Spine Cases - Ref 148BC - Draft Transcript

with Bob Chatterjee

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TRANSCRIPT

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Steven Bruce
We got Bob Chatterjee back in the virtual studio with us today, we had an abortive attempt to run through the second half of his presentation on spinal cases some time back. All we want to look at is pitfalls in spinal assessment. And we're going to recap a little bit on some cauda equina information because it's so important in clinic, and then we're going to move on to some other interesting stuff that Bob has checked. Bob, great to have you with us. Lovely to really, I mean, you've been a spinal consultant for quite some time, you've been on the show two or three times before now I think, so people I hope are familiar with you. And you are, trained at Guy's and St. Thomas', and you're now at the Royal Free, is it?

Bob Chatterjee
Yes, I've got my medical degree from Guy's and St. Thomas' London, little mountain a little bit. But I spent most of my sort of training career in London, and then spent some time in Oxford, some time in Stanmore in North London, Cambridge, doing some neurosurgery and North Cambridge, which has got a long established spinal deformity unit. So as is with training, you go around a bit and learn things from different people in different places. But I'm now based in central London at the hospital St. John and St. Elizabeth does with John's work, and the London clinic, which is Harley Street.

Steven Bruce
But you also, you're part of the Total Orthopaedics Consultancy, aren't you and we've built up quite a rapport with you and your fellow consultants down there. And I presume that, you know, part of this for you is the hope that more and more people in your catchment area will become aware of you and start referring patients.

Bob Chatterjee
Yeah, I just, you know, I see these things as a way of really introducing us, I think, you know, everyone chooses to refer to people who they feel happy with and *audio drops out* good quality advice. And, you know, there's a variety within doctors like all of us. So I'm very hopeful that, you know, some people like me and value some of my opinions and that we could develop some working relationships?

Steven Bruce
Well, I think one of the things that we've developed and learned in APM, quite different from your line of work, obviously, is that your responsiveness to clients, or customers or patients is key, because, you know, if they feel that they can talk to a human being, then they're much more inclined to do business with you. And what we found with total orthopedics is that, you know, you've been very responsive to our requests for help, whether it's, you know, presentations like this or anything else. So hopefully, people will find that when they start referring patients. I should say, you've got, we've already shared your presentation for today. But we'll make it available to everybody after the broadcast again, along with the graphics that came with it, because there's that really, really lovely graphic about cauda equina, which many people found useful. I told you, after the last presentation on quarter, Cent packet and activation, they have recently had a patient that the GP had said, No, this is not called a recliner syndrome, they refer them back again. And actually, the GP

agenne referred or a person was sent in for surgery. So, you know, it just goes to show that this education is very useful in our practices.

Bob Chatterjee
I'm really pleased to hear that. It is all about you know, no one's perfect the way you are in your career. But yeah, the more we share this information around and the more we will

Steven Bruce
surely make use off with your presentation.

Bob Chatterjee
So I just wanted to talk a little bit about cord recliner syndrome in the context of spinal assessment. I think spine assessment is is the most important thing all of us do it to you and me because I always say that if you don't really understand the story, sorry. You know, sometimes I think not enough thought process has gone into the sort of understanding of you know, why some comes to see you in clinic. There'll be a range of conditions, some some some sort of acute lesson, but I think that the the condition that that is probably the most familiar emergency condition and spinal cord recliner syndrome, I just really wanted to have a little bit about that so that you get a handle on it. It's not an easy condition to deal with because, you know, it's it's rare and you don't see that many on them and whenever you see things not very frequently, it always rather test your diagnostic skills.

Bob Chatterjee
So the first thing I wanted to say is that cord recliner syndrome is a clinical diagnosis. It is not a radiological diagnosis, although the radiology certainly helps. And and quarterfinal syndromes really refers to acute compression of your spinal cord and mark that word acute. It's not something that happens over a long period of time already. So Most of the time it happens rather suddenly. So the the the image I've got on the right hand side there, show something that looks horrendous as a side on view looking at the spine, and you'll see the light things with the with the black rim around them all the distance, the gray squares are the vertebrae. And then you'll see the full five region a large black disc bulge heading over towards the right side cause of compression of the sort of gray spinal cord, you can see it like a tails coming down in the middle of that picture. Now that looks horrendous. And that might be coordinate Aquinas syndrome. And it might not be a syndrome because the trouble is, is that it is not a radiological diagnosis. So a condition that you'll often see a scan looking like that is spinal stenosis. And when you got spinal stenosis, you've often got significant compression of the spinal cord. So what's the difference I hear you say, because they look the same on the MRI scan. So it's a question of time. spinal stenosis is something that happens over years. And as it gradually occurs over the years, what will happen is, is that your spinal nerve elements have got a great deal to sort of comp a great deal of compensation. And as a result of that compensated ability, they can continue to function. Even if it looks like that, there is significant compression going on, because the bodies can time to to react and to that and keep the nerves working, working well. So spinal stenosis can give you horrendous looking pick, just but may not have issues of cord recliner. Whereas to contrast that if you get a an acute disc prolapse, that suddenly comes out of nowhere and suddenly starts pressing on the spinal cord,

