Our Clinical Team

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The team also comprises Mrs Caroline Evans, Clinical/Surgical Assistant and Mrs Gail McArdle, Clinical Assistant. Plus three rotational Registrars.

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INVESTOR IN PEOPLE

The Robert Jones and Agnes Hunt
Orthopaedic Hospital NHS Foundation Trust
Oswestry, Shropshire SY10 7AG

Generic Referral Guide for Spinal Disorders

The Spinal Disorders Team at the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust treats a number of spinal conditions including:

- All aspects of spinal deformity including scoliosis & kyphosis
- Spinal trauma
- Primary and chronic back pain (failed backs)
- Radicular arm and leg pain
- Tumours
- Inflammatory disorders
- Disorders of the cervical spine including cervical myelopathy
- Spinal Stenosis
- Degenerative disc disease

Procedures include:

- Decompression for lumbar canal stenosis
- Decompression for cervical and thoracic myelopathy
- Spinal fusions in lumbar, thoracic and cervical spine
- Deformity surgery including scoliosis, kyphosis & adult degenerative scoliosis
- Fixation & fusion of spinal fractures in lumbar, thoracic and cervical spine
- Primary and metastatic spinal tumour surgery.

Our clinical team comprises five Consultant Spinal Surgeons and two spinal physiotherapy trained Clinical and Surgical Assistants, as well as three rotational Registrars. To keep waiting times to a minimum, we would encourage you to refer to the Spinal Disorders Team, rather than to a specific Consultant.

Based on an assessment of the referral information, the clinical team will decide which individual would be best suited to treat the particular needs of the patient. Please do allow patients to book via the Choose and Book mechanism, in order to improve services to patients.

Oswestry's Guide for General Practitioners
Low Back Pain

Introduction
The problem with low back pain, for the General Practitioners, is the distress factor. This term covers all the mystique, fear, anxiety, psychosocial manipulation, and diagnostic difficulty which comes with the complaint. It means that much of the management of low back pain involves reassurance. Many practitioners share the fears of their patients and cannot give that reassurance. Whatever your insecurity in this area, NEVER use the word "arthritis". Not only is it very seldom correct in the context, but it is regarded by the majority of lay people as a condemnation to a life of crippledom.

Classification
Background: The vast majority of low back pain is "mechanical".... associated with soft tissue strain, or disc dehydration, or facet joint arthrosis, and presents no threat to limb or longevity, however distressing. Lower limb pain is common but relatively rarely caused by nerve root compression.

Question
First Filler

1. Is it mechanical? Mainly back pain.

2. Is it neurological? Mainly lower limb pain and paraesthesiae.

3. Is it both? Patient can't decide... "50/50".

Second Filler

1. Probably "instability"? Pain worse with activity: better with rest. (Special case: "LOCKED BACK").

2. Probably "facet arthrosis"? Pain worse at rest: better with movement.

3. Probably "combination"? Pain at rest AND pain with movement. "NO HIDING PLACE!".

Examination
Stance: Quality of movement
Bending: Forward vs Backward
Power: Tiptoe
Palpation: "tennis elbow" of the spine

Straight Leg Raise: True or False?
Result is true ONLY if pain is felt IN LOWER LIMB - ask!!!
Reflexes / Feeling / Pulses

Investigation
(After Initial Failure of Treatment)
Plain X-Rays: AP, Lateral, Coned Lateral L4-S1, AP Pelvis.
Blood: FBC, ESR, RA Latex.

Management
Acute
Rest - NO MORE THAN 2-4 DAYS!
Analgesics - standard plus NSAIDs.
(Special case of "locked back").
Local infiltration.

Subacute/Chronic
Reassurance
Investigation
Analgesics
Corset
Physiotherapy / Manipulative Therapy
Local Infiltration

Red Flags!
1. Loss of weight and appetite.

2. Sudden onset of pain, day and night, in "oldies", intractable.

3. Low back pain, in children & teenagers, especially painful scoliosis (spinal tumour or adolescent disc or infection).

4. Sudden kyphosis / gibbus.

5. Recent loss of perineal sensation plus incontinence.

This guideline was originally produced by Stephen Eisenstein, Centre for Spinal Studies, The Robert Jones & Agnes Hunt Orthopaedic Hospital Oswestry, Shropshire SY10 7AG.

Low Back Pain
Qualified Referral Pro-Forma
(Referral preferred when all boxes can be ticked)

1. No red flag symptons. ☐
2. Back pain worse than lower limb pain. ☐
3. Trial of standard analgesics unsuccessful for at least 6 weeks. ☐
4. FBC and ESR done, and results enclosed. ☐
5. Plain X-rays lumbar spine done, and films available herewith. ☐
6. Examination: no objective lower limb neuro deficit: (power, sensation, reflexes). ☐
7. Examination: straight leg raising limited by back pain. ☐

8. "Red Flag"
Referrals: should be accompanied by:

a. Record of clinical exam findings (at least).
b. Results of routine blood tests (if urgency allows).
c. Recent plain x-rays of lumbar spine (if urgency allows).

i. Urinary and/or faecal incotinence or other dramatic neuro deficit of recent onset.

ii. Unexplained recent onset of weight loss and loss of appetite.

iii. Constant severe pain, day and night.

iv. First severe back pain attack aged 55 years plus.

v. First severe back pain attack aged 15 years, or less.

Back/Leg Pain Complex
Primary Care Algorithm