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

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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 neck[1] and low-back pain[2] 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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