that suddenly the spinal cord and the nerves in it, suddenly seeing stars and and they in the body and the spinal cord can't deal with that. And then you start to get these horrendous symptoms of Cauldre Aquinas syndrome. And the the thing we call the whiner syndrome is that the trouble is, is that you don't have much time. Sadly, it's something that needs to be done sooner rather than later. And, and it is virtually the only thing that I will sort of get out of the bed as an emergency to do something about because there's no question about it, that the quicker you get on on topic or refining decompresses buying the battery, the better it gets.

Steven Bruce
So can I ask you said that, in the slow moving? scenario the nerve can contact what physically happens to them to help them constantly compensate? Do they move? Or is there some structural change around them to protect it, there's

Bob Chatterjee
no way to move to that they remain compressed. But what's happened is is that that the the the oxygenation of the nerves, because it's not been rapidly cut off, if you like, has got time to climb the desert. So nerve cells can survive on low oxygen tension, but not as an acute change. It's a bit like Senator altitude training, you can get used to having, you know, less oxygen at a higher altitude. But but it's got to adapt to it. So if you suddenly go and do that on one day, then suddenly you will feel desperately short of breath and you weren't used to it. But if you do it over a slow period of time, that the nerves can accommodate it.

Steven Bruce
How well there's been, Bob, I've just had a message from PIP who says that she had a patient just last week who told her that previously she had an episode of low back pain. So acute as she's described it, she lost control of her bladder, she went to her GP who was unconcerned and just told her to take painkillers. Pepper, so she was alarmed to say the least and says that the patient tells her that her blood has never been quite the same since I don't know how long ago it was.

Bob Chatterjee
So that would be very worrisome to me. And one of the things I sort of see it now it may be that that particular lady that it isn't called recliner syndrome. But the trouble is, you don't know. And I always said this, you know, as a consultant in the NHS, I expect to get lots of negative referrals sent to me that that's not something that worries me. I used to sort of get run across with my junior registrar's when they sort of used to say, Oh, well, look, I've taken a call from a GP and I don't think it's called required. And I always used to reply, you happy to put your name to that just over a telephone call. Because if you're happy to put your name in your future career, and go ahead, if you think oh, I better check the patient, then bring them in. And the I will be happy if I get 10 referrals and one of them ends up being according to that I'm delighted. And the reason for that is you expect to see lots of false positives here. And if you're not seeing lots of false positives, then your threshold for referral is too low. We just don't want to miss that one disaster. We know they'll come with a lot of other cases that nothing of nothing. In that particular case that you just mentioned, I would certainly be worried because how you can you can sort of say that one episode

of you know, loss of control of blood. It's got nothing to do with it, unless the GP did a very careful clinical examination and he or she may The answer and if they did it on that basis, fair enough, but if they did it over the telephone or without having seen them, I'm struggling to see how you make the diagnosis. And I know I sent them in now, though, sorry, I still send them in now not not the cord requires inability to understand why you need to understand whether the blood has got anything to do with the spine or not. So you know, that there would merit in an MRI in my book, even if to say that it's got nothing to do with the spine, at least that's a positive piece of information. And you could, you know, send the patient to the right sort of person. But you know, you if you're getting an episode of loss of bladder control with severe back pain, that's gonna raise some alarm bells in your head.

Steven Bruce
But we've we've said this on when we previously spoke, I know and I hesitate to say things too many times. But I just don't think you can emphasize enough here that when you get these signs or symptoms, you you do refer because as an osteopath, you can be very nervous about making this referral and having having a GP or consultant think that you're in competition, because you prefer to refer someone who doesn't have cord recliner syndrome. But it's really reassuring to hear you say that, you know, that's what you'd expect us to do.

