National back pain pathway Cauda Equina
Diarmaid Ferguson and Chris Mercer Q&A

what specifically is affected re sexual dysfunction.. ie what questions should be asked? **For men- are you able to achieve and maintain and erection and can you ejaculate normally?** **For women- do you have normal vaginal sensation and can you climax normally/**
Can you get false positives for cauda equina in patients with lumbar stenosis? i.e MRI scans showing cauda compression but the patient doesn't have any clinical signs or symptoms of cauda equina **Yes this is really common to see. Compression of the cauda equina is not the same as cauda equina syndrome. We do not refer these patients urgently unless they are exhibiting symptoms of CES**
I'm interested in your opinion of bladder scanning and saddle dermatomal testing in an FCP role. Will it be diagnostically definitive, to the point that it would change your decision making / pathway? Ie/ would you still refer to A&E/escalate with a suspected CES even if saddle testing was negative or bladder scan was satisfactory? **Yes still refer even if objective testing negative. CES is predominantly a diagnosis made in the subjective examination- the physical testing , especially saddle sensory testing may have some predictive value but it is not definitive, so if the history suggests CES, then refer.**
How do you differentiate from side effects from the medications (neurogenics) that patients may be on for their back pain? **It's really hard to do. Symptoms related to medication use may come on at either the start of new meds, or changes in doses, but it would take a very brave person to be totally consident that CES symptoms were only related to this- the BASS statement about a LOW threshold to imaging is a safer way to travel**
How do you clinically process one off symptom presentations such as reported one off unexplained urinary incontinence 2 weeks ago and not repeated for example. **It's always a balance. In this example I would watch and wait and not refer urgently or as an emergency, but unfortunately you need to make a judgement on each case as they come through. A lot sit in the "grey zone", so make sure you document your reasoning in each case and explain your decisions.**
How do you overcome issues with secondary care. I recently had a patient who presented with CES and I sent them round to A and E where they were turned away. Numerous attendances later to urgent care by the patient and being turned away as 'just back pain' they then attended back to myself for review whereby I sent and went with the patient to A and E again, in the end they had surgery the same day. But this was obviously a delay to treatment. **This is really hard and really common- I think it is a case of keep going with communication and working on keeping communication with A and E and secondary care colleges as open as you can. Often phone discussions can help, so that you can explain your concerns, and we always follow these up with a referral letter too.**
please share any examples of litigation around CES.
chris any advice on dealing with the grey patient presentations despite second layer questions you remain uncertain (eg one episode bladder incontinence 2 weeks prior and not had it again since) thanks.-

see previous answer

To Chris and Diarmaid;
What would you make of biltareral /symmetrical muscle fasciculation which is intermittent, and occuring over months after back pain, but with no other clearly abnormal neurology ?

Could be a sign of bilat radiculopathy or potential for it to link to more concerning issues /neurology. I think a full and thorough neuro- UL and LL, UMN and LMN would be good to do. If nil of note, then a watch and wait approach and review Appt might be useful

What would you recommend doing if you sent a patient to the emegency department, with a letter, suggesting suspected CES, and the patient was told it was not CES but no MRI was done? (I work as a physio)

please see previous response- in addition I would follow up with A and E and try to talk to the person that saw the patient, or one of the Consultants. Also may need to follow up with the patient and push again to get them imaged if symptoms are still concerning.

Sometimes we will bleep the oncall reg and they will dismiss our concerns - what would you recommend in this case ? a/a-

speak again or go higher if not getting the response you need

is there an example paperwork anywhere we could look at thaould be used to send a patient to ED with? So we can put it forward as an example when developing a process/pathway in our local areas

Lots of examples out there, but essentially ours is headed as "possible CES" and documents clinical presentation, features we think may be CES related, and our recommendation for imaging

Are you happy to share the links and information on the new PCRMM website.

yes

one of the early signs listed of CES was straining during micturation. as a lot of patients with back / leg pain are prescribed codeine and some are constipated, can you recommend a way of clarfiying this question as some patients arent very good at describing their symptoms ?

It is difficult, but relates to onset in terms of timelines, but also any relevant other PMH that might cause similar- also relates to pain and meds, so it is a balanced judgement. I am always wary of totally new/different symptoms that are not related to previously known pathology and clearly linked to onset of back/leg pain.

Potted Hx - Patient with back and unilat radicular pain > 11/12s; intermittent bladder incontinence over 6 months - was sent to A&E where MRI not CES. On-going sx and increasing bladder / bowel sensation changes - returned to A&E where post void bladder scan -ve and returned to GP recommending they ref for urgent MRI if they feel necessary. GP has referred but still waiting for urgent MRI. I/T bladder incontinence; I/T S/A; episodes of bowel incontinence over last 2-3 weeks - not consistent. ? poss GU / GI issues but also insidiously increase CES Sx's - do we refer back to A&E? Do there have to be rapid changes for CES to be considered more likely?

Changes don't need to be rapid, but any suspicion of CES then A and E is the right place initially. Previous MR I doesn't protect you or the patient, especially in the case of evolving symptoms. If Lx MRI clear, then don't forget that pathology higher in the spine can cause CES like symptoms , as can pelvic pathology, so these 2 areas may need to be investigated too.