***Acute musculoskeletal pain and acute spinal pain***

*Musculoskeletal injury* may be present in any patient who has sustained other trauma, and it is managed according to the extent of injury and other injuries. In this section, focus will be on the musculoskeletal aspect alone.

Patients presenting with *spinal pain* (neck, thoracic, lumbar or sacral) must be evaluated by taking a thorough systemic history followed by a clinical examination. Take note of the following: the type of pain (duration, location, constant, intermittent, referred, spreading), chills and fever, local tenderness, physical activity, overuse injury, other skeletal pains, age (aortic aneurism), neurological complaints (spreading or referred pain, numbness, spasticity, weakness), GI complaints (peptic ulcer, jaundice, weight loss, faecal incontinence), genitourinary system (haematuria, incontinence, difficulty to pass urine) and haematological problems (anaemia, bruising). Also examine the breasts and thyroid.

*Acute musculoskeletal pain* usually follows injury (muscle injury, ligament injury, fracture, haemarthrosis or septic arthritis), overuse, gout and exacerbations of inflammatory arthropathies, such as rheumatoid arthritis and osteoarthritis. However, less common but very important causes must be kept in mind, including malignancy and haematological disorders.

The same approach is followed as with spinal pain. Usually, the diagnosis is obvious from the age of the patient and their history. Important information suggested in the history should not be overlooked. For example, an elderly person presenting with acute hip pain after a fall may have a fractured hip, but why did they fall? *Dizziness and falls* could be caused by, among others, autonomic neuropathy, diabetes mellitus, cardiac disease, carotid disease, epilepsy and drugs such as antihypertensive agents and analgesics (tramadol and meprobamate-containing preparations). Remember, shoulder pain may be referred cardiac pain.

***Sports injuries***

These are usually associated with musculoskeletal injury and pain and include skeletal injury (stress fractures, fractures, sprains, strains, joint dislocations, muscle haematomas, muscle rupture, etc.). These injuries may heal completely leaving no pain; others may be complicated by long-term morbidity, including dysfunction and chronic pain. Yet, the pain associated with sports injury is not always of a musculoskeletal nature. The *apparent good health* of persons presenting with sports-related pain may be misleading. Moreover, sports-related pain may not be of (the expected) musculoskeletal origin or even sports-related. Pain may also be out of proportion to the injury.

Patients may present with *headache*. Primary headaches (migraine, tension headache and cluster headache [CH]) occur commonly, but secondary headaches should always be suspected in a patient partaking in contact sports. These are trauma-related, vascular or nonvascular