Cauda equina syndrome

IS THE CURRENT MANAGEMENT OF PATIENTS PRESENTING TO DISTRICT GENERAL HOSPITALS FIT FOR PURPOSE? A PERSONAL VIEW BASED ON A REVIEW OF THE LITERATURE AND A MEDICOLEGAL EXPERIENCE.

NV TODD.

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Author's reply:

RE: cauda equina syndrome. eLetter of Xu P and Shi J

Nicholas Todd, Neurosurgeon, Newcastle Nuffield Hospital

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Sir

I thank Messrs Zu and Shi for their interest. I agree that a central PLID is uncommon and CES even less common. A large central PLID does not imply CES which is a clinical diagnosis. What I believe the science tells us is that the clinical diagnosis of CES has low sensitivity and specificity unless and until the symptoms and signs are obvious and often irreversible. If a clinician identifies symptoms or signs that cause them to question CES, MRI should be performed because this is the only way of triaging the patient. If the MRI shows no compression of the CE roots, all is well. If there is marked compression, the patient can be offered surgery before severe, irreversible deficits develop. In some patients neurological deterioration can be rapid which is my justification for advising MRI urgently within one hour. I agree that human studies to date have a poor evidence base and times to treatment are ambiguous. I can see no way of improving outcomes in the CES patient other than urgent MRI in those patients who, clinically, are suspected of having CES with rapid surgery for those who have a positive MRI.

Yours faithfully

CONFLICT OF INTEREST None declared