

North East and North Cumbria Clinical Management Guidelines Spinal Pathway

Patients with symptoms and signs suggestive of serious pathology requiring **emergency** intervention i.e. suspected deteriorating spinal cord pathology (gait disturbance, multilevel weakness in the legs and / or arms), suspected spinal infection, suspected cauda equina syndrome (< 2 weeks' symptoms), **should not be** referred to Intermediate MSK (Musculoskeletal) services. These patients should be referred to A&E or ambulatory care as appropriate.

All patients referred to Intermediate MSK services will be screened for red flag signs and symptoms as part of triage, clinical history, and examination. Patients with suspected serious pathology will be managed according to this guidance.

Intermediate MSK services will identify urgent and emergency symptoms and signs, and make the appropriate onward referral. The Intermediate MSK services **will not ask** the GP to make the referral.

Suspected Serious Pathology/Red flags	
<p>Most spinal pain is mechanical in nature and non-specific – i.e. is not due to a specific pathology. Emergency presentation requires admission same day. Urgent presentation requires referral to intermediate MSK service and will be seen face to face within 2 weeks.</p> <p>Emergency/Urgent action is required when either:</p> <ol style="list-style-type: none"> 1. A serious pathology is suspected as being the cause of spinal pain (e.g. cancer, infection, fracture, inflammatory). 2. The patient has a significant neurological deficit. 3. A combination of the above. <p style="text-align: center;">Detailed below is what action should be taken when each specific serious pathology is suspected</p>	
Neurological deficit:	
Condition	Required action
<p>Suspected Cauda Equina Syndrome (CES) < 2 weeks since start or symptoms have deteriorated in the last 2 weeks</p>	<p>Emergency referral to ED (Emergency Department)</p> <p>After considering alternative serious causes for back pain/leg pain, Refer to ED if patient has any of the following suspected CES features</p> <ul style="list-style-type: none"> • New (within 14 days) or deteriorating difficulty initiating micturition or impaired sensation of urinary flow. • New (within 14 days) or deteriorating altered perianal, perineal, or genital sensation S2-S5 dermatomes – area may be small or as big as a horses' saddle (subjectively reported or objectively tested). • Severe or progressive neurological deficit of both legs, such as major motor weakness with knee extension, ankle eversion, or foot dorsiflexion. • New (within 14 days) or deteriorating loss of sensation of rectal fullness. • New (within 14 days) or deteriorating sexual dysfunction (achievement of erection or ability to ejaculate, loss of genital sensation) Note: Low

	<p>back pain with sexual dysfunction as the only other feature is unlikely to be due to CES.</p> <p>Safety net and provide patient with letter to take to Emergency department with suspected CES and give text /leaflet, CES patient information with info in 36 languages. Video also available.</p> <p>Spinal – CES Presentation in Primary & Community Care. GIRFT (Getting It Right First Time) – Interactive Pathways</p> <p>For more detail see National Suspected Cauda Equina Pathway February 2023</p>
<p>CES symptoms and signs of > 2 weeks duration</p>	<p>Urgent referral to Intermediate MSK services</p> <p>After considering alternative serious causes for back pain/leg pain,</p> <p>Refer urgently to Intermediate MSK services if patient develops any of the following:</p> <ul style="list-style-type: none"> • Sudden onset bilateral radicular pain, or unilateral radicular leg pain that has progressed to bilateral leg pain. • 14 days or more with new difficulty initiating micturition or impaired sensation of urinary flow. • 14 days or more of new altered perianal, perineal, or genital sensation S2-S5 dermatomes – area may be small or as big as a horses’ saddle (subjectively reported or objectively tested) • 14 days or more of new loss of sensation of rectal fullness • 14 days or more of new sexual dysfunction (achievement of erection or ability to ejaculate, loss of genital sensation) Note: Low back pain with sexual dysfunction as the only other feature is unlikely to be due to CES. <p>Referrer to highlight referral as Urgent and document symptoms, signs, frequency, duration, and progression. Time and date of assessment(s). Subjective perianal sensation and neurological examination findings should be recorded.</p> <p>Safety net and provide patient with text/leaflet, CES patient information for info in 36 languages. Video also available</p> <p>Action for Intermediate MSK services Should be triaged within 72 hours and seen face to face within 2 weeks of referral. Patient should be managed on an urgent basis in line with national suspected CES guidance.</p> <p>For more detail see National Suspected Cauda Equina Pathway February 2023</p> <p>Spinal – CES Presentation in Primary & Community Care. GIRFT – Interactive Pathways</p>
<p>Sudden onset of bilateral radicular leg pain or unilateral radicular pain that has progressed to bilateral but no CES symptoms or signs.</p>	<p>Urgent referral to Intermediate MSK services</p> <p>Action for Referrers Highlight referral as Urgent/Bilateral Radicular Pain and document symptoms, signs, frequency, duration, and progression. Time and date of assessment(s). Subjective perianal sensation and neurological examination findings should be recorded. Document no CES symptoms or signs.</p>

