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When back pain and imaging tell two different stories: How to navigate in the clinic

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Industry Buzz

> Once everything starts pointing toward cord compression, that's not a watch-and-wait situation. Get them to a spine surgeon. Fast.
> —John Gorecki, MD

> The key for primary care physicians, rheumatologists, and other frontline clinicians is not to dismiss these changes as routine arthritis.
> —Bayan Aghdasi, MD

Every clinician who sees patients with neck or back pain is familiar with the challenge: How do you identify serious pathology in a timely manner—and what happens when imaging doesn't paint a complete picture?

Consider the recent malpractice case of Robert-Michael M. Giordano, who sustained a spinal injury after a fall.[1] At the emergency department, he complained of a 10/10 pain level, but emergency physicians sent him home after a chest CT scan was reported to show "no abnormalities"—although there was a calcification protruding into the spinal canal that was not mentioned.

Over the next month or so, Giordano reported worsening pain, numbness, weakness, and an inability to stand, in communications with his primary care provider as well as an orthopedic provider. Yet in both cases he wasn't referred back to the emergency department nor given an MRI referral.

> When he eventually couldn't feel his legs, he went back to the emergency department, where doctors discovered a disc herniation at T6-7, along with severe spinal stenosis and impingement on the spinal cord. Despite having emergency surgeries, Giordano was paralyzed from the chest down. He was awarded $23 million in a record-breaking malpractice case.

So, how can physicians prevent cases like this?

Watch your patients closely

"On an MRI or CT, I am checking the canal diameter before I even look at why the scan was ordered. Patients who come in after a fall can have a finding that looks minor but can actually be more serious, especially if they are elderly patients," says Robert Norton, MD, an orthopaedic spine surgeon and founding partner at Florida Spine Associates.

He also notes that spinal cord compression may not always be apparent on early imaging because it gets worse over time—underscoring the importance of follow-up and additional imaging, as in Giordano's case, given his complaints of worsening symptoms.

Embrace different kinds of imaging

Neel P. Shah, MD, a spine surgeon at NYU Langone Health, says that MRI tends to be the gold standard for diagnosing issues like spinal cord compression.

In the Giordano malpractice case, emergency physicians initially sent him home based on unremarkable CT scan findings. "In a trauma setting or if MRI is not available, a CT scan can be used, [but] the spinal cord is better visualized with MRI," Dr. Shah explains.

> He describes a few types of cases in which creative imaging may be necessary:
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> - A supine MRI can completely miss dynamic problems, instability, and positional compression. In this case, add standing X-rays or flexion-extension views.
> - If infection or tumor is anywhere on your differential, order an MRI with contrast, which can catch an epidural abscess.
> - In a patient with acute neurological complaints, don't skip a rectal exam. Poor rectal tone, for example, can signal cauda equina—and no single finding rules it out.

Treat the patient, not the imaging

"The biggest trap I see is treating the MRI report instead of the patient," explains Dr. Gorecki. On one hand, he says, most people over the age of 40 have some wear-and-tear on an MRI, whether it's a disc bulge or mild stenosis. "This is normal wear-and–tear, same as wrinkles," he says. "The problem is when a clinician anchors on those findings and stops asking questions."

Dr. Gorecki says he asks the patient how they're actually functioning. "Does the scan explain what I'm seeing in front of me? Get your hands on the patient. Check for a Hoffman's, a Babinski, or a clonus. Those reflexes will tell you things no radiology report ever will," he says. "And when the exam and the imaging don't agree, believe the exam. That mismatch is usually where the real diagnosis is hiding."

Consider mimics

Dr. Gorecki warns clinicians to consider an array of diagnoses. "Stay humble about mimics," he says. "For example, ALS can give you hyperreflexia and spasticity that look exactly like myelopathy, and atrophy and fasciculations right alongside them. I've seen clinicians chase the spine while the real disease was in the motor neurons."

Time is of the essence

Bayan Aghdasi, MD, a board-certified, fellowship-trained orthopedic spine surgeon at DISC Carlsbad, says that an MRI should be obtained urgently for patients with spinal

pain as well as progressive arm or leg weakness, gait imbalance or falls, loss of hand dexterity, abnormal reflexes, numbness or a defined sensory level, saddle anesthesia, or new bowel or bladder dysfunction.

This is particularly important for patients with cancer, infection risk, recent trauma, or rapidly worsening symptoms, like in Giordano's case.

"The key for primary care physicians, rheumatologists, and other frontline clinicians is not to dismiss these changes as routine arthritis. Perform and document a focused neurologic examination, including strength, sensation, reflexes, gait, and hand function. Compare these findings with the patient's prior level of function," Dr. Aghdasi says.

"Once everything starts pointing toward cord compression, that's not a watch-and-wait situation. Get them to a spine surgeon. Fast," Dr. Gorecki asserts.

A note for primary care providers

Jeremy Smith, MD, an orthopedic spine surgeon and Division Chief of Spine Surgery at Hoag Orthopedic Institute, offers a word of advice to clinicians at the frontline.

> "Primary care providers evaluating presumed spinal arthritis should routinely screen for upper motor neuron signs on exam such as reflexes, clonus, and gait, even when the chief complaint is axial pain, since myelopathy can coexist with or mimic degenerative disease early on," he says.

And if your patient is complaining of new deficits? "Aim for same-day imaging and a spine surgery referral rather than a scheduled follow-up."

Link: https://www.mdlinx.com/article/when-back-pain-and-imaging-tell-two-different-stories-how-to-navigate-in-the-clinic/vv91lwQ48OmS5wCEeNOsL?mdl_cp_loc=bottom_extender&mdl_cp_imp=4CKL2ejPv6d0rg109nsh8q%7C34SyvGv7MFeDiKo2LFPCxR%7Cvv91lwQ48OmS5wCEeNOsL