Neck pain: management in primary care

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Introduction

Neck pain is a musculoskeletal complaint commonly seen in primary care. It can be disabling to varying degrees and costly in terms of visits to healthcare providers, sick leave and lost productivity.

Women are affected more than men, with highest prevalence in middle age. Two-thirds of people will experience neck pain at some time in their life with half to three-quarters of these people having a recurrence of their neck pain within 5 years. As neck pain can be recurrent and can vary in disability it is important that healthcare professionals provide simple, clear advice on management at an early stage.

This report aims to provide the clinician with the latest evidence-based assessment and treatment strategies and provide practical advice on things people can do to help themselves for the management of non-specific neck pain. Pharmacological treatment is not included in this review.
Different kinds of neck pain

There may be no apparent reason for the onset of neck pain and recovery is often difficult to predict. Common diagnoses of neck pain include non-specific neck pain, whiplash (WAD – whiplash-associated disorder), cervical spondylosis and acute torticollis. Neck pain may be accompanied by pain radiating down the arm (radiculopathy) or headaches (cervicogenic headaches).

Non-specific neck pain, sometimes called ‘simple’ or ‘mechanical’ neck pain, is the most common type. Typical signs and symptoms include:
• pain around the neck region that may spread to the shoulder or scapula area or towards the base of the skull
• associated muscle stiffness or spasm
• pain aggravated by particular movements, postures and activities and relieved by others
• associated headaches
• restricted range of neck movement
• tenderness in neck and shoulder muscles.

What are the risk factors?

Age, gender and genetics are of course non-modifiable risk factors. Modifiable risk factors include smoking (both active and passive), lack of physical activity, poor posture, anxiety and depression, and psychological health. Other risk factors associated with neck pain in workers include previous musculoskeletal pain, high quantitative job demands, low social support at work, job insecurity, poor job satisfaction, ongoing litigation relating to the neck pain, poor computer workstation design and work posture, sedentary work positions, repetitive work and precision work.2 Disc degeneration has not been identified as a risk factor.3

Assessment and screening of neck pain

Screening and clinical assessment are the same for all patients presenting with neck pain. Red flags can be used to rule out signs of serious spinal/structural pathology (Box 1) and patients with these should be investigated.

Asking questions on the history of the presenting neck condition, including the mechanism of onset, duration, site and type of symptoms, can help with the diagnosis and subsequent management of neck pain. A physical examination (Box 2) that includes observation and palpation, assessment of range of neck movements and a neurological examination to identify any possible radiculopathy (Box 3) should be performed. If the neck pain varies with different activities and time, or is associated with poor posture, injury or overuse, suspect non-specific neck pain.

It is important to identify patients who are at risk of developing long-term pain and disability, i.e. to assess for yellow flags (Box 4) and address these as soon as possible.

Investigations

Cervical x-rays and other imaging studies and investigations are not routinely required to diagnose or assess neck pain with radiculopathy or non-specific neck pain. In primary care, triage
should be based on history and physical examination alone, including screening for red flags plus a neurological examination for signs of radiculopathy. It is best to be open about the limitations of investigations for the assessment of non-specific neck pain while reassuring patients that they can still be helped without such investigations.

**How to treat non-specific neck pain**

For the vast majority of patients, appropriate advice with simple analgesia is the best way to treat non-specific neck pain. The choice of analgesia will depend on the chronicity and severity of pain, personal preference, tolerability and risk of adverse effects.

Neck pain has commonly been labelled by the duration of symptoms: acute, subacute, chronic.

**Acute neck pain**

During its acute phase (within the first 3–4 weeks) it is important to give reassurance that neck pain is common and that symptoms are likely to resolve. Patients may ask about or have already tried non-NHS treatments such as alternative or complementary treatments which are often expensive and encourage dependency. It is important therefore to provide good, clear advice to patients on how best to manage their neck pain from the start.

Encourage the patient to:

- remain as active as possible
- restore their neck movements as pain allows (see ‘Information and exercise sheet’)
- correct poor posture if precipitating or aggravating the neck pain
- sleep with one pillow which provides lateral support and also gives support to the hollow of the neck. Two pillows may force the head into an unnatural position.

Discourage the patient from:

- prolonged absence from work
- wearing a cervical collar (which paradoxically may hinder recovery).

**Subacute neck pain**

If symptoms persist from 3 or 4 weeks to 12 weeks, in addition to the above advice:

- Refer to physiotherapy for a multimodal treatment strategy that includes postural advice, exercises and manual therapy. Acupuncture may be included at this stage.
- Promote positive attitudes to activity and work.
- Address any psychosocial factors – ‘yellow flags’ (Box 4).
- Consider referral to a psychologist or occupational health clinician.
Chronic neck pain

If symptoms persist for more than 12 weeks, in addition to the above advice:

- Continue physiotherapy if it is helping, discontinue if not.
- Avoid passive interventions, e.g. electrotherapy and massage.
- Reassess psychological factors.
- Consider referral to a pain clinic for people with chronic pain or nerve root symptoms where there is poor control.

Core treatment recommendations are outlined in Figure 1.

Conclusion

This report provides a practical overview of neck pain seen in primary care. It has focused on the appropriate assessment and management of non-specific neck pain. Key messages have been presented and core treatments highlighted.

The management of this condition has great similarities to that of low back pain with regard to the assessment and management of the majority of patients. Many of these patients require reassurance, simple primary care management and minimal investigations.
Key messages

- Neck pain is very common.
- Neck pain may be related to poor posture.
- Serious structural injury is unlikely.
- Self-management is key.
- Encourage patient to remain as active as possible and avoid immobilisation of the neck.
- Clinical management is important: to identify and address yellow flags, to exclude red flags and to provide reassurance and information.
- Don’t x-ray for non-specific neck pain.

References


Further reading


Clinical Knowledge Summaries (CKS). London; CKS; 2009:
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