

October 24, 2014

**Sum of public comments received by this date on the draft guideline:
Diagnosis and Treatment of Cervical Radiculopathy and Myelopathy**

Note: These comments have been edited to remove personal greetings and comments, patient case testimonials, and contact information.

General Feedback	
Comments:	Responses:
<p>1. From: Cindy Moyer, LMP, Chehalis WA:</p> <p>I can't provide medical studies to support this, but from personal experience I have found Orthopedic Massage Therapy to be helpful in the treatment of patients with Cervical radicular symptoms and dysfunction. It appears that by relaxing and stretching the muscles of the cervical area, the encroachment on the nerves is lessened and postural positions that exacerbate the problem can be addressed.</p> <p>I read the conservative measures and saw that physical therapy was advised. After a 28 year career in this field, prior to my lateral shift into the practice of manual therapy, I can attest that the amount of hands on, soft tissue work and stretching they provide is minimal. Massage therapy offers focused treatment with the goals of decreasing soft tissue restriction, decreasing muscle hypertonicity, decreasing pain, increasing range of motion, improving posture and increasing tolerance of functional mobility and activity. I have found my patients are better able to handle the riggers of physical therapy when they are receiving massage therapy.</p> <p>It is with this personal testimony that I request that Massage Therapy be added the the Conservative Measures in the Diagnosis and Treatment of Cervical Radiculopathy and Myelopathy.</p> <p>Thank you for accepting my Public Comment. If I can be of further assistance please contact me at:</p>	<p>We value the input of health care providers who care for patients with these problems, and appreciate your comment. Our guidelines were developed by researching the current literature on the surgical and nonsurgical care for the problem of cervical radiculopathy and myelopathy. We agree that there is limited research on the use of massage therapy and so were not able to include it as a recommendation within this guideline. If newer research suggests an advantage for massage therapy over or equivalent to physical therapy, we can re-assess once this guideline is up for re-review.</p> <p>No changes made to guideline.</p>

<p>2. From: Jon Geffen DO:</p> <p>I wanted to comment on a few of these points:</p> <p>Just a couple notes. CT should never be done for cervical transforaminal / Selective nerve blocks. They inadequately image vascular flow and vascular flow by the medications can cause catastrophic sequelae like brain and spinal cord emboli/infarction.</p> <p>My biggest concern is the emphasis on diagnosis for the operation without clear guidelines on conservative treatment. Asking for a diagnostic cervical Selective nerve block, which is extremely dangerous, should not be done unless physical therapy and a trial of epidural injections have been tried and failed. I see too many surgeons now evaluate patients with this method which is not only non-therapeutic but extremely dangerous. If all possible treatment options have failed then and only then should the final route to surgery be considered.</p>	<p>We agree that nonsurgical measures are the primary treatment for cervical radiculopathy. This guideline is one that is called into play when a surgeon has requested approval for surgical treatment of this condition, and is not designed to provide a full management algorithm for the standard nonsurgical treatment of this condition. We used our review of the scientific literature to determine what nonsurgical interventions should be done prior to approval for surgery. Regarding the CT vs fluoroscopic guidance for cervical nerve blocks, we solicited input from practicing anesthesiologists. There were proponents of each method, and there didn't appear to be a clear contraindication to one over another within the scientific literature. Our primary goal was to ensure that SOME means of imaging was utilized, since the use of imaging had positive effects (over no imaging) on patient outcomes within the articles we reviewed.</p> <p>No changes made to guideline.</p>
<p>3. From: Elaine Armantrout, PT, DSc, ECS; President of the Physical Therapy Association of Washington:</p> <p>On behalf of the Physical Therapy Association of Washington, I'd like to offer comments on the Draft Diagnosis and Treatment of Cervical Radiculopathy and Myelopathy.</p> <p>I commend the Industrial Insurance Medical Advisory Committee for their work addressing guidance in the area of cervical surgeries performed on injured workers. This is a well-crafted draft medical treatment guideline. Please consider the following comments to enhance the document.</p> <p>1) On page 2, the table <i>Cervical Surgery Review Criteria ACDF or TDA for</i></p>	<p>We will review the language that you have proposed and attempt to clarify the inconsistencies you noted regarding the either/and/or discrepancy for noninvasive treatments. We agree as well that nonsurgical interventions can provide significant benefit for many patients with these conditions. This guideline is not intended to direct care for patients who are initially presenting with these symptoms, but are instead designed as a checklist to ensure that patients have had a full and worthwhile attempt at nonsurgical treatment prior to being approved for surgery. The counseling that you advocate will therefore have been completed by the surgeon and nonsurgical providers caring for the patient. The committee spent some time debating the appropriate way to incorporate outcome scales in the approval process. While we feel that these</p>

