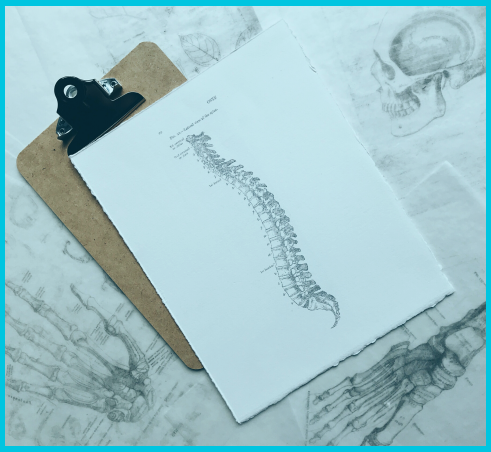
Spinal Masqueraders

AT A GLANCE



A QUICK REFERENCE GUIDE TO:

Cauda Equina Syndrome
Metastatic Spinal Cord Compression
Spinal Fracture
Spinal Infection
And More...

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Contents

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How To Use

Disclaimer

This At A Glance Booklet aims to help faciliate early detection

It is not a replacement for clinical reasoning

Follow local pathways at all times and discuss with a senior colleague if unsure on how to proceed

Always Consider

Symptom Chronology

How long have these symptoms been present?

Symptom Stability

Same/better/worsening?

Symptom Frequency

Constant/intermittent?

Contextualise Symptoms

Is a more likely explanation possible?

Thank You for choosing this At A Glance reference guide for Spinal Masqueraders

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CES AT A GLANCE

Cauda Equina Syndrome

Presenting Features

Unilateral or Bilateral Radicular Pain – especially if progresses from unilateral to bilateral

+/- sensation loss

+/- loss of reflex

+/- myotomal weakness

Altered saddle sensation – light touch, pinprick

Bladder disturbance – frequency, retention

Bowel disturbance – usually incontinence, constipation possible

Reduced anal tone

Sexual dysfunction – inability to orgasm/achieve erection, loss of sensation during sex

Comorbid/PMH

PID

Stenosis

Spinal surgery

Demographics

<50 Years Old

Investigations

MRI <24h via ED or local pathway

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Spinal Infections AT A GLANCE

Presenting Features

Spinal pain

Spinal tenderness – palpation, percussion

Neurological symptoms, cord signs i.e. radiculopathy, myelopathy

Malaise

Pyrexia

Comorbid/PMH

Recent infection e.g. UTI

Diabetes

HIV

IVDU

Spinal Surgery

Tuberculosis

Demographics

Social factors i.e. migrants, homeless, prisoners

Environmental factors i.e. overcrowding

Recent Travel

Investigations

MRI

ESR > CRP

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MSCC AT A GLANCE

Metastatic Spinal Cord Compression

Presenting Features

Worsening pain that may become constant, typically worse at night

Pain often described as severe

70% spinal metastases occur in the thoracic spine

Spinal tenderness – palpation, percussion

Neurological symptoms, cord signs

Unexpected weight loss

Comorbid/PMH

PMH of Cancer

Breast, Prostate, Lung, Kidney, Thyroid

25% have no known primary at diagnosis

consider risk factors e.g. smoking

Investigations

Ordered via MSCC Co-ordinator:

Whole Spine MRI (+/- pelvis) within 1-week

(if spinal pain, no neurology)

Whole Spine MRI (+/- pelvis) within 24-hours

(if spinal pain and neurology)

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MS AT A GLANCE

Multiple Scerosis

Presenting Features

Variable as can affect any part of the CNS

Symmetrical or asymmetrical sensorimotor symptoms

May have had previous episode(s)

Fatigue
Visual disturbance
Impaired co-ordination
Ataxia
Difficulty speaking/swallowing

Hyperreflexia
Babinski/Clonus
Heel/shin; Finger/Nose
Tandem Walking

Comorbid/PMH

Optic Neuritis
Transverse Myelitis

Demographics

Female
<50
Family History

Investigations

MRI Whole Spine (to rule out spinal cause)
FBC, LFT, U&Es, TFT, CRP, ESR, Vitamin B12, Hba1c

Referral

Neurology

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Spinal AT A GLANCE

Fractures

Presenting Features

Trauma - major vs. minor
Thoracic pain – new, may worsen
Spinal tenderness – palpation, percussion
Increased kyphosis +/- loss of height
Contusion/abrasion
Fracture sequalae – neurological symptoms, cord signs

Comorbid/PMH

Osteoporosis
Corticosteroid use
PMH of Cancer (see MSCC)
Previous spinal fracture
History of Falls (+/- associated injury)

Demographics

Female (65 years+)
Early hysterectomy
Post-menopause
Males (70 years +)

Investigations

X-ray – first choice
MRI – multiple fractures, rule out pathological fracture, acute vs. chronic

Family History

Osteoporosis
Maternal hip fracture

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Multiple Myeloma AT A GLANCE