Bob Chatterjee
I definitely do. I hate that that is an utter failure of failure of medical necessity, if I can put it like that, that all this nonsense. This hierarchy doesn't exist, the only thing that counts and the only thing that any of us are interested in is the welfare of our patients, mine or yours, it doesn't matter. And so you know, if you think I've always been like this, even when I was a junior, if you feel there's something, then surely it's just my job to look into it. And you might be writing your mind wrong, just like I might be writing might be wrong. So please refer people who criticize you for doing so talking poppycock, in my opinion.

Steven Bruce
Yeah. As you said earlier on about people putting their names to something, I think we reassured one osteopath in a previous broadcast that, you know, if he's even mentioned cauda equina syndrome in his clinical notes, and he hasn't referred he could have a damn good reason why he didn't.

Bob Chatterjee
Yeah, I think so I think the documentation is very, very important. Even if you're getting an obstructive, you know, doctor or whatever on the outside saying, Please do document that you have made the call and you've made the referral. And sadly, when I've done medical, legal expert witness things in court, these things matter. So please, I do feel that you are very vulnerable in primary care, because you're sort of out there really without necessarily a sort of all the legal protections you get from from the NHS. So please, time, even if they're not giving you the answer you're looking for,

Steven Bruce
thank you, sorry, I interrupted.

Bob Chatterjee
I just put some charts up. As I said, hopefully, you'll receive a copy of the the presentation, but just to you know, mean, you you know the symptoms, but just a few things to add to sort of read through the chart, there's a few things that so usually the the first thing that you're going to get is an onset of urinary symptoms. So things like bow, for example, come later. So you know, if I see someone who's got loss of bowel through cord recliner, I'm already rather worried for him because I think it's too late. So the early signs you see is a disturbance to the bladder, as you see in the top left corner. And it's it's difficult because it's that it's the urination is different, different to normal. And usually what they it's they don't know that they need to go to the loo. And that's the sort of first sign that they tend to get to, and then they have the inability to control that comes a little later. So it's this loss of knowing that you need to go to loo the loss of ability to control it, when you get to the loo these are the sort of first signs that you're looking for you they often tell you about the subtle numbers of well, only because that's what they feel when they're sort of wiping their bottom. With with tissue, they can't feed it too well. So it's it's definitely the opportunity in terms of in terms of the charter of what tends to present First, the lowest symptoms the bowel function has they've come to the latest sexual dysfunction is there often a later a later manifestation of cord require, and you may well get low back pain weakness, the difficulty with a low back pain and weakness is sometimes you have that in that symptom will come out of the blue and it sort of helps you to sort of understand what's going on. But often you'll see people getting sort of this problem on the background of a pre existing low back pain and weakness. So it's not often easy to to distinguish some of the things that we have up in

Steven Bruce
surprise that I'm still I'm getting questions coming in quite interestingly, Louise has said that she had caught Aquinas syndrome sometime. But her problem was not loss of control. It was urine retention is that common?

Bob Chatterjee
It is common, but that's later on. So when you get to uni retention, that's further along that we'd like it so it'd be interesting to know if she had absolutely any disturbance in her normal urinary function before that. So when you look at cord recliner, we often talk about whether they've got any retention or not Deciding retention is a bad sign for us, it means that the cord requires progressing and we need to do something sooner rather than later. It's preceded with some symptoms,

Steven Bruce
sir.

Steven Bruce
Apparently she had surgery within three hours. Okay. Jacqueline has asked for clarification if we get somebody who we suspect called a coiner. And should we the GP or should we send them to a&e?

I think

Bob Chatterjee
he probably is my better bet because it bypasses all the other nonsense. So I would probably 70 to 80

I maybe

Bob Chatterjee
it's just sort of my experiences of life, but usually these called recliners, they never come in civilized hours. I don't know why they rarely sort of probably between nine to five on a Monday to Friday, they're often late in the evening or whatever. I would say if you've got a good relationship with the GP, if you think that if you're if you're sort of not certain, but you'd like some to examine them, then you might be able to get a GP to have a look, I have to say, under the current circumstances that we're in at the moment, I'm afraid a lot of the GPS are doing things really by remote and, and sort of remote consultation, so forth. And this is something that you just simply cannot diagnose by remote consultation. It needs an examination. So I think it's certainly the current circumstance, I think it is the best.

