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Noble, John S., *British Medical Journal*, 1977, 2, 886

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Gould, Donald, *New Scientist*, 1977, 76, 236

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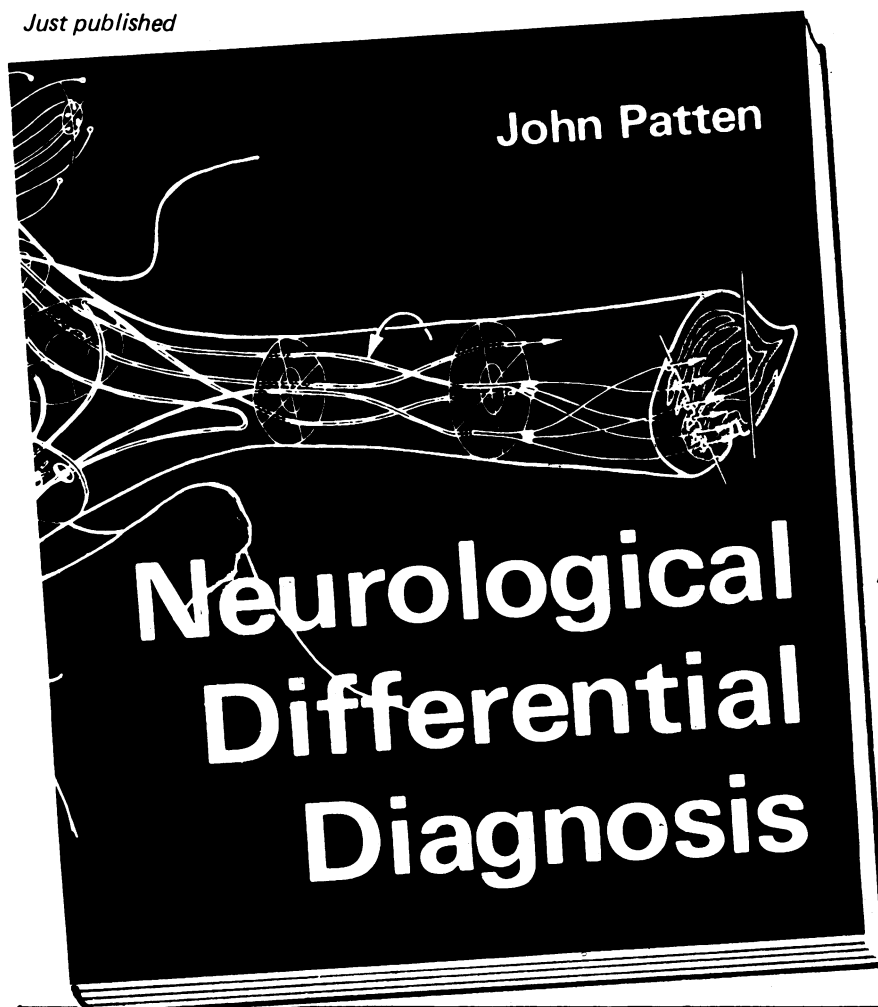
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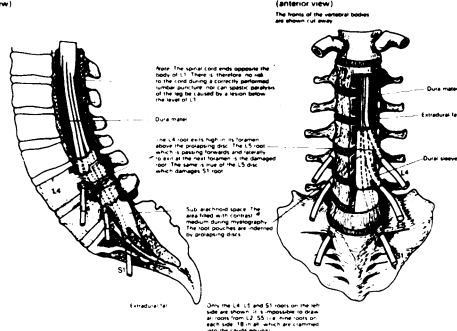
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Figure 15.7 The Lumbar Spine and Cauda Equina (lateral view)



seems to have any effect on the condition, although it may relieve any co-existent root pain.

Unfortunately so many middle-aged patients have some degree of cervical spondylosis on plain x-rays that its presence cannot be regarded as confirming that the patient's illness is due to the condition. Subsequent myelography may show no evidence of compression and the diagnosis then often turns out to be multiple sclerosis or motor neurone disease. On the other hand, an unexpected neurofibroma or meningioma is occasionally discovered. As discussed previously it is wise to keep the diagnosis of cervical spondylosis with neurological complications under continual review.

#### THE LUMBAR SPINE AND LUMBAR DISC LESIONS

The most important anatomical difference between the cervical and lumbar spine is that the spinal cord ends opposite the lower border of L1 vertebra. Therefore, lumbar

disc lesions can only cause root syndromes. Any lesion below L1 vertebral level cannot cause a spastic paraparesis. As there are eight cervical roots and only seven cervical vertebrae the relationship of the root to the interspace alters below D1. Therefore, the lumbar roots emerge below their respective vertebrae, that is, the L4 root emerges at the L4/5 interspace. It also follows that a disc lesion may damage a root anywhere between its origin from the cord and its exit foramen (the S1 root, for example, could be damaged anywhere along its six-inch intraspinal course). Fortunately, disc lesions produce anatomically accurate root damage in the majority of cases.