Presenting Features

Variable as can affect multiple systems
Unexplained bone/back pain >4-weeks
Symptoms not improving
Symptoms not relieved by rest or simple analgesia
Ominous night pain
Fatigue
Thirst
Abdominal pain

Comorbid/PMH

Overweight
Recurrent Infections

Demographics

60+ years
Family History
Male
Afro-Caribbean

Investigations

FBC, Serum Calcium, U&Es, ESR, Serum Electrophoresis
Bence Jones Protein (urine)
Plain x-ray of affected site (Peripheral symptoms)
Whole Spine MRI (Spinal symptoms)

Referral

Liase with GP to organise Haematology 2 week wait

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AAA AT A GLANCE

Abdominal Aortic Aneurism

Presenting Features

Can be asymptomatic

Low back pain, sudden, can be severe

Abdominal/Flank pain

Syncope

Concomitant peripheral aneurysm i.e. femoral/popliteal

Comorbid/PMH

Smoker

COPD

Hypertension

Ischaemic Heart Disease

Peripheral Arterial Disease

Demographics

Family History of AAA

Male > Female

60+ Years

Investigations

Ultrasound

Referral

Refer to vascular service

Consider whether emergency/urgent referral required dependent on speed and severity of onset i.e. potential ruptured aorta

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PVD AT A GLANCE

Peripheral Vascular Disease

Presenting Features

Activity limiting pain/ache in the legs

Bilateral: consider aorta (see AAA)

Calf pain: consider femoral or popliteal artery

Buttock: consider iliac artery

Minimal symptoms (if any at rest)

Palpable pulse abnormality

Cool skin to touch

ABPI <0.9 or >1.3

Demographics

>60

Smoker

Comorbid/PMH

Diabetes

Hypertension

High Cholesterol

Stenosis

Symptoms provoked by standing

Symptoms relieved by sitting/leaning forward

Symptoms located above the knees

or

Intermittent Claudication

Symptoms relieved by standing only

Symptoms located below the knees

(Nadeau et al. 2013)

Referral

Lifestyle advice and progressive, individualised exercise programme = First line

vascular if symptoms/functional limitations persist/worsen

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CAD AT A GLANCE

Cervical Artery Dysfunction

Presenting Features

Pre-Ischaemic

Atypical head/neck/jaw pain
(often acute and unilateral)
Horner's Syndrome
Cranial nerve palsies
Neck Swelling

Ischaemic

Speech disturbance
Swallowing difficulties
Visual disturbance
i.e. double vision, nystagmus
Sudden falls to the floor
+/- loss of consciousness
Dizziness
Facial numbness/paraesthesia
Nausea

Comorbid/PMH

Hypertension
Hypercholesterolemia
Hyperlipidemia
Diabetes Mellitus
FHx of MI, Angina, TIA, Stroke, PVD
BMI >30
Repeated or recent trauma
(including repeated Grade Vs)
Upper Cx Instability
Connective tissue disease
e.g. Ehlers-Danlos, Downs Syndrome

Demographics

Smokers
High-alcohol intake
Type A personality
i.e consider stress

Referral

Pre-Ischaemic – discuss with GP +/- vascular referral
Ischaemic – vascular referral via appropriate local pathway

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AxSpA AT A GLANCE

Axial Spondyloarthritis

Presenting Features

Back pain >3/12

Age of onset <45

Early morning spinal stiffness >30 mins

Better with activity, worse with rest

Night pain in the second half of the night

Good response to NSAIDs

Comorbid/PMH

Psoriasis

Iritis/uveitis

Crohns/colitis

Demographics

Age of onset <45

2:1 Male:Female

Non-Axial Features

Peripheral arthritis/synovitis 30%

Peripheral Enthesitis 40%

Dactylitis 7%

Fatigue

Family History

Inflammatory arthropathy

Imaging

MRI Spine - SpA Protocol

Bloods

HLA B27 +ve (85+%)

CRP and ESR – may be raised

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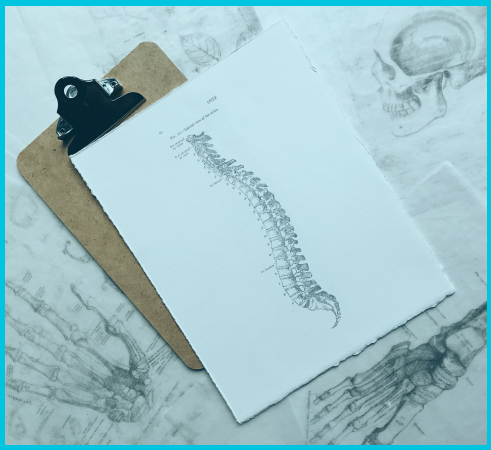
Contact

Follow @AndrewVCuff on twitter for links to resources, updates and current developments

CPD Courses

Whole or half day bespoke CPD courses are available
Please contact Andrew for further details of courses in your area or if you wish to host in your department
Andrew's website is www.spinalredflags.co.uk



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