

Community MSK Recovery Objectives – NHS England

Theme	Objective
PIFU	Ensure that community physiotherapy services are utilising PIFU methodology to maximum effect.
Self Management	<ol style="list-style-type: none">1. Self referral2. Waiting well
MSK triage and MDTs	<ol style="list-style-type: none">1. Optimise the use of community MSK triage services2. Optimise the use of community/secondary care MDTs
FCP Optimisation	Optimise the governance of FCPs and support FCPs to upskill their primary care colleagues in MSK assessment and treatment.
Support systems to achieve key targets	<ul style="list-style-type: none">• Agree appropriate metrics• Support systems to provide timely data with a standard data platform• Explore unwarranted variation to identify services who need additional support
Mutual Aid	Explore the feasibility of a mutual aid pilot where waiting list pressures can be shared
Pathways	Support the localisation and implementation of national pathways
Expanding the workforce	Explore the feasibility of expanding the support workforce e.g. band 4 therapy assistant practitioner roles

CERVICO-CRANIAL RED FLAG SCREENING

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THE TEAM

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Cervico-cranial red flag screening tool

Tabrah, Taylor, Kerry, Mourad, Bridge and Herdman - 2021

This resource is an aide-memoire which outlines some of the key cervical spine and headache red flags. It is not a triage tool and is not an substitute for. We advocate thorough history taking, multi-systems clinical reasoning and a low threshold for onward referral/triage if concerning features.

IMPORTANT: Avoid waiting for a 'full hour' of late stage red flags - listen out for the more subtle early/intermediate stage red flags and act if concerned

Neurological considerations - myelopathy

EARLY:

- gradual/intermittent/variable hand clumsiness
- weakness/loss of dexterity
- bilateral arm abduction/leg adduction
- loss of interdigital sensation
- weakness of the hands and/or feet
- poor balance
- reduced flexibility
- bladder/bowel dysfunction, etc.

TEST:

- gait
- upper/lower limb reflexes/paraspinal reflexes
- EMG tests e.g. Radwax, FullScan, Traxion, Clonus, Romberg, Tandem

Sign	Early stages	Intermediate stages	Late stages
Hand clumsiness			
Weakness			
Sensation			
Balance			
Bladder/bowel			
Reflexes			
EMG			
Gait			
Paraspinal reflexes			
Spinal cord compression			
Myelopathy			

FURTHER INFO: Diagnostic/clinical Assessment (MYP/SC/CS) Outcome | Detecting spinal cord compression in adults | Quality standard | NICE

Vestibular considerations

EARLY:

- Unilateral hearing loss or tinnitus
- Progressively decreasing balance
- Severe vertigo symptoms or acute vestibular syndrome positional changes e.g. DIX or rolling in bed
- Rapid neurological symptoms e.g. ataxia, dysarthria, ataxic gait/imbalance, isolated nerve palsy, etc.
- Any vascular symptoms

TEST:

- Dix-Hallpike and Sustained Roll Test/ Roll-over
- Romberg with and without eyes open/closed
- ENG
- Dix-Hallpike Test - follow/assess each side
- Head-Thrust - eyes and standing
- UCLL neurological exam and cranial nerve exam
- Romberg and Tandem

Assessment | Diagnosis | Triage | CMC | NICE

Vascular considerations

EARLY:

- Flaccid
- associated risk factors e.g. HTN, smoking, etc.
- unusual presentation e.g. atypical headache and focal signs and 'flag' signs* or new and focal symptoms
- cranial nerve symptoms e.g. hoarseness with isolated voice, hoarse, bulbar, etc.
- focal neurological symptoms e.g. sensory loss, weakness, palsy, etc.
- focal and/or regional arterial symptoms e.g. jaw claudication, acute or chronic limb ischaemia, tenderness of temporal artery, etc.

TEST:

- upper/lower limb neurological examination
- consider DVT/PE tests
- jugular venous distension
- carotid/vertebral and galli
- blood pressure

FURTHER INFO: DVT Assessment and Clinical Reasoning (Wojcik) Cranial nerve finding: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC357176/>

Headache considerations

EARLY:

- Systemic features e.g. fever, rash, malaise, persistent vomiting, etc.
- neurological features e.g. acute loss of sensory/motor function, vision, speech, cerebellum, isolated/significant weakness, etc.
- onset - sudden, isolated, chronic, thunderclap headache, thunderclap, maximum intensity for 1 minute
- onset - age less than 18 years or over 50
- previous history similar, W/O, etc.
- new headache, brief history with the use of OTC
- headache associated e.g. triggered by cough, exertion, sexual, hormonal, standing up on lying down
- features change/progressive - significant worsening of frequency or intensity of symptoms

