

patient towards a bio-psycho-social vision that considers all aspects related to the health of the individual in order to achieve therapeutic interventions that go to improve quality of life of the person. This system has been identified in the ICF (International Classification of Functioning Disability and Health), around which you can build the evaluation/diagnostic process, pharmaceutical, rehabilitation and subsequent outcomes.

### Red Flags

In line with the 2011 SIMFER diagnostic and therapeutic recommendations for back pain, in order to exclude a serious cervical disease, specific research is necessary to evaluate alarm signals (red flags), in reference to the criteria for specialized medical responsibility for good clinical forensic medical responsibility for good clinical practice.

The red lights are the following: (tab)

- Age less than <20 years or >50 years
- Signs of systemic disease
- Incessant pain at rest
- Altered state of consciousness
- Language disorders
- Symptoms or signs of alteration of the central nervous system
- Ligament weakness
- Sudden onset of acute neck pain or headache with unusual characteristics
- Suspected carotid dissection
- Suspected neoplasia
- Suspected discitis, osteomyelitis and tuberculosis
- Surgical outcomes
- Structural deformities with progressive pain

### Diagnostic Imaging

Studies of diagnostic imaging should be targeted to the confirmation of a clinical suspicion and not used routinely. The execution of the radiograph

Then we begin palpating bones in a supine position, so that the deeper muscles are released and the bony prominences more attainable. In the first we can palpate the hyoid bone, thyroid cartilage, the first cricoid ring and the carotid vertebrae. In the rear the occiput, theinion, the superior nuchal line, the mastoid process, the spinous processes of the cervical and, moving sideways to 3 cm, the facet joints. Palpation of the soft tissues also identifies two zones: front and rear. In the first we will find the sternocleidomastoid muscle, the lymphatic chain, thyroid, parathyroid, the carotid pulse and supraclavicular fossa. In the second: the trapezius muscles, occipital nerves and the superior nuchal ligament.

Then you can evaluate the articulation. The range of motion of the cervical spine allows six degrees of freedom: flexion, extension, left and right rotation and tilt. This range of motion allows the head and neck large movements. About 50% of the flexion and extension occurs between occiput and C1, the remaining 50% is distributed evenly among the other vertebrae; mind 50% of the rotations occur between C1 and C2, the other 50% involves the breaking 5 cervical vertebrae. You will first consider active motility and then passive motility. For the cervical spine more than for any other district, the neurological examination takes a very important role for the presence of the brachial plexus. It consists of two phases: the evaluation of muscle strength of the intrinsic muscles of the cervical spine and peripheral neu- rological examination of the upper limbs (muscle strength, sensitivity and tendon reflexes). Clinical evaluation can be completed with the execution of some provocative tests such as: Spurling's Neck Compression Test, Shoulder Abduction (Relief) Test, Neck Distraction Test, Lhermitte's Sign, Hoffmann's Sign and Adson's Test and Valsalva Maneuver.

A very important step to monitor the effectiveness of treatment and the course of the disease is the administration of district specific rating scales, as the Neck Pain, Cervical Radiculopathy, Neckache Scale, and so on.

In recent years, however, the World Health Organization is trying to guide the framing of the