



Facet joint pain sits in an awkward middle ground. It is common, often quite treatable, and still easy to misunderstand. Patients are frequently told they have "arthritis in the spine" or "wear and tear," which may be true in a broad sense but does not always explain why pain flares when standing, twisting, looking up, or rolling over in bed. In practice, the real challenge is not just naming the condition. It is matching the right patient to the right treatment at the right point in the process.

A good Pain Management Clinic can make that difference. Not because every person with back or neck pain needs procedures, and not because injections are a cure-all, but because facet-mediated pain requires careful examination, sensible use of imaging, and a stepwise plan. When that plan is done well, many people avoid months of trial and error.

Facet joints are the small paired joints at the back of the spine. They guide motion and help stabilize each spinal segment. Like other joints, they can become inflamed, arthritic, irritated after injury, or overloaded when surrounding muscles and discs are not doing their share of the work. The result can be pain in the neck, mid-back, or low back, sometimes with referral into **interventional pain clinic** the shoulder, buttock, or thigh. Unlike true nerve root pain, it usually does not follow a clean line all the way down an arm or leg. That distinction matters because the treatment path is different.

What facet joint pain typically feels like

Patients often describe facet pain in ordinary, practical terms rather than textbook language. Low back facet pain tends to worsen with standing still, arching backward, or getting out of a car after a long drive. Neck facet pain often flares with looking over the shoulder, working at a computer for hours, or sleeping in one position too long. Morning stiffness is common. So is the complaint that walking can feel better than standing.

One pattern shows up repeatedly in clinic. A patient says their MRI mentions a disc bulge, but the symptom pattern does not fit classic sciatica or a pinched cervical nerve. The pain stays closer to the spine, sometimes spreads into the upper buttock or shoulder blade region, and is strongly linked to extension and rotation. That is when the facet joints move higher on the list of suspects.

This does not mean imaging alone can diagnose the problem. Many adults have arthritic facet joints on scans and no pain from them. The opposite also happens. A scan may show only modest degenerative change, while the joints are still clinically important. That is why a strong history and examination remain the foundation.

Why diagnosis is more nuanced than most people expect

Facet joint pain is rarely confirmed by one dramatic MRI finding. Instead, clinicians piece it together from symptom behavior, tenderness patterns, pain provocation with certain movements, and response to targeted diagnostic procedures.

In a well-run Pain Management Clinic, the workup usually starts with three questions. First, does the pain pattern fit facet-mediated pain better than disc pain, nerve compression, sacroiliac joint pain, myofascial pain, or hip pathology? Second, have conservative measures had a fair trial? Third, if a procedure is being considered, which one will provide the most useful information and the best chance of relief?

This is where experience matters. Not every back pain flare should be steered toward injections. On the other hand, waiting endlessly while a patient cycles through generic physical therapy, oral medications, and frustration helps no one if the pain generator is fairly clear.

The conservative treatments that still matter

Procedures get the attention, but the basics still carry weight. Facet joints are sensitive to mechanics. If a patient has weak trunk stabilizers, stiff hips, poor thoracic mobility, or habits that keep the lumbar spine in repetitive extension, those factors can keep pain active even after a technically perfect injection.

Physical therapy is often useful when it is specific. Broad advice to "strengthen your core" is less helpful than a plan that addresses spinal loading patterns, gluteal strength, hip motion, pacing, and posture under real-life conditions. A golfer, nurse, delivery driver, and office worker may all have low back facet pain, but the way the pain is fed by daily movement can be very different.

Medication has a role, though usually a supporting one. Acetaminophen may help some people. Nonsteroidal anti-inflammatory drugs can reduce inflammatory pain if a patient can tolerate them safely. Muscle relaxants sometimes help during acute spasm, but their benefit tends to be short-lived and sedation is a real limitation. Topical agents are occasionally useful, particularly in older adults who should avoid more systemic medication burden. Opioids are generally not ideal for chronic facet pain and often create more problems than they solve over time.

Simple activity modification also matters more than patients expect. Someone with lumbar facet pain may need a temporary break from repeated extension drills, prolonged standing on hard surfaces, or aggressive back-bending yoga. That is not the same as telling them to stop moving. Usually, the aim is to keep them active while reducing the motions that are repeatedly irritating the joint.

When a Pain Management Clinic becomes especially helpful

There are a few scenarios where referral is particularly worthwhile. Persistent spinal pain despite a solid trial of conservative care is one. Pain that seems mechanical and focal but is not explained well by prior imaging is another. A third is when surgery has been proposed or dismissed, yet the source of pain still feels uncertain.

The strength of a Pain Management Clinic is not merely access to needles and fluoroscopy. It is the ability to sort spinal pain by generator. Disc-related pain, radicular pain, sacroiliac pain, vertebrogenic pain, and facet pain can

overlap. The treatment options are not interchangeable. Patients often arrive after hearing several opinions that are technically plausible but not well integrated. The clinic visit should narrow the field, not widen it.