Steven Bruce
I've spoken to a GP, MSP specialist in the past commented that GPS are pretty much useless at musculoskeletal medicine, I would have thought I would have kind of thought that most osteopaths and chiropractors would be better at diagnosing this than a GP

Bob Chatterjee
to agree with you without getting into trouble. But I know that the

Steven Bruce
GP specialist topic

Bob Chatterjee
is accurate in all honesty, I think that don't get me wrong, you know, GP and my my dad was a GP so he knows DPS know. Tons and tons and tons of stuff about stuff that I know nothing. Okay. But if it comes to spine, no, they're not that great at it. In all honesty, they're much better things that kill you, you know, things like cardiology, oncology, but not so much fun.

Steven Bruce
Somebody asked me whether saddle anesthesia is always present in quarter one.

Bob Chatterjee
Not always, not none of these always are. That's one of the problems you don't get a consistent presenting sort of picture record with whiner it's a very one. That's one of the problems with picking it up. It's often it's

it's it's a change from what they're normally like as much as anything but no suddenly does not is not always that.

Steven Bruce
Okay, we've got a question which I think I raised Him from my own experience with you in the past. Yeah, Rob has said what do you do when a and he still dismiss a suspected quarter required and they refuse to MRI them? He says it's happened to him a couple of times. And you probably know, Rob, because he works closely with total orthopedics down there in London.

Bob Chatterjee
I don't rob very much. It's difficult. So from the point of view of the patient, you tend to go somewhere else. From the point of view of yourself, you document it secretly, often, I mean, Robin, I actually is an example of what I mean by building working relationships, you know, you know, I've got to work in ratio with Robin, and I'm sure that Rob would have no hesitation, I'd like to think you'd have no hesitation quarterly whatever time of day or night it was because, you know, we'll take it seriously. And he knows that. And and that, you know, said it's sometimes difficult to do. So it shouldn't be the way but for Robin, sometimes what I've done other colleagues of mine is that sometimes saying exactly what Robert said, but unfortunately with my name at the end of it, the qualifications go with it sadly gets taken more seriously than though, and I know it shouldn't be that way. But that's the real world we sometimes live in.

Steven Bruce
So I guess the nice The nice thing from your point of view is that most osteopaths and chiropractors wouldn't be open at two in the morning. So if they get recorded. Yes.

Bob Chatterjee
But no, I think you know, if you genuinely you know, Rob makes a comment that that has happened if you genuinely think it as you call them again, or you send it somewhere else in some different ad department or you get hold of the hopefully friendly, friendly doctor me. Yeah. Yeah. Okay, so. So I put up here some of the sort of the symptoms that we talked about, you know, tablets is not always there, the pain and the incompetence numbers, I think we've sort of covered that already. Really, these are more sort of, sort of charts, if you like, for your, for your workplace. I wanted to start on this particular one. So, you know, it says in the sort of 123 steps, just a few things so you know, if if it I think they put it beautifully if it's a possible by diagnosis, you must investigate now that's, you know, for us if you like but it equally applies to you. If it's a possible diagnosis, you must refer just change the investigate to refer and those are the symptoms that you know, with back pain plus disturbance or bladder plus The sort of sensory disturbance. So as you say, there is an and or not not not a have to be. And, and the rest of it is really for us and in terms of hospital things in terms of we know we should be doing MRIs. There's a problem with that at the moment, because a lot of hospitals don't have ability to do MRIs out of hours. But we're changing that we've got government approval to change that. But as with many things, you have to demonstrate the problem before you can actually change it. So it's in the process of that, but we have definitely made progress on that, and getting funding for every hospital to do an MRI out of ours. For for CT recliner.

Steven Bruce
Bubbles at the bottom are the three myths. Yeah, I

Bob Chatterjee
was just gonna say. So I just wanted to sort of 333 myths, partly for some partly for you. So one is if there's no your attention, it's not so cool. So as I was saying earlier, that that unique tension is often a slightly later side bite. so upset that, you know, the patients who have on their ways you haven't gotten there yet, are the ones that you would really like to pick up on, because they tend to have the best outcome. And by the time we you know, your retention is established, I'm afraid the prognosis is not not so good. anal tone, if it's not, if it's normal, again, that is not a finding that has to be that you have to put your, you know, I say this to the doctors, I'm afraid, you have to do a PR examination. You know, we say if you don't use your finger, then go to court. If you do not document a PR examination, you are going to be in big trouble. There's no, there's no query about that that is an absolute standard of examination for us. What do you think? Or what are you looking for, you're looking for you're looking for the squeeze, you're looking to see how you can squeeze down on your finger, and you're looking for how good they can squeeze it for, and also the sensation in that area that you must do. And the last myth is, is really more for us. The It used to be that the MRI could wait first thing in the morning. But we're now very much changing to the pattern that we want to know about it ASAP, because we may we'll do something about it out of ours. The guidance used to be that the operation can wait till the morning on the grounds that you have a more familiar grasp, you know, sort of staff who used to operating with, you know, where the equipment is, and so forth. But, but it's changed, we now feel that that's valuable hours lost, that can make the difference with debt recovery and the lack of it.

