

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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LETTER

RE: “Cauda equina syndrome”

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Sir

I read this article with great interest.

I have some concerns. The author states that, “The only reliable way of including or excluding CES is to perform MRI on all patients with suspected CES.” It is not possible, however, to confirm that a large central disc prolapse which compresses the roots of the cauda equina would be diagnosed as CES. Therefore, the value of MRI is still controversial: there is certainly no need for it “within one hour”. The author also states, “If the diagnosis is being considered, MRI should ideally be performed.”

CES occurs in only about 0.07%–0.12% of PLIDs: it is difficult to predict which patients will develop CES during the early phase.

The author believes that “damage to the cauda equina nerve roots occurs in a continuous and progressive fashion which implies that there are no safe time or deficit thresholds.” Although the implication is true, the nerve roots of the cauda equina have

considerable tolerance to compression: the risk factors for deterioration in CES (e.g., lumbar sprain/trauma, long-term standing/sitting) are crucial. Furthermore, as the author states, many studies on treatment time are inconsistent and the symptoms of early CES are ambiguous. Therefore, classification by time to surgical treatment (12, 24, 48 or 72 hour) is meaningless, and may not reflect the degree of neurological deficit.

Common causes of CES include lumbar disc prolapse and intra-operative or postoperative injury. In our experience, mistakenly removing one cauda equina nerve root does not always result in CES. Also, some patients with CES show only slight evidence of intervertebral disc herniation, lumbar spinal canal stenosis, but with tethering of the dural sac and nerve root. Shortening the spine intraoperatively could alleviate the symptoms of CES.

CONFLICT OF INTEREST

None declared.

1. Shi, J., et al., *Clinical classification of cauda equina syndrome for proper treatment*. Acta Orthop, 2010. **81**(3): p. 391-5.