A practical example helps. A patient in her late fifties may come in with low back pain after gardening, worse with standing and extension, better when sitting, with no weakness, numbness, or true leg pain below the knee. An MRI shows mild disc degeneration, some facet arthropathy, and no major stenosis. In that setting, facet pain climbs toward the top of the list. The next step is not automatically surgery, and it should not be a random epidural if there is no convincing nerve root syndrome. That is where targeted diagnostic thinking earns its keep.

Facet joint injections, what they do and what they do not do

Facet joint injections place medication directly into the joint, usually a local anesthetic combined with a steroid. These can be helpful, but they are not always the best first procedural option. Their value is often greatest when there is suspected inflammatory irritation within the joint itself, especially in cases of more acute flare, localized tenderness, or imaging that shows active arthropathy in a plausible location.

The public often imagines any spine injection as a dramatic fix. Real outcomes are more modest and more variable. Some patients get weeks or months of relief. Some get only a short window. Some learn something diagnostic from the response, even if the treatment effect does not last. That information can guide the next step.

There are trade-offs. Intra-articular facet injections can be technically harder in certain spinal levels or in joints with advanced degeneration. The medication may not stay where intended if the joint anatomy is severely altered. Relief can be meaningful but temporary. For some patients, especially those with chronic recurring pain, the more informative target is not the joint space itself but the medial branch nerves that carry pain from the facet joints.

Medial branch blocks, the diagnostic workhorse

Medial branch blocks are small anesthetic injections placed around the nerves that supply sensation to the facet joints. They are commonly used as a diagnostic tool to determine whether the facet joints are truly generating the pain. This matters because radiofrequency ablation, one of the most effective longer-lasting procedural options for facet pain, is directed at those same nerves.

A common misunderstanding is that a medial branch block is meant to be a lasting treatment. Sometimes patients do feel prolonged relief, but that is not the main point. The goal is to see whether numbing the correct nerves significantly reduces the typical pain for the expected duration of the anesthetic.

Interpretation takes judgment. If a patient reports 80 percent relief for several hours and can suddenly stand straighter, turn more easily, or tolerate an activity that usually triggers pain, that is a meaningful signal. If relief is vague, delayed, or mixed with heavy sedation from other medications, the picture gets muddy. This is why careful instructions and good follow-up after the block are essential.

Different clinics use slightly different protocols. Some use one diagnostic block, others prefer confirmatory blocks before moving to ablation. Insurance rules also influence this process. Patients are often surprised by how much paperwork and documentation surround what seems like a simple injection. It is not glamorous, but it affects access to care.

Radiofrequency ablation, often the most durable non-surgical option

For chronic facet-mediated pain that responds clearly to medial branch blocks, radiofrequency ablation can be an excellent option. The procedure uses heat generated by radiofrequency energy to disrupt the small sensory nerves that transmit pain from the facet joints. It does not "burn the joint out," and it does not fuse anything. The goal is simply to interrupt the pain signal.

When it works, it can work well. Relief often lasts several months and sometimes longer, commonly in the range of six to twelve months, though there is real variation. The nerves can regenerate, which means pain may return. If the first response was good and the pain pattern recurs in the same way, repeat ablation is often reasonable.

This option tends to suit a specific patient profile. The pain is mechanical, localized, and chronic. Conservative care has not been enough. Diagnostic blocks were convincingly positive. There is no dominant nerve compression syndrome that would be better treated another way. In that setting, radiofrequency ablation is one of the most practical tools a Pain Management Clinic offers.

The trade-offs deserve an honest discussion. Relief is not immediate. Some people feel sore for days or even a couple of weeks after the procedure. A temporary increase in pain is possible. The result is not permanent. In rare cases, patients report numbness, neuritis-type irritation, or odd sensitivity around the treated region. Most side effects are manageable, but they should be part of the conversation before anyone signs consent.

Cases where surgery is not the answer, and cases where it might be

Facet joint pain by itself usually does not push a patient directly toward surgery. Most surgeons are appropriately cautious about offering an operation for isolated axial neck or back pain unless there is a clear structural reason and a high likelihood of benefit. That is partly why non-surgical spine specialists play such an important role here.

Still, there are edge cases. Severe facet degeneration can contribute to spinal stenosis, instability, or deformity. A patient may have facet pain as one component of a larger surgical problem, especially if there is slippage of one vertebra over another, major narrowing around nerves, or progressive neurologic symptoms. In those situations, injections and ablation may help clarify pain generators or provide temporary relief, but they are not the whole answer.

Clinical judgment is vital. A patient with severe leg weakness, bowel or bladder dysfunction, worsening balance from cervical cord compression, or rapidly progressive neurologic change needs urgent surgical or emergency evaluation, not a routine facet injection. A competent clinic recognizes these red flags immediately and redirects care.

The role of imaging, and its limits

X-rays can show alignment, degeneration, or instability with flexion and extension views. MRI is helpful for looking at discs, nerves, marrow changes, and soft tissues. CT can show bony facet arthropathy in sharp detail. Yet none of these studies alone can prove that a specific facet joint is the pain source.

