ISAEC

Inter-professional Spine Assessment and Education Clinics (ISAEC) Pilot

ISAEC Quick Stats…

Pilot days remaining: **84**
Patient referrals to date: **1050**
Average wait time: **<2 weeks**
Patients needing Imaging/Specialist: **58**

How important is imaging in the management of our low back pain patients?

ISAEC was established to coincide with Ontario's shift to an innovative, evidenced-based and cost-effective low back pain strategy. Through rapid access, thorough assessment and patient education the aim of ISAEC is to decrease the prevalence of unmanageable low back pain in Ontario. Simultaneously, we have strived to reduce wait times for patients that need specialist care as well as the financial burden of unnecessary lumbar spine MRIs. As such, each pilot site runs a monthly joint surgical clinic (Practice Lead/Spine Surgeon) for patients that require a surgical consultation. This month, we analyzed the surgical consultation data and are happy to report that the numbers are exceeding our expectations. Even after evaluation of patients by our spine surgeons **only 3.5%** of our patients required MRI imaging. MRIs were only requisitioned for surgical planning if patients were interested in surgical management of their condition. Effectively, this demonstrates that imaging is not necessary in managing the majority of low back pain patients.

When is imaging really necessary?

This Month's Case Study…

By Henry Candelaria, DC
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Questions?
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This 42 year old male geologist was referred to ISAEC with an 8 week complaint of left sided leg dominant pain in the L5 distribution. He reported a 12 year history of recurrent lower back pain. As a result of his current condition he was having difficulties with prolonged standing and walking. Previous treatment included physiotherapy which helped manage his past episodes of lower back pain but had no effect on his current leg dominant complaint. He continued to work at his job which at times was labour intensive and required frequent travel. ISAEC risk stratification identified him as being at low risk for inflammatory arthritis, chronicity and opioid dependency.

Physical examination revealed that his symptoms were aggravated with extension, walking and standing. He had a positive left SLR, left EHL and FHL myotomal weakness as well as a left foot drop that was elicited on heel walking and tandem gait. As such, he was diagnosed with intermittent leg dominant pain (neurogenic claudication) most likely due to a disc as it was acute in onset. He was provided with an individualized flexion-based self-management program consisting of positions of comfort, stretches, exercises as well as weight management. Additionally, he was provided with an extensive amount of education, activity limitations, and an ISAEC Surgical Consultation referral.

At the time of his ISAEC Surgical Consultation he reported resolution of his intermittent leg dominant pain as well as his left foot drop. However, he presented with a recent onset new left leg dominant pain now localized to his posterior leg and plantar aspect of his foot. He noted that his new symptoms were made better with walking and standing and worse with sitting and flexion unlike his previous condition. Additionally, he reported weakness with toeing off during gait. Physical examination revealed a positive left SLR, left S1 dysesthesia and myotomal weakness in his left FHL. He was diagnosed with a recent onset resolving left S1 radiculopathy due to an L5/S1 disc. Given that his claudicant symptoms had resolved conservatively and that his current left S1 radiculopathy was resolving he was encouraged to continue with conservative management. He was asked to stop his flexion based exercises in favour of an extension type program as his claudicant symptoms had resolved and to follow-up with his ISAEC APC.

He returned to his ISAEC APC three weeks later. Examination revealed that his leg pain and back pain had completely resolved. He was left with a mild dysethesia in the left S1 distribution and mild myotomal weakness in the previously described myotomes. His exercise program was further progressed providing him with a comprehensive core strengthening program and further advice on work modifications. He was discharged from care and advised that if his condition worsened he should be referred back to ISEAC.

You Asked, ISAEC Answered…

Consolidated Consult Note and Treatment Plans being released this Month

…..larger comment sections, easier to understand and less paper