

# Only certain patients with chronic neck pain need invasive procedures to treat it

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The use of radiofrequency ablation—targeted heat from an electrical current to ease nerve pain—may be helpful for treating chronic neck pain, but only in patients meeting particular criteria, conclude evidence-

based consensus guidelines, published online in the journal *Regional Anesthesia & Pain Medicine*.

And while the application of nerve blocks is likely to be far more useful in identifying these patients than steroid injections into the joints, only one block rather than the mandated two is required, says the guidance, drawn up by an international panel of 22 experts from 18 professional societies and government bodies.

While dual blocks may increase the success rate of [radiofrequency ablation](#), the evidence indicates that doubling up will result in a significant proportion of unnecessary procedures and higher costs, the guidance concludes.

Spine pain, to include the neck and lower back, is the most common cause of disability in North America and globally among 25–64 year olds, with nearly half likely to be affected at some point during their lifetime.

The cervical facet joints, which allow the neck and back to tilt forwards, backwards, and rotate, are considered to be the primary source of the pain in around 40% of patients with [chronic neck pain](#) and in over half of those with neck pain after whiplash injury.

The use of procedures, such as joint injections, nerve blocks and [radiofrequency](#) ablation to ease chronic neck pain, has soared over the past two decades. But their diagnostic and therapeutic effectiveness remains in doubt, while each carries a risk of complications.

Nor is it clear which patients might stand to benefit the most from any of these procedures. This has led to inconsistencies in clinical practice, patient safety concerns, and disputes with medical insurers, particularly around the use of radiofrequency ablation, the use of which has

increased 112% over the past decade.

The American Society of Regional Anesthesia and Pain Medicine and the American Academy of Pain Medicine therefore convened an international panel of experts to draw up consensus guidelines based on the best available evidence in a bid to standardise [clinical practice](#), enhance patient safety, and minimise unnecessary tests and procedures.

The group drew on over 400 publications to address a range of pertinent and contentious issues. These included the role of medical history and physical examination; imaging findings; conservative (non-invasive) treatments; anatomical details; diagnostic indicators; procedural techniques; the need for sedation; and safety measures.

They also looked at the value of clinical signs and imaging to select patients for particular procedures; the diagnostic and prognostic value of procedures; and several aspects of radiofrequency ablation, including how best to curb complication risks and the circumstances in which the procedure should be repeated.

The guidelines conclude that radiofrequency ablation may be helpful for easing chronic neck pain, but only in patients meeting particular criteria: those whose pain corresponds to the joints being treated; those whose signs and symptoms don't emanate from a nerve root; and those who obtain meaningful pain relief from properly performed diagnostic nerve blocks.

One of the most contentious issues the guidelines address is the number of diagnostic nerve blocks required before radiofrequency ablation.

Many insurance carriers now mandate dual blocks, but the evidence indicates that doubling up will result in a significant proportion of unnecessary procedures and higher costs. The rationale for performing

only a single block is much stronger for the neck than for the lower back. The evidence is clear on this point, the guidelines show.

The guidelines also conclude that more stringent selection criteria, such as requiring nearly total pain relief from diagnostic blocks, might improve the level of pain relief afforded to individual patients after radiofrequency ablation.

But this threshold is likely to exclude a significant proportion of patients who would benefit from the procedure. This is important, because many of these patients would end up getting surgery or opioids instead, the guidelines note.

In fact, none of the studies reviewed in the guidelines support using pain relief thresholds above 50%. International guidelines used to design clinical drug trials and evaluate invasive treatments such as spinal cord stimulation recommend even lower degrees of pain to designate a treatment as successful.

Because acute neck pain often resolves by itself, the guidelines recommend 6 weeks of conservative management, such as non-opioid painkillers and physiotherapy, before opting for nerve blocks, to minimise unnecessary invasive procedures and associated healthcare costs.

And physicians should tell patients about the common side effects of radiofrequency ablation, which can include pain, tingling/burning sensation, numbness, dizziness, and loss of balance/coordination, lasting from a few days to a few weeks after the procedure.

Patients also need to be told that radiofrequency ablation isn't necessarily a cure, recommends the guidance: pain relief typically lasts between 6 and 14 months.

Another key question the guidelines address is the effectiveness of repeating radiofrequency ablation in patients with whiplash and neck pain unrelated to trauma.

While most patients in whom the procedure is repeated will obtain pain relief for a further period of between 7 and 20 months, the benefits may wane over several years and the procedure shouldn't be repeated more than twice a year, the guidelines recommend.

Other key recommendations include:

- Using only soluble, short-acting steroids when injecting into the upper neck joints or after radiofrequency [ablation](#) to prevent pain from nerve inflammation
- Using smaller needles and electrodes than those used for the lower back
- Using nerve and muscle stimulation to improve effectiveness and reduce the risk of complications
- Taking steps to minimise interference with implanted electrical devices such as pacemakers

"These multi-society guidelines have been developed to serve as a roadmap to improve outcomes, enhance safety, and minimize unnecessary tests and procedures," conclude the authors.

They add: "Unlike standards, which often come from an unimpeachable authority and define standards of care, our recommendations are not meant to usurp clinician judgment or personalized medicine."

Dr. Steven Cohen, Co-Chair of the Guidelines Committee and lead author, comments: "It is precisely because [neck pain](#) and cervical spine procedures are so common, and there is so little high-quality evidence to guide care, that consensus guidelines are needed."

**More information:** Consensus practice guidelines on interventions for cervical spine (facet) joint pain from a multispecialty international working group, [rapm.bmj.com/lookup/doi/10.1136/rapm-2021-103031](https://rapm.bmj.com/lookup/doi/10.1136/rapm-2021-103031)

Editorial: Evidence-based cervical facet consensus: access or outcome? [rapm.bmj.com/lookup/doi/10.1136/rapm-2021-103111](https://rapm.bmj.com/lookup/doi/10.1136/rapm-2021-103111)

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