



3rd July 2024

Reference Number: NCO-31-24

Re: GP Access to Community Diagnostics – Referring for MRI

Dear Colleagues,

Thank you for your invaluable contribution to the GP Access to Community Diagnostics schemes. These schemes, which provide GPs with direct access to radiology diagnostics (X-ray, CT, MRI, DXA and US), are crucial in our collective effort to enhance patient care.

As part of the ongoing National Radiology Review, we have engaged with the National Clinical Programme for Trauma and Orthopedic Surgery, consultant radiologists participating in this review and the National Clinical Advisor and Clinical Programme Lead for Primary Care, which has led to the development of this memo. Its purpose is to guide GPs in making informed decisions about the use of specific MRI imaging studies available on the GP Access to Community Diagnostics Scheme, thereby ensuring its ongoing sustainability.

MRI Knee/Shoulder/Hip/Bony Pelvis/Pelvis

High volumes of **MRI knee/shoulder/hip/bony pelvis/pelvis** are completed annually on the scheme, with approximately 1/3 of these being completed in the **over 60 years age category**. Osteoarthritis is most common in this age category, and imaging may not alter clinical management. Therefore, in the absence of red flags and where imaging is required, osteoarthritic pathologies are typically more discernible and appropriately evaluated through x-ray. This communication is not designed to supersede clinicians' clinical reasoning but to clarify the most optimal radiological investigation required for that patient at the time of presentation. To decide on the most appropriate exam, you have full access to iRefer guidelines: <https://www.irefer.org.uk/>. Please use the following login details: **Email address: community.diagnostics@hse.ie Password: Community.Diagnostics23!**

In addition to iRefer access, the HSE has worked with the ICGP, who have developed a Quick Reference Guide for GPs in practice that focuses on the use of specific imaging modalities (those most commonly referred for on the scheme) for various clinical issues. It is available to ICGP members via the ICGP website.

MRI Lumbar and Lumbosacral Spine

High volumes of **MRI Lumbar and Lumbosacral spine** are completed on the scheme. Please ensure that the patients presenting with low back pain meet the clinical criteria for referral for lumbar/lumbosacral MRI (See below):



QUICK REFERENCE GUIDE

TITLE Referrals for Diagnostic Imaging:
A Practical Guide for General Practitioners

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- For Acute low back pain (≤ 6 weeks) with no red flag symptoms and without suspicion of spinal malignancy, infection, fracture, or cauda equina syndrome, MRI is a ¹Specialised investigation.
- Patients with non-specific back pain, +/- radicular symptoms (no red flags) are best managed conservatively as it is usually self-limiting. MRI should be reserved for patients referred for a specialist spinal opinion where specialist interventions may be required, i.e. injections +/- surgery, as positive imaging findings on MRI are common and often unrelated to the patient's presenting symptoms.
- For Chronic lumbar back pain (> 12 weeks) with no clinical or serological indicators of neoplasia, infection or inflammatory arthropathy (i.e. no red flags), MRI is ²Indicated only in specific circumstances. Lumbar imaging for isolated low-back pain does not improve clinical outcomes.
- MRI should be considered in patients with low back pain and in the presence of at least one of the following:
 - Failure to respond to conservative management
 - Progression of symptoms
 - 6 weeks history of radiculopathy refractory to conservative management
 - Planning surgical intervention or specialist chronic pain management.

NICE National Institute for Health and Care Excellence

This guideline covers assessing and managing low back pain and sciatica in people aged 16 and over and provides guidance on imaging (see below).

Imaging

1.1.4 Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica. [2016]

1.1.5 Explain to people with low back pain with or without sciatica that if they are being referred for specialist opinion, they may not need imaging. [2016]

1.1.6 Consider imaging in specialist settings of care (for example, a musculoskeletal interface clinic or hospital) for people with low back pain with or without sciatica only if the result is likely to change management. [2016]

For full guidance, see [Low back pain and Sciatica in over 16s: assessment and management](#)

National Integrated Low Back Pain (NiLBP) Pathway

¹ Specialised investigations are frequently complex, time-consuming and/or resource-intensive, and will usually only be undertaken after discussion with the radiologist or according to locally agreed protocols

² Non-routine investigations, usually only undertaken if a clinician provides cogent reasons or if the radiologist believes the examination represents an appropriate means of furthering the diagnosis and management of the patient. With certain clinical problems which may resolve with time, it may be correct to defer investigation.



The HSE are currently piloting the National Integrated Low Back Pain Pathway on two sites – further information on this is available on <https://www.hse.ie/eng/about/who/cspd/ncps/trauma-and-orthopaedic-surgery/>

For patient information on managing Acute and Persistent Lower Back Pain, please see Appendix 1. Appendices 2 and 3 include useful NHS Best MSK Health Collaborative resources.

