

vate the Canada Safety Council to take such irresponsible positions. Canadians need to know more about this organization, but its Web site gives no clues as to how Therien decides on the positions he takes, whether he is counselled by colleagues and, if so, what their competence is to judge scientific issues. A request for such information yielded a large packet of press releases and — the coup de grâce — comic books featuring Elmer the Safety Elephant (another unproven safety measure).

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[The author responds:]

Barry Pless has criticized the Canada Safety Council on several fronts, apparently unaware of the strong body of evidence supporting our stance in each case. I encourage readers to visit our Web site (www.safety-council.org) to see the breadth of safety issues that we address.

It is true that cell phones can be a dangerous distraction. However, the 1997 study¹ had serious shortcomings. New research is available from organizations with recognized expertise in traffic safety; the methodology used in this research includes large, representative samples and control groups studied over significant periods of time.² Current findings should not be dismissed if we truly wish to improve safety on our roads.

The Canada Safety Council fully recognizes that laws and regulations

and their enforcement are critical to the prevention of deaths and injuries. The Hazardous Products Act, labour legislation, laws against impaired driving, laws making seat-belt use mandatory and many other regulations have played a major role in improving safety. Perhaps because of the success of these laws, more and stricter rules are demanded in the name of safety. However, it is counterproductive to have too many laws on the books if they cannot be enforced.

Before calling for new laws, it is important to consider the following questions. First, can the problem be addressed through existing laws? In the case of driver distractions and impaired driving, laws are already in place. Second, can the proposed legislation realistically be enforced? Resources for the enforcement of traffic laws, including those concerning impaired driving, are generally inadequate. Third, can non-regulatory approaches such as public education be used to address the issue?

I wrote my original letter to *CMAJ* not as an attack, but because I feel that it is vital that the members of the medical community and the safety movement work together to make Canada a safer place.³

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Neck pain

I enjoyed Ian Tsang's concise and useful lesson on neck pain.¹ I was especially interested in Tsang's comment that consultation with a specialist may be necessary for patients with disabling or progressive neurologic problems.

With or without neurologic deficits, patients often consider their neck condition to be disabling and progressive, so they and their family physicians are understandably anxious for a specialist's opinion. As a result, neurosurgeons are inundated with referrals for patients with neck (and back) problems, most of which do not involve the cervical nerve roots or the spinal cord and would not be appropriately treated by surgery.

Compounding this situation in Alberta is that many patients with chronic spinal pain turn to private MRI clinics, not uncommonly with their family physician's encouragement. A positive scan might fast-track a patient to a surgeon. However, few cervical spine MRI scans in middle-aged or older people are actually normal, and the reports often contain disturbing descriptions of degenerative changes, including bulging disks, osteophytes and "foraminal stenosis." It is difficult to convince patients without neurological involvement that these changes are of quite uncertain significance.

If I can take the liberty of speaking for my specialty, our plea to family physicians would be to investigate and refer patients to surgeons judiciously. For example, cervical radiculopathies may be associated with a knot of pain in the parascapular region but are always associated with more pain in the limb than in the neck; upon careful investigation they are usually found to be associated with a neurologic deficit in the form of weakness, a depressed stretch reflex, dermatomal numbness or some combination of these. When these symptoms and signs persist for over a month without significant improvement, further investigations are appropriate. An almost identical strategy can be recommended for sciatica.² If imaging demonstrates pathology that correlates with the clinical picture, referral to a surgeon should follow. One should also be on the lookout for red flags that should prompt more urgent investigation: fever, severe pain at rest, a history of cancer or risk factors for bacteremia, and signs of spinal cord compression. Overinvestigation and overreferral of patients with neck (and back) pain im-

pede the assessment and treatment of the few patients who might benefit from surgical intervention.

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2. Deyo RA, Weinstein JN. Low back pain. *N Engl J Med* 2001;344(5):363-70.

Ian Tsang should be commended for his well-organized article on neck pain.¹ In the final paragraph, Tsang describes a case in which there was complete resolution of neurologic symptoms after spinal cord decompression. Elsewhere he states that patients whose pain arises from the cervical nerve roots or spinal cord often do not achieve complete pain relief.

In my experience with patients who have myelopathy secondary to significant cord compression, complete resolution of the myelopathy is rarely achieved, particularly if there has been significant, sustained spinal cord compression. Although the symptoms decrease in severity after decompression, spasticity and impaired intrinsic hand function often remain. I would appreciate it if Tsang would comment further on this point, as my impression in reading the article is that the prognosis for complete neurologic resolution of the symptoms of myelopathy is good.

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I found Ian Tsang's recent article on pain in the neck to be quite useful and in fact used parts of it in a lecture I

gave.¹ However, I feel that 2 points need to be clarified.

Tsang mentions the lack of a history of a specific injury as one of the ways to discriminate group 1 pain (cervical problems arising from neck joints and associated ligaments and muscles) from group 2 pain (cervical problems involving the cervical nerve roots or the spinal cord). This is not consistent with the fact that neck pain resulting from whiplash primarily involves the soft tissues of the neck.

Second, he states that a burning sensation is characteristic of group 2 pain. This is more typical of pain arising from muscles, such as myofascial pain syndromes, than of radicular pain.²

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The otherwise-excellent articles on neck¹ and low-back pain² may have misled physicians about how best to prevent chronic pain disability. For example, Ian Tsang encourages physicians to "identify the pathology early so that these patients can be managed properly" but warns that "in most cases of neck pain, no clear-cut underlying definable pathology can be identified."¹ Advising physicians to first establish a specific diagnosis leads them to perform repeated investigations and seek multiple consultations with specialists. I have repeatedly seen this strategy produce iatrogenic outcomes such as false-positive diagnoses, unnecessary treatments and fear and distress in the patient. Physicians consequently become barriers to more timely interventions.

Work-related musculoskeletal disorders often have multifactorial causes.³ It

is primarily the family physician's responsibility, not a specialist's, to rule out serious organic disease by means of a simple history and examination. Then, without delay, the family physician should clearly communicate to the patient a confident, optimistic diagnosis and a treatment plan that encourages "the maintenance of an active life including work activity."²

What is insufficiently appreciated is that a patient with a work-related musculoskeletal disorder who has been off work for 4 weeks is at high risk for long-term disability.⁴ High levels of pain and the presence of Waddell's nonorganic signs should alert the physician that a patient is in distress and in imminent danger of becoming a "claimant," with all the suffering and insecurity that this label may entail. The best evidence suggests that it is urgent at the subacute stage (4–12 weeks postinjury) to refer these high-risk patients to a multidisciplinary cognitive-behavioural rehabilitation program.⁵ These programs focus on ergonomic and psychosocial workplace issues and teach patients strategies to manage pain and increase function. Physicians should work with employers and insurers to make such programs more widely available for their patients.

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