Document Control

Title

Guidelines for the management of suspected cauda equina syndrome & decompensating spinal stenosis at NDDH

Author	**Author's job title** Consultant T&O
Directorate Planned Care	**Department** Trauma & Orthopaedics

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2.0	June 2019	Draft	Revised version, incorporating details of Spinal ReferBack referral system and National Low Back and Radicular Pain Pathway
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Main Contact Consultant T&O North Devon District Hospital Raleigh Road Barnstaple, North Devon, EX31 4JB	**Tel: Direct Dial** – **Tel: Internal** – **Email**:
Lead Director Associate Medical Director for Planned Care	
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• Lead Clinician in T&O • Lead Clinician in ED • Lead Clinician in Radiology • Lead Clinician in Medicine • Lead Clinician in General Surgery • Associate Specialist with interest in spinal surgery	Not applicable as minor amendment to pre-existing guideline **Education/ training will be provided by:** Not applicable as minor amendment to pre-existing guideline

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1. Background

1.1. Cauda Equina Syndrome (CES) is a relatively rare, but very disabling condition. Spinal stenosis is a common condition. Rarely, progressive narrowing of the spinal canal may cause compression of the spinal cord and myelopathy with clinical features similar to those seen in CES. This may be called Decompensating Spinal Stenosis (DSS)

1.2. Bilateral sciatica, perineal and perianal sensory loss, incontinence or retention of urine, incontinence or retention of faeces and disturbance of sexual function are well recognised features of CES.

1.3. There is a risk of permanent neurological damage, including incontinence, in patients with CES or DSS if appropriate treatment is delayed.

1.4. Patients with suspected CES or DSS require urgent investigation to guide immediate management.

2. Purpose

2.1. This Standard Operating Procedure has been written to expedite imaging & appropriate management for patients with suspected CES or DSS.

3. Scope

3.1. This Standard Operating Procedure relates to the following staff groups who may be involved in the assessment and management of CES or DSS:

- ED SAS doctors and consultants
- T&O SAS doctors and consultants
- Senior doctors in other inpatient specialties
- Radiologists
- MRI radiographers

4. Location

4.1. This Standard Operating Procedure is for implementation at NDDH.

5. Procedure

5.1. If a patient is suspected of having CES or DSS, a full history and clinical examination, including neurological examination must be performed and recorded on an ASIA chart. This must include documentation of sphincter function.

5.2. There should be a low threshold for performing MRI lumbar spine if CES or DSS is suspected. Emergency (same day) MRI scan should be performed in patients with:

- Acute or progressive bilateral lower limb neurological symptoms or signs, including sciatica, altered sensation or motor deficit.
- Recent deterioration in mobility on a background of established spinal stenosis.

- Perineal, genital, perianal or “saddle” anaesthesia, altered sensation or pain (if surgical cause for pain not apparent).
- New bowel or bladder dysfunction, including reduced sensation, in patients with acute back pain or sciatica.

MRI for these patients may be requested by senior doctors from ED, T&O or other inpatient specialties.

5.3. It is recognised that some patients report less severe symptoms and/or have limited clinical signs of myelopathy or cauda equina compression. In these circumstances, urgent MRI may still be appropriate but should be discussed with the on-call T&O consultant or SAS surgeon and radiologist. Isolated urinary symptoms are rarely a feature of CES, and should prompt a urological or gynaecological opinion first dependant on their nature. Unilateral neurological symptoms and signs are not an indication for emergency scanning.

5.4. If no lesion is found in the lumbar spine, consideration should be given to whole spine imaging, particularly for patients with positive neurological signs.

5.5. If emergency MRI is indicated but not available at NDDH, the patient should be discussed with the on-call spinal team at RD&E.

5.6. If critical stenosis, with compression of the spinal cord or cauda equina, is identified on MRI, the patient should be referred directly to the on-call spinal team at RD&E for consideration of urgent spinal decompression. This referral should be made by the team in charge of the patient’s care at that time (ED, T&O or other specialty). If a patient is already under the care of a spinal surgical team at a different spinal unit (e.g. Derriford), it may be preferable to refer the patient to that unit.

5.7. Access to a spinal opinion at the RD&E is via the electronic Spinal ReferBack system at https://spinalreferback.co.uk/. Referrals or requests for advice may be made by any doctor but there is an expectation that the patient will have been discussed with a specialty registrar, SAS doctor or consultant prior to referral. Registration with a GMC number and NHS e-mail address is required. The spinal on-call team at the RD&E are also available by telephone if necessary but an electronic referral should always be completed.

5.8. If significant stenosis is not identified but a potential cause of the patient’s clinical picture is found then appropriate treatment should be initiated and communicated to the patient’s GP. This may include:

- Advice.
- Analgesia.
- Physiotherapy.
- Referral (either direct or via patient’s GP) to an appropriate service, such as the orthopaedic interface back pain service or neurology (if non-compressive pathology is seen).
- Discussion with the surgeon in charge of the patient’s care for those patients with pre-existing spinal pathology. This may be a surgical team at NDDH, RD&E, Derriford or other spinal unit.
- Very rarely, admission to hospital may be necessary for symptom control.

5.9. If no cause for the patient’s symptoms is apparent then a plan for further management should be made; this may not require intervention or discussion with inpatient specialties but should be communicated to the patient’s GP.

5.10. Management should be consistent with NICE guidance and the NHSE National Low Back and Radicular Pain Pathway. This should include the use of the Keele University STarT Back screening tool to determine prognostic risk and triage to appropriate treatment.

6. References

6.1. Standards of Care for Suspected and Confirmed Compressive Cauda Equina Syndrome; British Association of Spine Surgeons & Society of British Neurological Surgeons; January 2016

6.2. Cauda Equina Syndrome – risk management; Jeremy Fairbank; Journal of Trauma and Orthopaedics: Volume 02, Issue 03, pages 49 & 50

6.3. NICE Guidance NG59 “Low back pain and sciatica in over 16s: assessment and management” 2016

6.4. NHS England National Low Back and Radicular Pain Pathway 2017