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Inspiring Minds

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Dear Colleague,

Spine related disorders, including disc disease, stenosis, neck and back pain, constitute the majority of referrals to the neurosurgical service in Nova Scotia. Many patients currently wait up to two or three years before being seen by a neurosurgeon. For most patients, symptoms related to neck and back pain cannot be helped with current surgical techniques and these patients are often better served using conservative approaches. It is of no benefit for a patient to wait two or three years to see a neurosurgeon, only then to be told that surgery is not appropriate for them and have a Pain Clinic referral initiated. Patients who do have pathology which is surgically amenable are then penalized by the excessive waiting lists as well: not only do they suffer physical symptoms and potentially lost income for long periods of time, but the delay may reduce their chance of successful outcomes.

Our goal is to improve triaging of spine referrals, so as to more quickly see your patients for whom surgery may be necessary or beneficial.

Neurosurgery at the QE II, Nova Scotia Health Authority is working to streamline the referral process and deal efficiently with the backlog of spine referrals. We have initiated a centralized referral and review for neurosurgical spine-related consultation requests. The standardized spine referral form will help us to better triage your patients. The spine referral form can be accessed from our website <http://neurosurgery.medicine.dal.ca>. Also, see direct link to the spine referral form below.

All referrals will be triaged and objectively scored based on the information provided and a review of any imaging available.

Patients with a high likelihood of requiring surgery (e.g., myelopathy, instability, neurogenic claudication, disc herniation with unremitting radiculopathy despite an adequate trial of conservative management) will be seen sooner. Patients with mechanical low back pain and/or with imaging that does not demonstrate a surgically treatable lesion may not be offered an appointment; rather advice and management suggestions will be provided. It is still anticipated that the majority of consults seen will not result in surgery, as our screening tool has low specificity.

Furthermore, various checks and re-entry options will help provide a "safety net" to ensure that patients with surgical disease are assessed appropriately. Emergent cases will of course continue to be accepted by phone consultation, as they are now; the changes we are implementing are aimed at dealing with the mountain of "elective" spine consults.

We anticipate adjustments to the system as we move forward and we appreciate and encourage your comments.

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