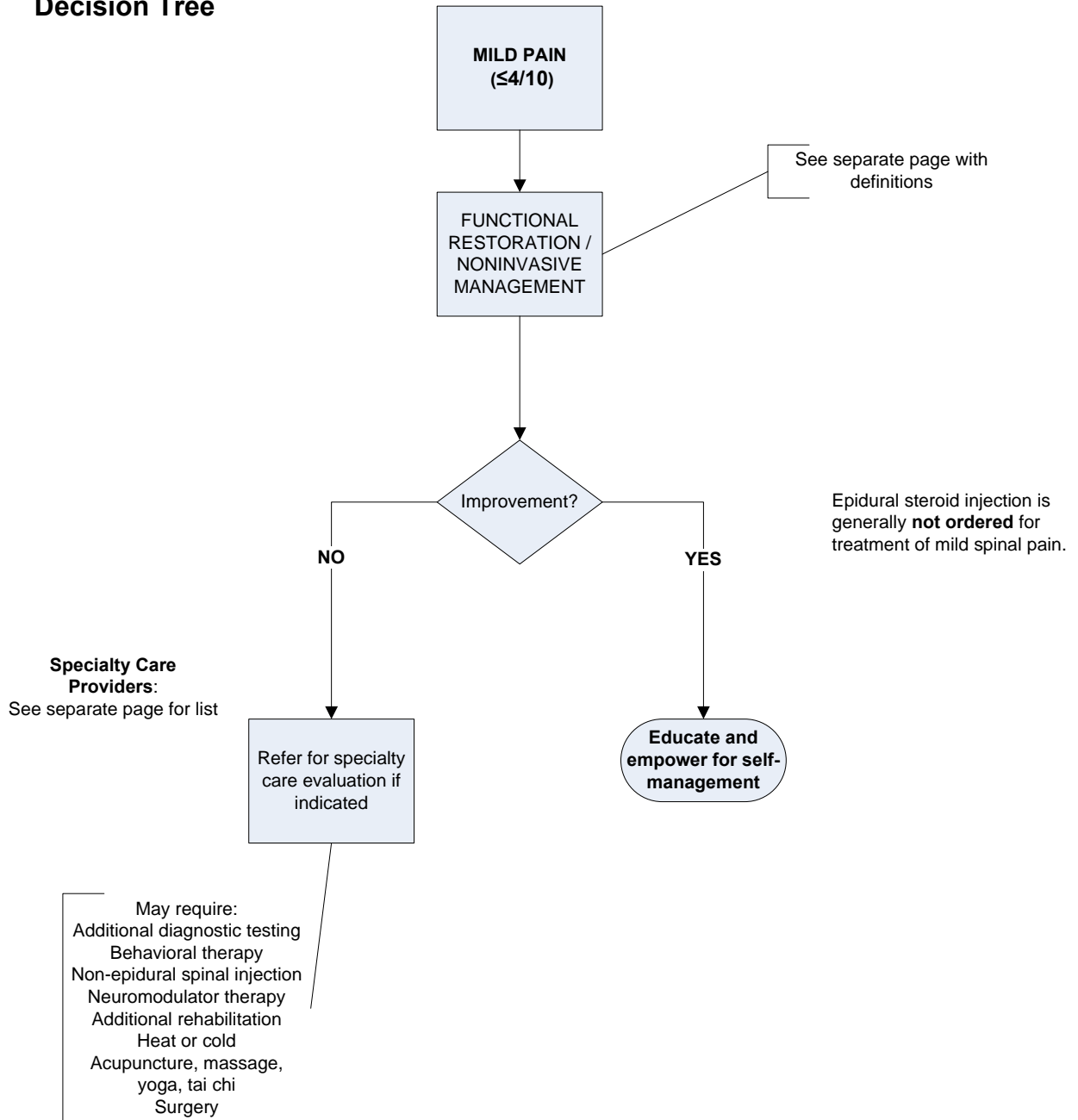
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