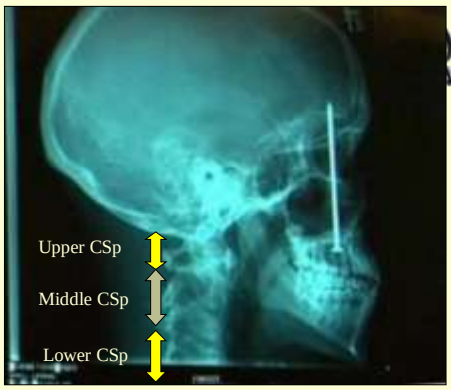
Subjective Examination of the Cervical Spine

How to Apply the Skills Used for the Lumbar Spine to the Cervical Spine

Examination of the Cervical Spine

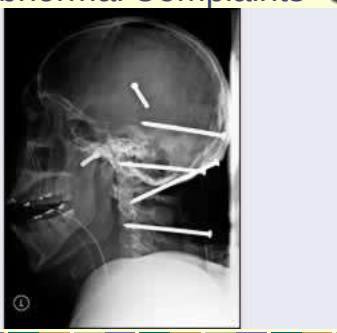
For examination and treatment purposes, the cervical spine can be divided into head on neck (upper cervical), neck on neck (mid cervical), and neck on trunk (lower cervical



Normal Complaints

Patients with neuromusculoskeletal disorders of the neck usually complain of pain as well as associated symptoms such as stiffness, headache or dizziness.

Abnormal Complaints



Kind of Disorder

- Need to establish why the patient has sought treatment – look for the obvious
- Is the main reason:
  - Pain, stiffness, weakness, instability
  - Acute onset
  - Post-surgical, trauma, MUA, support, traction

Kind of Disorder

- Identification of the kind of disorder guides the rest of the assessment
- Usually this is 'pain' in the cervical spine
- Attempt to establish a link between pain and movements
- If dizziness is the main symptom again a link between symptom and movement is identified

History

- Need to identify the recent and previous History – only what is relevant to the presenting case
- Attempt to identify the onset of symptoms and any provoking/relieving actions
- Similar questions as those asked in the Lumbar Subjective Assessment are used

History

- Of the present incident
- Of previous incidents or associated symptoms
- Are symptoms worsening or improving?
- Prior treatment and its effect
- Socio-economic history as appropriate

What Actually Happened?

- Quick
- Concise
- Facts
- Even if they seem bizarre

Area/Location

- Record on a body chart what type of disorder is present (pain, stiffness, etc)
- Note area and depth of symptoms
- Identify paraesthesia and anaesthesia
- Check other associated areas – joints above and below the disorder

Area – Upper Cervical Spine

- The site of sub-occipital pain must be determined accurately
- Is the focus the occipito-atlantal area, atlanto-axial area or the area between C2 and C3

Area – Lower Cervical Spine

- Need to consider the area across the suprascapular area
- May be a site of pain from the upper thoracic spine
- Do symptoms start in the lower cervical spine and spread down and laterally?
- Do symptoms spread from shoulder to shoulder at the T2 level without spreading to the neck itself?

Behavior of Symptoms

Behavior of Symptoms

- When are symptoms present?
- How do symptoms fluctuate – location or intensity
- Effect of rest on symptoms – local or referred
- Daily variations
- Pain and stiffness on rising, duration of

Behavior of Symptoms – Particular

- What evokes symptoms? (AGGs)
- What relieves symptoms? (EASEs)
- Determine severity and irritability
- What sustained positions provoke symptoms?
- Are quick movements painful/painless

Behavior of Symptoms

- Symptoms are rarely constant 24/7
- Usually cervical pain is worsened by movement
- Patients frequently waken with stiffness and decreased pain
- Exact aggravating movements must be identified

Pain

- Quality of pain – description of the pain – use McGill Pain Questionnaire words
- Intensity of pain – Edeling's headache classification, use VAS
- Depth of Pain – patient's interpretation of the depth of pain

Pain

- Abnormal Sensations – over the neck, the face, the head or upper limbs.
- Constant or Intermittent Symptoms – rarely is pain constant – if stated as such, persist in questioning.
- Relationship of Symptoms – do headaches accompany pain in the neck?

Special Questions

- Does the patient have any associated dizziness? (Query involvement of the vertebral artery)
- Does the patient have bilateral tingling present in the hands or feet? (cord signs)
- General health and recent unexpected weight loss (relevant medical history)

Special Questions

- What medication has been prescribed or has the patient taken?
- What other medication does the patient regularly take?
- Have recent x-rays been taken or ordered?
- What changes were identified on x-ray?

Symptoms of VBI

- Drop attacks, blackouts, loss of conciousness
- Nausea, vomiting, feeling unwell
- Dizziness or vertigo – especially if associated with head position
- Vision disturbances – blurred, diplopia
- Unsteadiness of gait

Symptoms of VBI

- Tinnitus/deafness
- Headaches
- Past history of cervical trauma
- Cardiac disease, vascular disease
- Blood clotting disorders
- Anticoagulant therapy

Contributors to VBI

- Oral contraception
- Long term steroid use
- History of smoking
- Immediately post partum

Purpose of Subjective Exam

- Direct the Objective Exam – sets the map up correctly
- Start the hypothesis process
- Identify any 'serious' issues that should be referred or indicate caution
- Evaluate the patient and their relationship with their condition

Any Questions?