Any questions about that I'll

Bob Chatterjee
move on to

Steven Bruce
the last one I have on that one is from Sallie Mae who says, are patients likely to feel better standing up or lying down or in any other position?

Bob Chatterjee
Feel better in terms of pain. So in terms of neurology, usually, leaning forward a little bit tends to make them feel a bit better. So that that's something that you sometimes see in the patients, but that usually that won't get rid of all the neurological symptoms. So feel a bit better in terms of discomfort and pain. Sure. But that in terms of would it improve the neurology, not when it's gotten to the stage of record required?

Steven Bruce

Sure. Okay, thank you.

Bob Chatterjee
So I suppose I'm going to flick really from, from the sort of emergency to the rest of and I was talking about pitfalls in diagnosis, because it's one of the things that I see a lot in my practice, where really, you know, someone comes to see me because things aren't as good as they should be, or aren't quite as good as they are. And, and I sort of, you know, put a lot of thought over the years into trying to understand, you know, why sometimes people have the, you know, the wrong diagnosis. And I think that sort of, you know, sort of a number of causes for that. So one of the causes might be that there's a degree of misattribution of the signs and symptoms, the signs and symptoms are there. But you think it's coming from one schools where it's actually coming from another, I think a different eyes is is a misdiagnosis where you've completely got the wrong system in the first place. And it does happen, although fortunately not not, but not frequently. Some of the things I encouraged my sort of students to think about is that the MRI will often show more than one pathology, have you got the right one, you know, and there's, there's no that you know, we've all got it wrong on times. You know, I recently saw a patient where I was absolutely convinced that the problem was coming from the slip disc in, in the elbow is one level on the right hand side, but actually had nothing to do with it. The she didn't have science here but it was coming from the femoral region where there was an injury to the nerve, rare for sure that happens. So you know, make sure you try to go get the right pathology. Be aware of the limitations of MRI as you know, they don't show everything so the M is not very good at si joints. It will show you if you've got inflammatory SI joint disease and it is sensitive at relatively picking that up. But if you go And overloaded SI joint because of problems elsewhere or so forth, then usually, you know, it's not going to show you what you need. An MRI is I always say, you got to remember that the sort of standard MRI is taken with you in one position and one on one day, it's a single snapshot, it doesn't really reflect what your pathology is, like in all the different positions you can be. And there's, as many of your patients will tell you their symptoms, aren't there 24, seven, they sometimes sort of come and go in waves. So you know, there are limitations within those, you've got to take them in with a pinch of salt. And as you all know, already, but just to re emphasize that MRIs are not gospel truth, they show lots of things that have got absolutely nothing to do with the symptoms.

Steven Bruce
Do you think is a problem with MRI is that generally they are not weight bearing?

I mean, it depends how bad is

Bob Chatterjee
it depends on the clinical examination. First, really, I think if the if the clinical examination really is the history and clinical examination that buys the diagnosis for me, and the MRI is that is there to confirm it rather than the other way around. So I will use a weight bearing MRI, if I if I feel that the symptoms they've got going to be accentuated on weight bearing level might show up a bit better. But I don't think that every

MRI has to be has to be weight bearing. If they've got a very good story of spinal stenosis, then you know, you don't need them to be were banged or be there on a standard scan.

Steven Bruce
What else what other sorts of things were you thinking weight bearing MRI would normal

Bob Chatterjee
response, follow this thesis from the past past effects of spondylus thesis where there's no alignment between the various vertebrate petitioner but the bird that might catch on a nerve root, particularly when I see inflamed facet joints, when you see very, very inflamed facet joints that can also promote movement that when you put them in a lying down position you won't pick up. The other thing is to listen to their story. So when they tell you, I asked him, you know what their symptoms are like we're in different positions. So they say to me, Look, I never get it when I lie down, but I only really get it when I stand up. I'm gonna want a standing MRI because it's more likely to show me the pathology. So it's a bit about what they might have in a bit about this story.