We ask that you utilise the guidance available to ensure that you are accessing the most appropriate exam for your patients. Sequential imaging within a year in the absence of red flags or significant changes in clinical features is unlikely to add value.

Finally, I would ask that you please prioritise urgent and routine referrals appropriately in line with the FAQ available at <https://www.hse.ie/eng/services/list/2/primarycare/community-healthcare-networks/gp-diagnostics/> and we will continue to engage as part of our regular engagement with providers around activity levels and waiting times.

If you have any questions or feedback in relation to this communication or service, please do not hesitate to contact community.diagnostics@hse.ie.

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'G. Crowley', written over a horizontal line.

Geraldine Crowley
Assistant National Director
Enhanced Community Care Programme &
Primary Care Contracts



Appendix 1 Resources for GPs and Patients



The booklets above are available at <https://www.healthpromotion.ie/> and links to other useful resources are listed below:

<https://www2.hse.ie/conditions/back-pain/>

<https://www2.hse.ie/living-well/exercise/increase-activity/>

<https://hsepodcasts.podbean.com/e/54-understanding-low-back-pain/>

BestMSK Spinal MRI: Clinician Advice



I'll just send you for a scan!

- Most back or radicular pain settles within 3 months.
- MRIs give an accurate picture of spinal anatomy which can help plan treatment in suspected serious conditions such as cauda equina syndrome, cancer, fractures, and infections.
- MRI is rarely indicated for back or neck pain and should only be organised after assessment by a musculoskeletal practitioner with spinal expertise.
- They cannot tell how someone feels and are not a diagnosis. Spinal MRI findings always need to be interpreted in the context of a clinical assessment.
- Findings described in MRI reports are very common in people with NO PAIN, such as disc degeneration (80%), disc bulges (60%), disc protrusion (36%), annular tear (23%)¹ (aged 50 years). These findings increase with age and can be signs of a naturally maturing spine.



- Nine out of ten people with NO neck pain have disc bulges on MRI and most people in their 20s have bulging discs².
- There is good evidence to suggest that unwarranted MRI scans are detrimental to patient wellbeing and lead to poorer outcomes³.

Please follow BestMSKHealth pathways for management of patients presenting with neck, back and/or radicular pain: <https://future.nhs.uk/NationalMSKHealth/view?objectId=30917712>

References:

1. W. Brinjikji, P.H. Luetmer, B. Corstock, B.W. Bresnahan, L.E. Chen, R.A. Deyo, S. Halabi, J.A. Turner, A.L. Avins, K. James, J.T. Wald, D.F. Kalish and J.G. Jarvik. Systematic Literature Review of Imaging Features of Spinal Degeneration in Asymptomatic Populations. AINR Apr 2015; 36 (4) B11-B16.
2. Nakashima H, Yukawa Y, Suda K, Yamagata M, Ueta T, Kato F. Abnormal findings on magnetic resonance images of the cervical spines in 1211 asymptomatic subjects. Spine (Phila Pa 1976). 2015 Mar 15;40(6):392-8
3. Sajid IM, Parkunan A, Frost K. Unintended consequences: quantifying the benefits, iatrogenic harms and downstream cascade costs of musculoskeletal MRI in UK primary care BMJ Open Quality 2021;10:e001287.



BestMSK Spinal MRI: Patient Advice



Some important things you need to know about what an MRI scan can tell us and when it is appropriate

- MRIs provide a picture of the anatomy of the spine.
- MRIs cannot tell how someone feels and are not a diagnosis.
- MRIs can be used to plan treatment with you and rule out serious conditions such as cancer or fractures.
- MRIs are rarely needed for people with back or neck pain.
- MRIs should be requested after assessment by a specialist.

Some important things you need to know about your MRI scan report

- Some of the medical words used in MRI reports can be complex and may sound scary.
- For example, eight out of ten people aged 50 or over with NO pain have something called 'degeneration of discs' noted in their MRI report'. However, findings such as this are more common as we become older and can be signs of a naturally maturing spine.



If you have any questions about having an MRI scan or need clarification on the report of an MRI scan, please discuss these with the clinician who sent you for the MRI.

References:

1. W. Brinjikji, P.H. Luetmer, B. Comstock, B.W. Bresnahan, L.E. Chen, R.A. Deyo, S. Halabi, J.A. Turner, A.L. Avins, K. James, J.T. Wald, D.F. Kallmes and J.G. Jarvik. Systematic Literature Review of Imaging Features of Spinal Degeneration in Asymptomatic Populations. AJNR Apr 2015, 36 (4) 811-816.