Radiculopathy-Single level under the conservative care column, it states “At least 6 weeks of physical therapy using active modalities or chiropractic OR anti-inflammatory medications.”

- a) Passive physical therapy modalities may be necessary in the early stages to achieve progress toward functional goals. When a patient presents with an acute single level cervical radiculopathy, passive modalities such as manual therapy techniques, electrical stimulation, heat or ice as well as cervical traction are often necessary during an initial or an early physical therapy treatment session to reduce the radicular pain component and get the patient able to participate in an active physical therapy treatment program. All physical therapy patients receive instruction in a home care/home exercise program for self-management of symptoms and advancement toward recovery. See comment 2 below.
- b) Anti-inflammatory medications and/or epidural steroid injection are commonly used simultaneously during the 6-week physical therapy intervention and should not be listed as an “either/or” intervention relating to physical therapy care. See comment 2 below.
- c) Neurological deficits (motor and/or sensory) relating to cervical radiculopathy or myelopathy relating to cervical disc herniation can be successfully treated with physical therapy care. The patient should be counseled on the pros and cons of both choices: conservative care vs. surgery¹⁻³.
- d) Functional improvement measures using the Neck Disability Index (NDI) should not only include an initial assessment, but also at the end of the 6 weeks of conservative care prior to approval for surgery. Used as an outcome measure, approval for surgery should include consideration of failure to meet the MDI minimal clinically important difference (estimated to be a decrease of at least 8 points or more⁴) at the end of 6 weeks of conservative care. Otherwise, continuation of conservative care should be considered as an option to surgery.
- e) It’s not clear on what “chiropractic” conservative care means in this context. IF the committee’s intent is to equate “chiropractic” to “spinal manipulation”

patient-centered outcomes (PCO) are an integral part in the assessment of these patients both pre- and post-intervention, we did not feel that there was enough data around one particular scale to require its use to the exclusion of others. Various studies have used the NDI, SF-36, SF-6, EQ-5D, Roland-Morris and VAS to assess for improvements after musculoskeletal interventions. We anticipate that future guidelines will have an increasing emphasis on PCO measures. At the present time, however, we have required that "providers should measure and document functional improvement throughout conservative and surgical treatment."

Change was made in the conservative care column, in response to comments a) and b).

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then:

- i) Spinal manipulation using high velocity low amplitude thrust rotational techniques on the same level as the motor deficit is contraindicated.
 - ii) Spinal manipulation may be of benefit at the thoracic level.
 - iii) Please note that spinal manipulation is a passive manual therapy technique.
- 2) On page 9, under A. *Conservative treatment* it states “Conservative management of cervical radicular symptoms may include active and passive therapy, traction, NSAIDS and steroid injections.” This statement should replace what is listed on page 2, the table Cervical Surgery Review Criteria ACDF or TDA for Radiculopathy-Single level under the Conservative care column.
 - 3) On page 12 *Measuring Functional Improvement* should include not only the initial measurements, but also during and after the course of interventions. This information including documentation of minimal clinically important differences reported as outcome measures can help drive clinical decision-making as well as improve population health and clinical guidelines such as this.
 - 4) On page 13 *Post-Operative Phase and Return to Work*, the document should specify when appropriate requiring physical therapy for ergonomic evaluations, pain management as well as rehabilitation for neurological deficits such as motor weakness or myelopathy sequela.

Thank you for allowing us to submit our comments. We look forward to helping our patients improve and get back to work.