Steven Bruce
But we also know this, but do all MRI Suites have the capability of doing weight bearing standing? MRIs? No,

Bob Chatterjee
hardly any. So the vast Yeah, over 90% of all MRI centers that have only got the ability to do a line down MRI scan. So the the weight bearing memorize a few and far between. That's why you certainly won't get one on the NHS. Certainly not routinely, we were able to move away from them. But it was designed to create as much paperwork as possible before they give you approval. So you'd be really unwilling to do it. And so, you know, fortunately got better access to the primary, but now the majority of you don't have the facility to do that.

Steven Bruce
Can I ask you a couple of questions from our audience. Georgina has said she wonders if tarlov cysts can be a differential diagnosis that obscures quarter recliner syndrome. She says she has a young patient who demonstrates all the symptoms but they've MRI and said she doesn't have it. Given that her physio actually given her physio exercises and she's just deteriorating apparently.

Bob Chatterjee
So tarloff sis can so first of all, what if for those who don't know Tomas This is what called a para neural system assist coming off of the the sheath of the nerve. Now they can be very, very large in size. And the thing with Thomas's is that they are often asymptomatic, but they can be symptomatic. I've seen a lady recently who was complaining psychotic symptoms, and she had a massive tarlov cyst around one of the nerve roots. And she she'd been sort of effectively ignored by the NHS to be told that it hadn't. It was nothing to do with the symptoms. But I sent her to one of my colleague, neurosurgeons to marsupials to

assist and it improved all the psychotic symptoms straightaway. Now that, to be fair, is the rarity, the majority of our losses don't cause it, but they are certainly some of those who do. It's not a common thing. So don't get too cross with with, you know, doctors for not necessarily picking it up. But for those of us who sort of, you know, purely spine specialists, it's definitely a possibility.

Steven Bruce
I've got another one which is about cord recliner and about inability to get a full diagnosis. Christina says that she's referred patients for cord recliner investigation, they only had a PR exam. They haven't had an MRI and they've been told they're fine. Do you think that we should or we should be more forceful? If that happens and say hang on the PR exam is not enough. They need an MRI as well. They should know that

Bob Chatterjee
already. I mean, you've got right, that it is you're going through a phase here where we're actually trying to change the mindset, you know, education takes a long, long time to sit down through to people that often end up making the decisions. Now, quite understandably, I'm sure they've got lots of other things to do, but, but that's why we changed the guidelines that you know, you should not be if you know you can't just say They're fine based on a PR examination. That's just nonsense. I'm afraid. You know that that doesn't have to be there. So if you suspect to clinically you should be doing an MRI. The thing always previous has been is that oh, well, we can't get it. We need to change that. So you can get it but no, you should be more forceful because, you know, or at least documents if nothing else. documented, but know the concept that you could say someone hasn't got quarterfinal that PR is complete nonsense.

Steven Bruce
Okay. Mel has just told me that the Bournemouth MRI Center, which is allied to what used to be called the Anglo European chiropractic college, and now as a longer, more complicated name, baby scan scans, apparently, and Georgina, Georgina talking about that last piece, and so she has a very large cyst exclamation mark. So

Bob Chatterjee
yes, a very large cyst can cause new or new symptoms. For sure, I'm afraid I've seen that. We've seen few patients like that, and a few of them in my time as well. So it's a it's a very, very large series that makes it a bit more likely that it can cause new, new symptoms.

Steven Bruce
What about these anatomical variants that I see on your slide here? Yeah, I've

Bob Chatterjee
got a few just to show you that. So right. These are some some things over the years that have caught me up. So you know, I like telling you about all my own failures and things because it just hopefully, you know, you get the impression that you should all we all should be happy to discuss the things that we've got wrong, I think, I think that's often now you learn a lot more than talking about all your successes. So a few things

are so things contributed system. So back pain and kidney stones, I've seen quite a few over the years, where people have had problems with severe back pain, it's actually coming from the kidney said kidney stones are intensely painful, really, really painful. It's one of the few things that gives you sort of, you know, back pain type symptoms, it's usually sort of a little higher up in the back is not usually the low low back, but more sort of junction of middle and lower third of the bat. And often you get symptoms associated with urination. So sometimes you sort of you almost think you may have something like a quarter requirement, because the symptoms are partly usually related, as well as back pain, that's something that you'll certainly see from from time to time. If you look at the picture on the right hand side, I've put it in dotted lines, this large black thing, just lying to the left of the of the spinal column there. And that's an abdominal aortic aneurysm. And when they the be able to should be narrower than that. And when it swells up like that, it causes pressure that can often present as back pain. And so that's something that you'll come across from time to time.