	<p>Safety net and provide patient with text/leaflet CES patient information for info in 36 languages. Video also available.</p> <p>Action for Intermediate MSK services Should be triaged within 72 hours and seen face to face within 2 weeks. Patient should be managed on an urgent basis with onward urgent referral following national radicular pain pathway.</p> <p>Safety net and provide patient with text/leaflet, CES patient information for info in 36 languages. Video also available.</p> <p>Thorough questioning to ensure no symptoms of CES, including no subjective change to perianal/ saddle sensation and timeframes of when all their symptoms and signs started and progressions since should be recorded.</p> <p>For more detail see GIRFT Back and radicular pain</p>
<p>Chronic myelopathy symptoms – not rapidly deteriorating symptoms</p>	<p>After considering alternative causes of myelopathic like symptoms Routine referral to intermediate MSK services for assessment and differential diagnosis</p> <p>Clinical note - Radiculopathy is used to describe compression of the nerve roots as they exit the spinal cord or cross the intervertebral disc, Myelopathy is compression of the spinal cord itself.</p> <p>Myelopathy symptoms are very varied whole-body experience, and not related to the severity of spinal cord compression. There are two main causes of myelopathy:</p> <ol style="list-style-type: none"> 1. Degenerative Cervical myelopathy, DCM– related to a maturing spine narrowing the spinal canal compressing the spinal cord, symptoms develop over a long time. 2. A spinal canal filling lesion, usually a disc prolapse compressing the spinal cord. symptoms may start more quickly. In rare cases caused by tumours, infection, fracture, or vascular conditions. <p>Frequent symptoms of Myelopathy</p> <ul style="list-style-type: none"> • Clumsiness in the hands (loss of manual coordination/dexterity) • Difficulties with walking, unsteadiness leading to trips/ falls. • Disturbance of bladder function, such as “increased urgency” or incontinence/urinary retention. • Tingling (paraesthesia)/ numbness in the limbs (often start in fingertips/ toes), altered sensations e.g. trickling water. • Weakness / pain in the limbs / neck / trunk. not all patients describe pain. • Tiredness/fatigue. <p>For more information - Key Facts (myelopathy.org)</p>
<p>Suspected spinal cord compression < 2 weeks since start or symptoms have deteriorated in the last 2 weeks</p>	<p>Emergency referral to spinal specialist usually via ED</p> <p>In patients with suspected spinal cord compression starting in recent weeks whose mobility is rapidly deteriorating / ‘going off their legs’- refer patients to ED</p>