TEST:

- Open/close limb neurological exam and a cranial nerve exam - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC357176/>
- blood pressure

Further Information: British Association for the Study of Headache (BASIS) - <https://basis.org.uk/signs-and-symptoms/>

Thorough history taking – Consider each symptom in context – Discuss with a colleague – Trust gut instinct – Act if concerned – Safety net – Monitor

<https://www.rcpai.org.uk/10.2076/ajcp.2021.1188>

THE RATIONALE

Confidence in screening for serious head and neck pathology varies

Lots of head and neck red flags to remember!

Cranial nerve testing and vestibular testing are not considered part of the mainstream MSK assessment

General fear of dizziness, vestibular testing and cranial nerve testing amongst some clinicians

Debate around 'over-imaging' and 'under-imaging'

This first resource is aimed primarily at physiotherapists, osteopaths, chiropractors and first contact practitioners

A separate resource will be created for GPs

BASIC CRANIAL NERVE TESTING

1 Olfactory: any problems with smell?

2 Optic nerve: visual fields test - cover one eye, should have 160 degrees horizontal vision and 120 vertical vision

3 Oculomotor, 4 Trochlear and 6 Abducens: H field test: cover one eye and see if they can follow you all along the H shape - test both eyes

5 Trigeminal: test facial sensation with light touch, ask them to clench their jaw and palpate the masseter muscle

7 Facial: raise eyebrows, show teeth, scrunch eyes, puff out cheeks, etc

8 Vestibulocochlear: test balance e.g. tandem walk and ask about hearing (or test hearing with finger rubbing)

9 Glossopharyngeal and 10 Vagus: any swallowing or choking? Say 'aah': is the uvula deviated?

11 Accessory: resist shoulder elevation and look for wasting SCM/UFT

12 Hypoglossal: resist lateral tongue flexion through the cheek and stick out tongue

If any tests are positive, further testing +/- onward referral may be needed. Tabrah & Butt, 2022

Cervico-cranial red flag screening tool

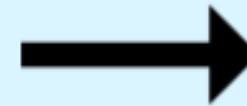
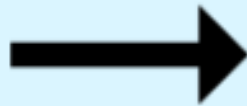
Tabrah, Taylor, Kerry, Mourad, Bridge and Herdman - 2023.

This resource is an aide-mémoire which outlines some of the key cervical spine and headache red flags. It is not a triage tool and is not an exhaustive list. We advocate thorough history taking, multi-systems clinical reasoning and a low threshold for onward referral/imaging if concerning features.

IMPORTANT: Avoid waiting for a 'full house' of late stage red flags - listen out for the more subtle early/middle stage red flags and act if concerned



e.g. unusual distribution of symptoms, non mechanical pattern, 'something doesn't feel right', etc.



e.g. paralysis, drowsiness, seizure, ataxia, incontinence, multiple neurological signs, etc

Neurological considerations - myelopathy

ASK:

- paraesthesia/numbness hands (glove) and/or feet (sock)
- neck pain and/or stiffness
- bilateral arm and/or leg pain
- loss of dexterity/clumsiness
- weakness of the hands and/or feet
- poor balance
- reducing mobility
- bladder/bowel dysfunction, etc

TEST:

- gait
- upper/lower limb sensation/power/reflexes
- UMN tests e.g. Babinski, Hoffmanns, Tromner, Clonus, Romberg, Tandem

DCM	Early symptoms	Middle-stage symptoms	Late symptoms
Hand numbness	[Green bar]		
Symptom variability day to day	[Green bar]		
Neck pain	[Green bar]		
Arm numbness		[Yellow bar]	
Clumsiness		[Yellow bar]	
Reduced dexterity		[Yellow bar]	
Heavy legs		[Yellow bar]	
Muscle spasms in the arms		[Yellow bar]	
Reducing mobility			[Red bar]
Loss of control of the legs			[Red bar]
Dragging legs			[Red bar]
Paralysis			[Red bar]
Muscle spasms in the legs			[Red bar]
Constipation			[Red bar]
Urinary incontinence			[Red bar]

Expert consensus project: Tabrah et al, 2023

Note: none of these symptoms are diagnostic of DCM in isolation. A combination of symptoms increases the risk of DCM. Consider the whole picture and have a low threshold for onward referral/imaging if concerned.