I often think of imaging as context rather than verdict. If the physical exam and story point strongly toward lower lumbar facet pain, and the scan shows facet hypertrophy and arthropathy at the matching levels, confidence rises. If the scan is dramatic but the history does not fit, caution is wise. Treating pictures instead of patients is one of the faster ways to get poor results.

This is particularly relevant in older adults. It is normal to see degenerative change with age. The question is not whether the spine has miles on it. The question is which structure is actually driving symptoms today.

How clinic quality affects outcomes

Not all procedure-based practices are alike. The best clinics spend time on selection, explanation, and follow-through. They do not promise miracle cures, and they do not push every patient toward the same intervention. They also know when not to proceed.

A strong Pain Management Clinic usually shows its quality in small operational details. The physician reviews the history carefully rather than relying only on intake forms. The exam tests movement patterns and provocative maneuvers instead of stopping at a reflex check. Imaging is correlated rather than merely read aloud. The plan includes what happens if the first step fails. Expectations are stated plainly.

Patients should also pay attention to whether the clinic explains why one procedure is being chosen over another. An epidural steroid injection, a sacroiliac injection, a medial branch block, and a facet joint injection are not interchangeable products. If the rationale is vague, confidence should drop.

Questions worth asking at the first visit

Patients do better when they know what they are agreeing to and what result would count as success. A few questions can quickly reveal whether the evaluation is thoughtful.

- What features of my symptoms make you think the facet joints are involved?
- Are you recommending this procedure for diagnosis, treatment, or both?
- If I get relief, how long would you reasonably expect it to last?
- If this does not help, what is the next most likely pain source?
- What should I do with activity and physical therapy after the procedure?

Those questions are not confrontational. They are practical. They help align expectations and force the care plan to become more precise.

What recovery and follow-up usually look like

After a diagnostic block, the most useful thing a patient can do is track the response honestly and in real time. Not in vague terms days later, but during the hours when the anesthetic should be active. Can you stand longer, turn farther, get in and out of a chair more easily, or complete a motion that typically reproduces pain? That functional feedback is often more informative than a single pain score.

After a steroid-based facet injection, improvement may not be immediate. The numbing medicine can wear off before the steroid has any effect, which means there may be a brief gap where pain returns. That can unsettle patients if nobody warned them. By the same token, immediate complete relief after a mixed injection does not prove the steroid solved the problem. Often it is simply the local anesthetic at work.

After radiofrequency ablation, most clinicians encourage a gradual return to activity while using the period of reduced pain to rebuild tolerance and strength. This is one of the most missed opportunities in spine care. If the procedure creates a window of lower pain and the patient uses it only to resume old aggravating habits without improving mechanics, the long-term benefit can shrink. Pairing procedural relief with smart rehabilitation generally gives the best odds of durable progress.

Patients who need a more tailored approach

Certain groups deserve special mention because the standard algorithm may need adjustment. Older adults with multiple pain sources can be difficult to sort out. Someone may have facet pain, spinal stenosis, and hip osteoarthritis at the same time. Procedural sequencing becomes important because a partial response may still be useful if it clarifies which structure is responsible for which symptom.

Patients on blood thinners require careful planning around injections and ablation. The decision depends on the medication, the procedure, and the patient's clotting risk. This should be coordinated, not improvised.

People with prior spine surgery can also present a challenge. Scar tissue, altered anatomy, hardware, and adjacent segment stress change the picture. Facet pain above or below a fused level is not rare. It can still be treated, but precision matters more and expectations may need to be adjusted.

Then there is the hypermobile or younger patient with recurrent extension-based pain but minimal imaging findings. These patients are sometimes dismissed because the scans look relatively benign. Yet if the symptoms are consistent and the exam fits, facet-mediated pain or posterior element overload may still be very real. Here, movement retraining and stabilization work often need equal billing with any injection strategy.

The larger point patients should keep in mind

Facet joint pain is not glamorous, but it is one of the more manageable causes of spinal pain when identified accurately. The best outcomes tend to come from a sequence, not a single event: careful assessment, targeted diagnostics, appropriate procedures when indicated, and rehabilitation that makes use of the pain relief achieved.

Patients often arrive hoping for certainty before treatment begins. Spine care rarely offers that kind of certainty. What it can offer is a rational process. A competent Pain Management Clinic narrows the diagnosis, tests hypotheses in a focused way, and avoids treating every spinal complaint with the same recipe. For facet joint pain, that disciplined approach is often what separates temporary frustration from meaningful relief.

Denver Pain Management Clinic

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FAQ About Pain Management Clinic

Do pain management clinics give pain meds?

Medication may be one part of a personalized care plan. A clinician reviews the condition, medical history, possible benefits, and risks before recommending treatment. A consultation does not guarantee a particular prescription.

Do I need a referral to go to the pain clinic in Denver?

Referral and record requirements can vary. Contact Denver Pain Management Clinic before scheduling to confirm which documents are needed and how appointments and payment are arranged.

What should I discuss with a pain management doctor?

Describe your symptoms honestly, including their location, duration, and effects on daily activities. Discuss previous treatments, current medicines, and your goals, and ask questions about the proposed plan.