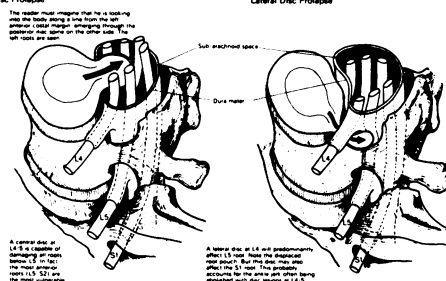
Individual roots are most vulnerable just above their exit foramina, as they are then the most anterior and most lateral root in the canal and lie in the immediate path of a lateral disc prolapse (Figure 15.7 and 15.8). The root exits very high in its foramen, usually above a disc that is protruding into its own interspace. The disc, therefore, damages the root that is passing to the interspace below. Thus a disc lesion at L4/5

will damage the L5 root and a disc at L5/S1 will damage the S1 root.

These anatomical features require very careful consideration when one is investigating a patient with lumbar or sacral root lesions. False negative myelograms occur, especially with disc lesions at the L5/S1 interspace. False positive myelograms are usually the result of over-interpretation of a bulging disc. The most important point to remember is that if no lesion is seen at L5/S1 in a patient with S1 root symptoms the myelogram must be run up to at least D10 level before it can be stated that there is no lesion involving the root. A neurofibroma on the L2 root, for example, can easily present as an S1 root lesion because of the peculiar anatomy of the cauda equina.

The other consideration depends on the frequency of disc lesions at various sites. Lesions affecting L5 and S1 roots account for ninety-five per cent of disc lesions. Lesions affecting L2, L3 and L4 account for only five per cent and the majority of these are at the L4 level. It follows that L2 and L3 root lesions are very unlikely to be a result of uncomplicated disc disease, and urgent investigation is indicated. There are four syndromes produced by upper lumbar root lesions that may prove to be due to disc lesions.

Figure 15.8 Diagram to show the effect of a Central Disc Prolapse



#### Anterior Thigh Pain

Pain in the anterior thigh, with wasting of the quadriceps and an absent knee jerk, is produced by lesions affecting the L3 or L4 roots. Disc lesions are an unusual cause of this picture. Metastatic carcinoma of the prostate gland and diabetic amyotrophy are the main conditions to be excluded.

#### Low Back Pain without Radicular Symptoms

One relies so much on radicular symptoms in the leg that if these are absent the question of a disc lesion is not raised. Occasionally, lesions at the L3/4 level may produce severe local back pain without radicular pain. The most ominous historical feature is rest pain. If the back pain is worse at night or in a lying position the chance of finding a serious underlying cause is very high.

#### Sciatic Syndrome

We have already pointed out this situation in relation to a neurofibroma. A disc lesion as high as L2/3 interspace may fail to damage the appropriate roots and present as pain in the L5 or S1 distribution. This adds further emphasis to the need for a complete myelographic examination of the area, up to and including the lower cord.

Diagram to show the effect of a Lateral Disc Prolapse




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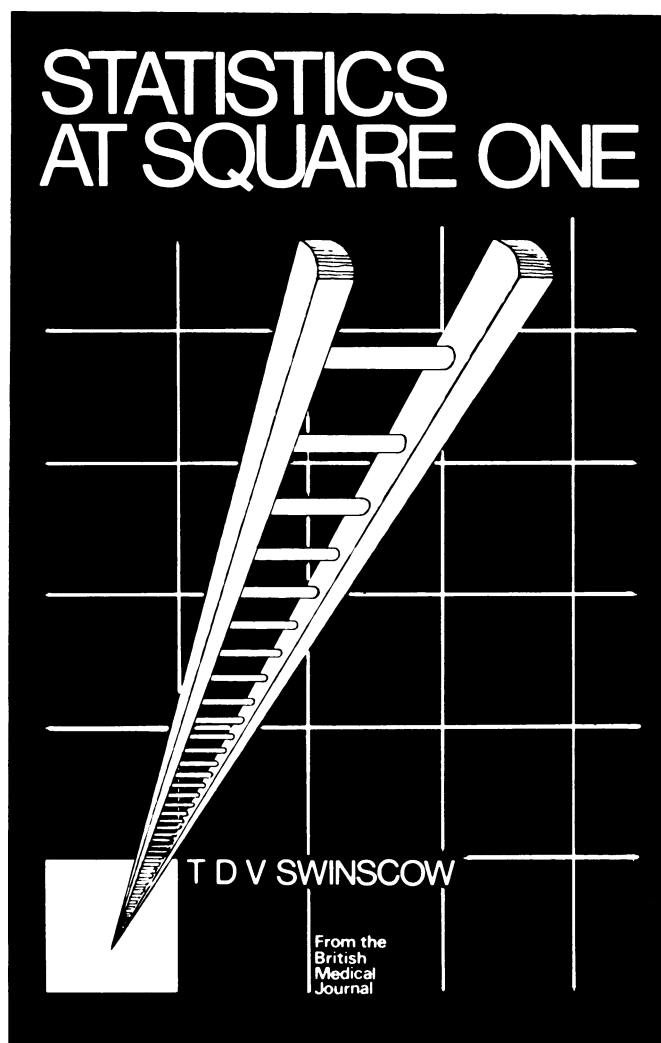
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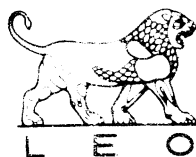
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