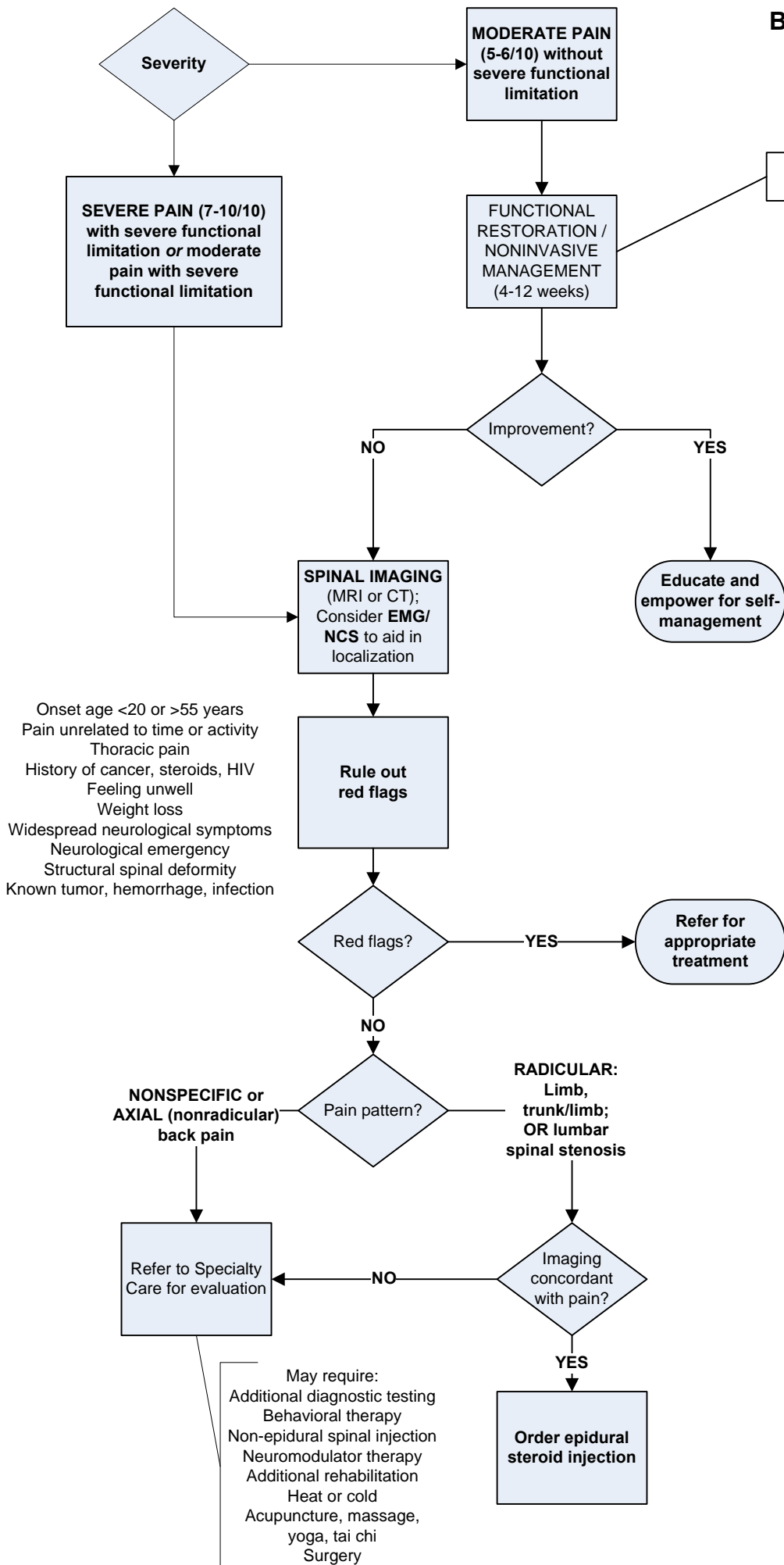
**BACK or NECK PAIN,
Initial Presentation:
Decision Tree**



