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REVIEWER'S COMMENT

ESJ: expert comment on number and cost of claims linked to minor cervical trauma (manuscript number: ESJO-D-07-00195R1, B. Soltermann et al.)

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In spite of the numerous prevention measures developed by the automobile industry, minor cervical trauma are increasingly frequent and are the cause of difficult therapeutic and medico-legal problems. For these reasons, the epidemiological paper based on data coming from the Comité Européen des Assurances (CEA) which compares incidence and expenditure of minor cervical spine trauma in ten European countries is particularly useful, as it emphasizes the major role of the cultural attitudes and of the medical approach in the natural evolution of this very unique traumatism.

The definition adopted by the authors is quite similar to the one proposed in 1995 by the Quebec Task Force [7]. The Quebec report carefully distinguished the whiplash mechanism from the resulting injury, which in turn leads to a variety of clinical manifestations, the so-called "whiplash-associated disorders". The cervical trauma described by the CEA paper mirrors grades I and II of the Quebec Classification. I see no good reason to change the terminology which is now universally accepted and used in clinical research.

There is a consensus on the reality of the whiplash injury and on the secondary subjective complaints. The real problem concerns the evolution of the syndrome. Although the majority of whiplash-injured individuals becomes rapidly asymptomatic, a group of patients (20–40%) does not recover completely, a small proportion (2–5%) being unable to resume work and usual activities [2]. The number of subjects with persistent pain and disability varies considerably among countries. This regional discrepancy is reflected in the wide variation of the number of claims and in the ensuing expenditures. These variations are clearly documented by the data generated by the CEA report.

One can question the cause of this discrepancy. In recent years a bio-psycho-social model of chronic late-whiplash has emerged [5], explaining this phenomenon. The potential initial source of the symptom-pool secondary to the acute injury is conceptually similar across countries. In whiplash 1 and 2, the severity of the soft tissue lesions cannot be correctly evaluated by imaging. The diagnosis relies entirely on the symptoms described by the patient and on the circumstances of the accident. The soft tissue lesions (sprains and strains) are considered to be the physical basis of the syndrome, although facet-joint studies and results of facet neurotomy indicate that the zygapophyseal joints can be the source of the pain in a subset of patients [1]. Soft tissue lesions in other parts of the body usually resolve in a few weeks or months, which is the case in the majority of whiplash grades 1 and 2. Interestingly, this favorable evolution is regularly observed in countries such as, for example, Lithuania where there is little awareness that this kind of injury can lead to chronicity. On the other hand, in other countries, including North America, there is widespread information available to the public concerning late whiplash and the possible high rates of compensation. The importance of the cultural setting is further highlighted in the CEA report by the great differences observed in the number of claims and costs between the German-speaking and the French or Italian-speaking parts of Switzerland. The higher number of claims in the German-speaking region seems to be related to the lobbying action of pro-active associations.

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The influence of the insurance system has been demonstrated in several good studies. The tort-litigation system is associated with a high number of claims and chronicity of symptoms. In the adversarial system, the not-at-fault driver, resentful of someone else's fault, is encouraged to put in a claim and to consult physicians, therapists and lawyers in order to demonstrate his bodily injury, thereby justifying compensation. For example in Cassidy's study [3], the change from the tort-litigation system to the no-fault system (no pretium doloris and no need to show damage) diminished the number of claims as well as the time for recovery.

Another area addressed by the CEA relates to the medical aspects. It is now accepted that if the patient is diagnosed with only soft tissue injury in the neck (grades 1 and 2), activation, early mobilization, and return to work and normal activities are strongly recommended [6]. A recent paper [4] has confirmed that early medicalisation, including intensive health care after whiplash, is associated with delayed recovery. In its recommendations, the CEA calls for an appropriate education of the healthcare professionals, whether GPs or medical specialists, who are the first contact with the patient and are in charge of his medical management and education. Moreover and very wisely, the CEA recommends that the role of the medical professionals be clarified: one acting as a medical manager, the other taking care of the assessment of the bodily injury. The need to provide a specialized training for these experts is also stressed. The very low number of claims linked to whiplash in France compared to other countries is probably due to the fact that the distinction between the medical manager and the assessor-expert already exists. Moreover, compensation for the partial permanent disability (IPP: Incapacité Permanente Partielle) is always set at a rather low level in the case of benign traumatisms of the cervical spine. In addition, there is little awareness in the French population that these benign traumatisms can generate sequelae.

References

1. Barnsley L, Lord SM, Wallis BJ, Bogduk N (1995) The prevalence of chronic cervical zygapophyseal joint pain after whiplash. Spine 20:20–25
2. Benoist M (2000) Whiplash injury of the cervical spine. Presse Med 29:196–202
3. Cassidy JD, Caroll LJ, Côté P et al (2000) Effect of eliminating compensation for pain and suffering on the outcome of insurance claims for whiplash. N Engl J Med 342:1179–1186
4. Côté P, Hoog-Johnson S, Cassidy JD et al (2007) Early aggressive care and delayed recovery from whiplash: isolated finding or reproductible result? Arth Rheum 57:861–868
5. Ferrari R, Schrader H (2001) The late whiplash syndrome: a biopsychosocial approach. J Neurol Neurosurg Psychiatry 70:722–726
6. Nordin M (1998) Education and return to work. In: Gunzburg R, Szpalski M (eds) Whiplash injuries. Lippincott Raven, Philadelphia, pp 283–290
7. Spitzer WO, Skovron ML, Salmi LR et al (1995) Scientific monograph of the Quebec task force on whiplash-associated disorders: redefining whiplash and its management. Spine 20(8):10–73