* DCM = degenerative cervical myelopathy

FURTHER INFO: [Diagnosis/Clinical Examination - MYELOPATHY.ORG](https://www.myeopathy.org)
[Overview](#) | [Metastatic spinal cord compression in adults](#) | [Quality standards](#) | [NICE](#)

Vestibular considerations

ASK:

- Unilateral hearing loss or tinnitus
- Progressively deteriorating balance
- Severe vertigo symptoms or acute vertigo during sudden postural changes e.g. STS or rolling in bed
- Focal neurological symptoms e.g. diplopia, dysarthria, ataxia, papilloedema, cranial nerve palsies, etc.
- Any cardiac symptoms

<https://www.bmj.com/content/366/bmj.l5215/infographic>

TEST:

- DixHallpike and Supine Roll test: <https://aao-hnsfjournals.onlinelibrary.wiley.com/doi/10.1177/0194599816689667>
- Occulomotor Tests - <https://novel.utah.edu/Gold/>
- Blood Pressure - lying and standing
- UL/LL neurological exam and cranial nerve tests
- Static and dynamic balance testing e.g. Romberg & Tandem

Assessment | Diagnosis | Vertigo | CKS | NICE

Vascular considerations

ASK:

- trauma
- vascular risk factors e.g. HTN, smoking, etc
- unusual presentation e.g. atypical headache - see headache red flags below* - or neck and orofacial symptoms
- cranial nerve symptoms e.g. issues with smell, vision, hearing, balance, etc.
- focal neurological symptoms e.g. memory loss, vagueness, ptosis, etc
- Giant cell/temporal arteritis symptoms e.g jaw claudication, acute visual disturbance, tenderness of temporal artery, etc

TEST:

- upper/lower limb neurological examination
- consider UMN tests
- cranial nerve tests
- co-ordination and gait
- blood pressure

FURTHER INFO: *OMPT Frameworks and Clinical Resources (ifompt.org)*
Cranial nerve testing: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8725776/>

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- 5 **Trigeminal**: test facial sensation with light touch, ask them to clench their jaw and palpate the masseter muscle
- 7 **Facial**: raise eyebrows, show teeth, scrunch eyes, puff out cheeks, etc
- 8 **Vestibulocochlear**: test balance e.g. tandem walk and ask about hearing (or test hearing with finger rubbing)
- 9 **Glossopharyngeal** and 10 **Vagus**: any swallowing or choking? Say 'aah': is the uvula deviated?
- 11 **Accessory**: resist shoulder elevation and look for wasting SCM/UFT
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Headache considerations

ASK: **SNOOP4** - <https://journals.sagepub.com/doi/full/10.1177/1024907920928688>

- **S**ystemic features: e.g fever, rash, malaise, persistent vomiting, etc
- **N**eurological features: e.g acute loss of memory, coordination, vision, speech, confusion, seizure, significant weakness, etc
- **O**nsset - speed: sudden onset thunderclap headache, first/worst, maximum intensity in <1 minute
- **O**nsset - age: new onset headache in over 50 or under 5
- **P**revious history: cancer, HIV, etc
- **P**ost traumatic: head trauma within the last 3/12
- **P**ositional/provoked e.g triggered by cough, sneeze, valsalva, forward bend, standing up or lying down
- **P**attern change/progressive - significant worsening of frequency or intensity of symptoms

TEST

- Upper/lower limb neurological exam and cranial nerve tests: <https://www.youtube.com/watch?v=wyBNYB0RLvU>
- Blood pressure

Further information: *British Association for the Study of Headache (BASH)* | <https://cks.nice.org.uk/topics/headache-assessment/>

Thorough history taking -- Consider each symptom in context -- Discuss with a colleague -- Trust gut instinct -- Act if concerned -- Safety net -- Monitor

<https://www.jospt.org/doi/10.2519/jospt.2022.11568>

REFLECTIONS AND TAKE AWAYS

Don't panic	Most head and neck presentations are benign
Don't be complacent	Don't wait for a full house of 'end stage' red flags
Catch them early	Listen out for the more subtle 'early stage' red flags and have a low threshold for onward referral/imaging if you are concerned
Context	Look at the whole picture – none of these red flags are diagnostic in isolation
Two heads are better than one	Always seek a second opinion where possible
Graded approach	Select the appropriate questions/tests and take a graded approach
Listen and believe	Many clinical tests lack diagnostic accuracy – history taking is key; listen and believe

THANK YOU FOR LISTENING
QUESTIONS?