Steven Bruce
I've known people in the past who said they could tell before they could palpate abdominal aortic aneurysm Is that likely, how easy is it to you can

Bob Chatterjee
but only when it's very big. So you can palpate it through through the front. And what you feel really you're feeling for a deep palpate a deep pulsation. So if it's very large, and when I'm saying very large, usually, you know, above eight to 10 centimeters, something like that, then if you if you palpate deep into the abdomen, you can feel that something was pulsing at you. In some ways. Some of this is historical, if you like this is the way I was taught. Sadly, I'm afraid to show my age a little bit but no, I was taught when half these investigations were that freely available. And therefore you really have to rely on your clinical skills as much as anything. I suspect that these days you know it history and scammers tend to have those but yes, you can't feel Thank you. Nick, I'm just gonna show you a few pictures. So this is a chest X ray. So this was a patient who's complaining of neck pain radiating over to the right, relative to the right shoulder and a little bit a little bit in this sort of upper arm and they had an MRI scan that showed irritation of the right seat for nerve root. And so I looked at it and thought oh well before never that goes to the sort of shoulder sort of what we call you know, regimental badge area on the side shoulder must must be see for nerve root irritation. So this was a mistake that if all you recognize is nails and everything is a nail and what I really need to do is think a bit outside the box. And I'm very glad that a very smart radiologist because I'd ordered a chest X ray as well because he had some some sort of coffee symptoms even though it wasn't quite my field. But if you look at the top of the picture here on the left hand side is you look at it can you see there's a capacity in the top that's that's a tumor of the lungs, quarter pancreas tumor, it's a little unusual because it just sits in the top of the lungs and it refers symptoms over to the shoulder and the neck area. to re read it right up into into the into the base of the neck so you don't see them very often fortunately, was a central

Steven Bruce
area normal Bob

Bob Chatterjee
and the central area of the Picture.

Steven Bruce
Yeah, there's a there's quite a sort of a circular opacity at the top of the thoracic right.

Bob Chatterjee
On the center, right? Yeah, that's the that's the knuckle of the aorta. It's a big

Steven Bruce
right. Oh, I see it's calcified. Yeah,

yeah, it's

Bob Chatterjee
just a bit castle gluttons for seeing it. So beware of lung tumors, okay with with sort of upper shoulder neck presentation. I don't know if anyone can see anything wrong with this. But I'll give some clues as we go along. So this patient had weird nerve symptoms that sort of work really typical of any particular nerve roots. It wasn't it was a bit of bit of sort of numbness everywhere of the legs, bit of pain, every bit of weakness in different areas. You know, sometimes when you're trying to get a diagnosis, you want to attribute it to one nerve root or something, you couldn't do that. But if you haven't played with him, and this is what's called a tethered cord, so if you remember, the cord requirement, usually sort of commences around about sort of L one l two region. So the sort of solid spinal cord then becomes just you know, the horse's tail, as we call it. But if you look here, can you see this is extending all the way down right down to the elbow is one area. So that's, that's a congenital failure of development of the spinal cord, and you get a whole weird, weird neurological symptoms with it. So sometimes when you look at the scan, just make sure that the cord recliner does finish where you think it finishes, and doesn't continue further on, on downwards. SI joint, it's like joint is the chameleon of the spine, as I call it, it mimics so many things, you know, it can it can mimic this prolapses facet joint problems, hip problems, it can radiate pain all the way down the leg. So, you know, it's I think it's one of those things that needs to be in your mind when you look at patients. And I think to be honest, doctors have been a bit slower at picking this up. I think the the new guys on the whole, but it's they're difficult to diagnose. We always like to have objective diagnosis, but the CT SPECT scan is probably the best method of diagnosis. If you look at this picture at the bottom, you see, can you see the left sacroiliac joint highlighted with with a with a red arrow there and that yellow highlighting that you don't see on the sacroiliac joint on the other side is typical of sacred joint. So often your plane Mr. Plane X ray, plain CT don't show an awful lot unless it's really bad. I mean, if it's really bad that it's eroded your sacred eyelid joint away, then that's different, you might see on some of those modalities, but if it's more like a biomechanical, overloading, CT SPECT scan is probably the better test to go for, although it's not that widely available.

