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Neck Pain & Physiotherapy | 2018 Newsletter

Neck pain is a common presentation to GP practices and represents a significant socio-economic burden with the volume of time taken off work.

Non-traumatic neck pain

Non-traumatic neck pain (including acute wry neck) usually results from sub-optimal postures or repeated positions, which causes abnormal or prolonged stresses onto the soft tissue and articular structures. Physiotherapy, including manual therapy and acupuncture, is effective at reducing symptoms and restoring normal movement (Trinh K et al 2016; Walker et al 2008, Copurgensli et al 2016).

Acute wry neck can be treated very successfully from day one. It is imperative that any sub-optimal postures or activities such as sleeping position, working posture, or various sporting activities are also identified so these can be modified to reduce future aggravations.
Age related/ degenerative changes can also be improved with physiotherapy, by addressing relevant soft tissue components and assessing and potentially adjusting postures to reduce strain.

Imaging for non-traumatic neck pain generally is not required except for the following (Best practice BMJ):

- Age >50 years with new symptoms
- Constitutional symptoms (loss of weight, anorexia, fevers)
- Infection symptoms especially if high infection risk (e.g. immunosuppressed, intravenous drug use)
- Moderate to severe neck pain lasting more than 6 weeks
- Neurological findings (upper motor neuron pathology)
- History of malignancy or RA
- Concurrent chest pain or shortness of breath (myocardial ischemia)

Traumatic neck pain from mild trauma (can be whiplash or direct trauma/impact from fall) usually respond very well to physiotherapy and would not usually require imaging.
Some patients however; still fare badly from minor trauma and can experience problems returning to work and full function. Whiplash has previously commonly been graded using the Quebec task force scale, but this is not always an accurate indicator of prognosis (Spitzer et al 1995, Kivoja et al 2008). This means that the velocity or severity of the accident or injuries does not always correlate with recovery.

Early screening specific to neck pain (similar to the validated screening tool STarTback for lumbar spine; Hill et al 2008) to identify these patients at risk of poor recovery is helpful to establish the best management plan. We are currently liaising with PhD student Joan Kelly at Griffith University regarding quantification of an equivalent screening tool specifically for neck pain.

Traumatic neck pain from major trauma generally will be assessed at the Emergency Department. However, they will sometimes be presented to GP's, especially if their pain sensation was impaired at the time of the trauma by either; alcohol, another more painful injury such as a limb fracture or simply not wanting to make a fuss. Altered mental status or concussion symptoms may also delay a presentation.

SPORTS & SPINAL PHYSIOTHERAPY
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Imaging would be required following major trauma as indicated by Nexus and Canadian C-Spine rule (Best practice BMJ, Panack et al 2001, Stiell et al 2001, Stiell et al 2003) if it involved:

- >65 years of age or osteoporotic
- Mechanism of injury involved: a fall >1m, axial compressive load, MVA >100km/hr, ejection from vehicle or rolling of vehicle, recreational vehicle or bicycle collision
- Sensory deficit in limbs
- Midline tenderness
- Less than 45 rotations bilaterally

If there is no radiographic evidence of injury, then physiotherapy treatment and return of normal movement patterns would be appropriate. Early physiotherapy in the emergency department has been associated with lower pain and disability levels. (Sohil et al 2017)

Sports & Spinal neck pain team:

Julie Gear (Caloundra & Kawana)

Julie graduated from the University of Otago in New Zealand in 1998 and has gained a wealth of experience working in busy clinics around the world, including a professional sports centre in France, the Crystal Palace National Sports Centre in London and a clinic in Verbier, a ski resort in Switzerland. She has worked with rugby teams in New Zealand and the England Volleyball team in the UK. Julie has postgraduate training in ergonomics and Pilates, and is also a qualified acupuncturist having studied both in the UK and in China. Julie combines her training in Traditional Chinese Medicine and Intra-Muscular Stimulation with traditional physiotherapy treatment techniques for optimum results. Julie has a special interest in spinal problems and headaches.

Briony McSwan (Maroochydore)

Briony has a wealth of clinical experience in diagnosing and treating neck pain, headaches and jaw problems. Head and neck pain can often be chronic and complex. Briony is passionate about looking at all aspects of your pain and achieving the best possible outcomes through hands-on treatment, strength and exercise and self-management strategies.

David Stevens (Buderim)

Since qualifying as a Physiotherapist in 2002, David has worked in both the NHS and the private sector treating a variety of acute and chronic musculoskeletal conditions. Using a holistic approach, he is able to tailor treatment to the individual and their goals. His areas of expertise are Cervicogenic headaches and shoulder injury. Working closely with shoulder surgeons in the UK has given David a sound understanding of the role that Physiotherapy has in the management and rehabilitation of complex shoulder conditions.

Please contact physio@sportsandspinalphysio.com.au for a full reference list.