eLetter

Spine:

N. V. Todd

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

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(Author’s reply):

Cauda equina syndrome (letters)

12 November 2015

Sir,

The letters of Mr Ajwani and Mr Summers raise concerns in relation to resource and medicolegal practice, concerns that I understand.

The resource argument essentially says that DGHs do not have MR imaging available 24/7 and 7/7 and it would be expensive to provide that degree of cover. The DGH MRI typically sits next to the DGH CT scanner which is working 24 hours per day; the MRI is never switched off and could be used. The radiographer providing 24 hour CT cover is often MR-trained and if not, could be. Fourteen percent of DGHs provide MR imaging 24/7 and 7/7; perhaps all DGHs should achieve that standard of care. Employing MR radiographers out-of-hours would increase radiography costs but those costs would be offset by reducing ambulance transfers to regional centres for what often turn out to be negative MRIs. Mr Summers is right to say that the majority of "? CES" MRIs are negative but the problem is we cannot reliably make a diagnosis on clinical grounds unless and until the patient develops a severe and often irreversible lesion; MR is part of triage of the "? CES" patient. The rates of positive MRI lie somewhere between 14% and 33%(3). This is not dissimilar to the rates of surgically treatable lesions detected by the CT imaging of head trauma.

The standard of care is set by the Court, not by individual doctors. The primary test is the Bolam test, the reasonable and responsible doctor test. Provided DGH orthopaedic surgeons act in accordance with current reasonable practice there would be no breach of duty of care and clearly it is not current standard practice to perform MR imaging within one hour of a clinical diagnosis of possible CES. However there is the supplementary Bolitho test, a test of logic which means that decision-making should have a logical, rational, basis. This is where I foresee difficulties with current practice. I believe that the following statements are correct and they might well be used to support an argument for rapid MR imaging. Neurological deficits in CES occur in a progressive and continuous manner (1,2). Outcomes are less good if patients deteriorate to CESR or if they have prolonged CESI (3). In hours, the MR imager is used for many routine MRIs, MRIs of the shoulder, knee and perhaps most pointedly MRIs of the low back in patients with chronic low back pain. I do not think that it would be easy to say that the "? CES" patient should be delayed whilst the patient with chronic low back pain is scanned. Out-of-hours there are options: the first is to push for MR imaging 24/7 and 7/7 at the DGH which to my mind is the logical, eventual, solution. Secondly there could be transfer to the regional spinal service (neurosurgical or orthopaedic) where MR imaging is always available. The third would be a direct transfer from the DGH emergency department (ED) to the major trauma centre ED for emergency scanning there. There seems to be no very good reason why the "? CES" patient should have delayed imaging. There is potentially also a lack of

logic in not prioritising the patient with a probable central disc prolapse when, in other pathologies, with similar new or deteriorating neurological deficits emergency MRI would be requested; I think of spinal epidural abscess, possible spinal epidural haematoma on the labour ward or new deficits occurring after spinal surgery where almost all patients would have an emergency MRI. Should the "? CES" patient be any different? Mr Ajwani asks about the responsibility of the DGH orthopaedic surgeon when the subsequent actions, arranging MRI and/or accepting the patient for treatment at a spinal centre are outside the scope of the local orthopaedic surgeon. Provided the DGH orthopaedic surgeon has made an effort to obtain urgent/emergency imaging and/or referral to a spinal centre then there would be no breach of duty of care upon the part of the orthopaedic surgeon even if delays occurred. I would strongly advise the local orthopaedic surgeon to write in the notes exactly when MR imaging and/or transfer was requested and, if turned down, the reasons for that.

A one-hour target for MRI is clearly aspirational and it could not be achieved in all DGHs tomorrow. Nevertheless it is my firm belief that this should be the direction of travel.

Yours sincerely

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Conflict of Interest:

None declared