MILD Back/Neck Pain: Decision Tree



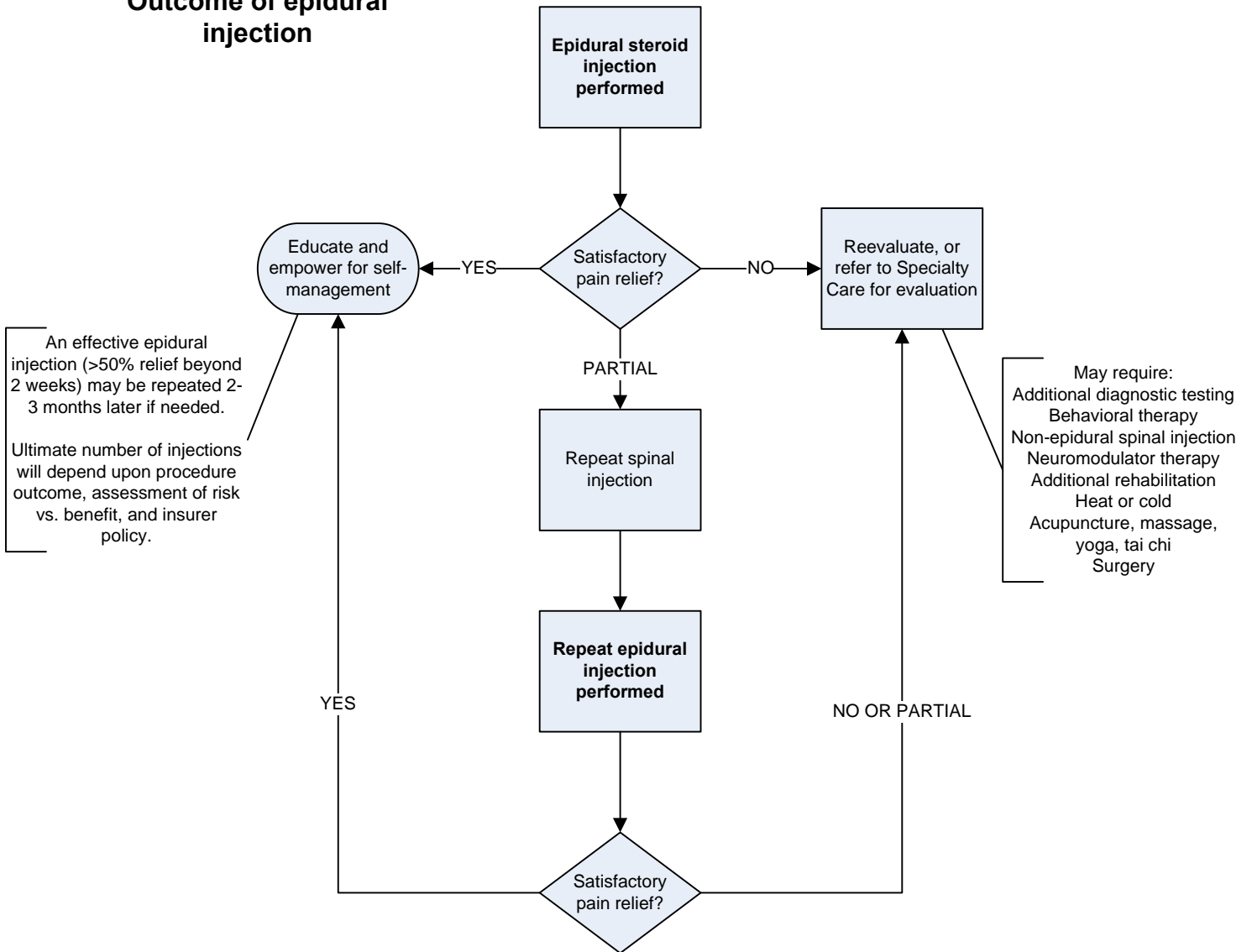
MODERATE TO SEVERE BACK or NECK PAIN: Decision Tree



See separate page with definitions

Notes:
Most patients with axial back pain should have specialty clinic evaluation before epidural injection, unless there is documented lumbar spinal stenosis at an area concordant with pain.
Contact your preferred interventional spine physician if there are any questions about whether or when to order epidural injection.