	<p>Provide patient with letter to take to ED and give patient information leaflet/text TIMS Myelopathy Patient Information Leaflet</p> <p>In some cases of myelopathy, patients may deteriorate very quickly (over 2 weeks span) and may require immediate medical attention. Refer to ED If symptoms combine with rapidly progressing</p> <ul style="list-style-type: none"> • Weakness in the legs affecting walking / 'going off legs.' • Loss of feeling or pins and needles between legs, around your genitals or back passage • Changes to bladder and bowel function, such as loss of sensation, loss of control or an inability to empty bladder.
<p>Major Spinal Related motor loss e.g. with foot drop or without foot drop</p>	<p>Urgent referral to MSK services</p> <p>If foot drop is present with back and leg pain, and spinal cause of foot drop is suspected. Refer urgently to Intermediate MSK services. Patients should be assessed and examined face to face prior to referral.</p> <p>Action for Intermediate MSK services Should be triaged within 72 hours and seen face to face within 2 weeks. Patient should be managed on an urgent basis following national radicular pain pathway. For more detail see GIRFT Back and radicular pain</p> <p>Clinical Note – The common cause of foot drop with leg pain is acute L5 or S1 disc prolapse – typically with weakness of dorsiflexion, inversion, and eversion. May lose ankle jerk reflex. If painless, consider other causes such as common peroneal nerve palsy and other neurological disorders.</p>
<p>Suspected Serious Pathology:</p>	
<p>Condition</p>	<p>Required action</p>
<p>Suspected malignant spinal cord compression</p>	<p>Emergency Referral</p> <p>If referring to NUTH (Newcastle University Teaching Hospitals), South Tees Hospitals or South Tyneside and Sunderland refer directly to Metastatic Spinal Cord Compression MSCC co-ordinator/on-call registrar via. switchboard –</p> <p>Newcastle Hospitals: 0191 233 6161 Gateshead: 0191 482 0000</p> <p>South Tees Hospitals NHS FT: 01642 850850 (Bleep 1425) - Call JCUH Oncology SpR/consultant on call</p> <p>South Tyneside and Sunderland NHS FT: 0191 5656256 EXT 47499 (Bleep 52156) Follow MSCC NICE guidance https://www.nice.org.uk/guidance/NG234</p>
<p>Suspected spinal cancer/malignancy (secondary metastases or spinal tumour) with or without history of cancer</p>	<p>If medically unwell, emergency referral to ED or ambulatory care as appropriate.</p> <p>Suspected spinal cancer/ malignancy (secondary metastases or spinal tumour): if known cancer - refer urgently to site specific cancer team. If no known cancer - refer urgently to malignancy of unknown origin service https://northerncanceralliance.nhs.uk/wp-content/uploads/2025/10/Malignancy-Unknown-Origin-May-2024.pdf</p>

<p>Suspected Spinal Infection: back pain with systemic symptoms/fever</p>	<p>Send patient to ED or ambulatory care as appropriate.</p> <p>If patient is post-operative:</p> <ul style="list-style-type: none"> • Discuss with operating team at the appropriate hospital
<p>Suspected acute traumatic spinal fracture</p>	<p>If acute traumatic spinal fracture is suspected:</p> <ul style="list-style-type: none"> • refer to A&E for assessment/investigation. • Be aware minimal spinal trauma in people with known ankylosing spondylitis (AS) can cause unstable spinal fractures.
<p>Suspected insufficiency fracture e.g. osteoporotic fracture without cord compression</p>	<p>Patient with known osteoporosis or risk factors for osteoporosis, diffuse idiopathic skeletal hyperostosis (DISH), axial spondyloarthritis (ankylosing spondylitis).</p> <p>Insufficiency fracture suspected and patient unable to walk Refer to ED</p> <p>Insufficiency fracture suspected, and patient can walk. Urgent referral to Intermediate MSK services who will manage case as per the regional guidance. <u>GP not to request MRI</u>. If indicated, imaging will be requested by MSK service.</p> <p>If insufficiency fracture due to osteoporosis is found by intermediate MSK services, patient should be referred to GP for ongoing management.</p>
<p>Suspected new onset inflammatory disease/ axial spondyloarthritis (ankylosing spondylitis)</p>	<p>Refer directly to rheumatology.</p> <p>GPs are requested to ensure patient has blood tests at time of (or <4 weeks preceding) referral. To include Haematology: FBC, ESR; Biochemistry: U+E, CRP, LFT, TFT, CK, HbA1c; Immunology: Rheumatoid Factor, Anti-CCP, ANA, ENA</p>
<p>Post-operative complication</p>	<p>Discuss with spinal surgical team as appropriate.</p>