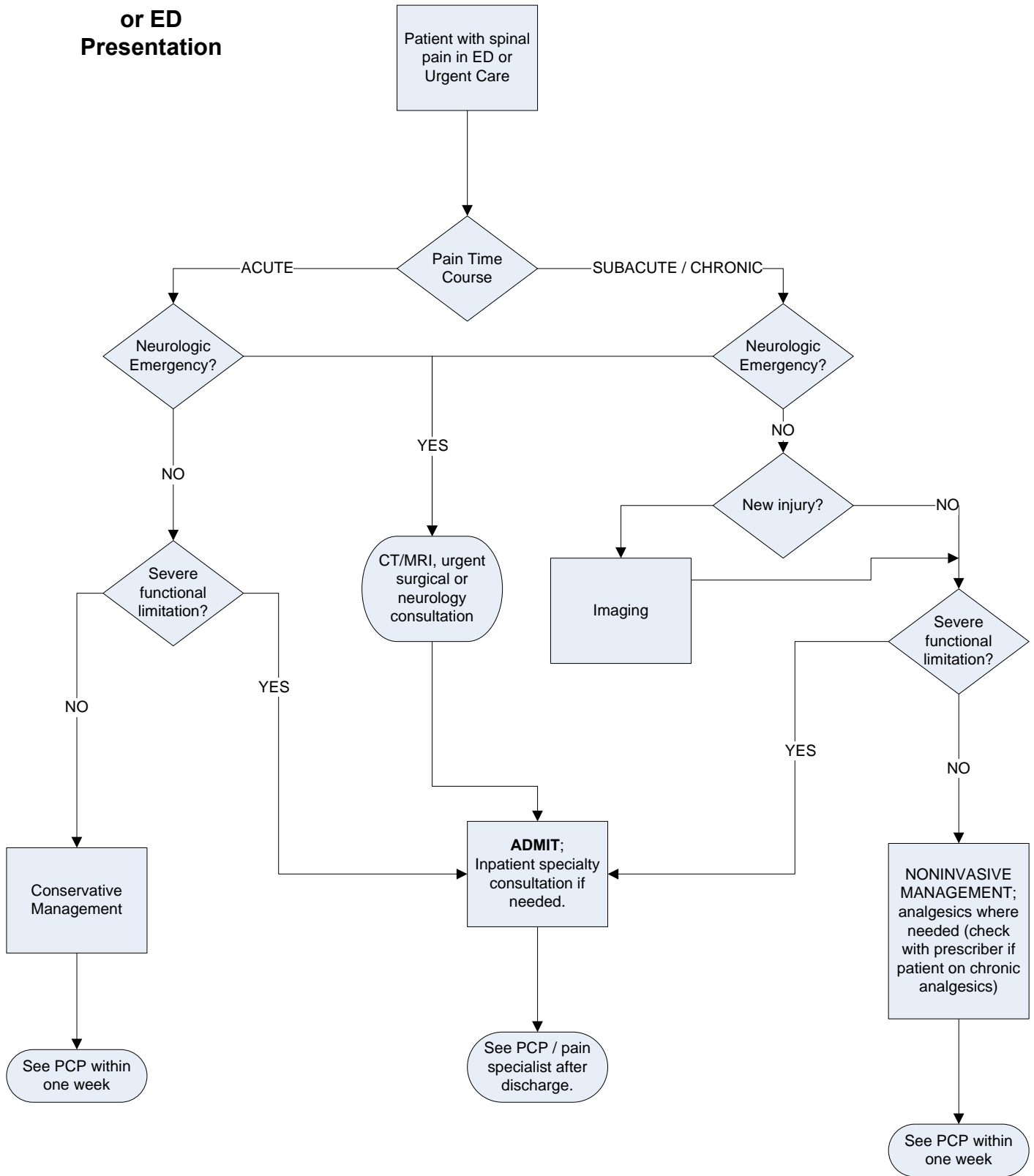
DECISION TREE: Outcome of epidural injection



Note:

Performing a "standard" series of 3 epidural injections in rapid sequence is **usually not indicated**. Literature does not support improved outcome with this technique.

URGENT CARE or ED Presentation



NONINVASIVE MANAGEMENT / FUNCTIONAL RESTORATION

Modified rest (for acute pain only; 3-5 days maximum)

Rehabilitation (Physical therapy, 6-12 weeks)

Thermal modalities (careful use of heat, ice; limit each application time to 10-15 minutes)

Other modalities: TENS unit, manual therapy et al.

Complementary/integrative therapies (massage, Qigong, T'ai Chi, acupuncture, chiropractic et al.)

NSAIDs (eg, ibuprofen, naproxen, acetaminophen)

Mild opioids (short-term) (eg, oxycodone, hydrocodone)

Adjuvant analgesics (eg, gabapentin, tricyclic antidepressants)

Muscle relaxants (short-term) (eg, baclofen, tizanidine, cyclobenzaprine)

AVOID benzodiazepines

AVOID carisoprodol – addictive and sedating