I put this

Bob Chatterjee
this question this picture at rather, just to explain to someone that nerve roots really. So sometimes you get the wrong nerve itself. On this picture here, you can see what we talked about the sort of the lateral recess that so if you look at the blue arrows on the left hand picture, it says traversing l five nerve roots, so that is one area of compression, and we call that area, the lateral recess, or paracentral, if you like, but the nerve roots then travel laterally outward. So if you look at this sort of area where it says the neural foramen sort of almost guided by the sort of pink purple lines on that picture, so the nursery could be entrapped further

out.

Bob Chatterjee
And I've seen some operations unfortunately, done for the wrong nerve root. So the the L five nerve root sits in the lateral recess of the L four, five level, but it's the L for nerve root that's traveling out on the side where the purple arrow is. So if you look at the picture on the on the right hand side, so you see a sort of a sort of essentially disbarred it's affecting the lateral raises where the L five root is, but can you see that the black stuff also extends further over to where the where the purple designated area is on the other picture. So that's affecting l five and l for nerve roots. So you've got to be certainly you've got the right nerve that you're treating either with an injection or an operation because otherwise you, you may treat one that's asymptomatic, and we see quite a lot of those nerve root areas if you'd like to know which one to treat. This This picture shows what's called a facet joint cysts, I know your cyst. So if you look at the picture on the left hand side, you'll see these high white signals and the facet joints, a large cyst coming out on on the patient's right hand side, and that's pressing on their on their nerve that can cause similar symptoms to get that not be due to a prolapsed disc. So there are a few sort of weird and wonderful things that you you will see then and it's important just not to sort of miss that. Cardiac pain can often be confused with left sided arm pain if you like. Always think of the brain and make sure they haven't got things like multiple sclerosis. So if you see neurological signs that don't quite fit everything it may be due to problems coming from further up, and then we may be due to intrinsic pathology. And what I mean by that is that a lot of things that we treat about things pressing the nerve from the outside was actually they can be problems within the nerves themselves, or they can be tumors within the nerve, we talked a little bit about nerve sheath tumors already in terms of time obsessed, you get infections, and nerves and so forth. So it doesn't always have to be something pressing on on the outside. And I always say just always remember to examine the associated judgment, I think you guys are very good at and perhaps less so. So the neck problems can be from the scapular can be from the shoulder can be from the clavicle, problems in the low back coming from the sacroiliac joint can be from the hip, and can even be from from the knee on occasions. So there are a number of other other locations that might be causing your your symptoms. So that's really what all I wanted to say really, sort of about a separate just want to leave a little bit of time for questions, things, but just remember that still, for me, the history is the most important thing. It's that that's what raises your index

of suspicion about things and taking a detailed history. There's, there's that's the easiest thing to do ever, and we need to put time on to that called Aquinas as a clinical radiological diagnosis. Please do refer if you suspect and do document it that MRI is still the most useful way of diagnosing things, but you just have to remember that they're not. They're not infallible, and they have limitations. And don't forget to consider the rare causes, some of which I've sort of been through with you today. So I'll stop sharing my screen there. And

Steven Bruce
well, that's been great. Yeah, we've not gone through this presentation before, because we've always had so many questions. I've got three more on my feet. Yes. Pierre has said, Is there a time frame for decompression of a confirmed quarter recliner case? Nice case, nice guidelines suggest 48 hours? Is that still realistic?

Bob Chatterjee
No, we've changed a bit. So always be a little bit careful of nice guidelines. Okay. Nice. I've heard you say, again,

Steven Bruce
you're being diplomatic in the way you phrased it. Yes, I know.

What I mean,

Bob Chatterjee
nice, nice guidelines have to be delivered. So whenever you sit on the nice guideline committee, it's not always about what is the best thing for someone, but what you can deliver in the structure you have, which isn't quite the same thing. So I think it's quite interesting. If you ask any spinal surgeon, whether they would have this confirm cord recliner, decompressed to 36 hours or 48 hours, every single one of us with a 36 hours, time matters. And actually, although that used to be that sort of feeding, it could wait 248 hours and no longer. As I said, it's the one thing I really would do, even if it was midnight as

Steven Bruce
I would do it because time makes a big difference. Okay, this is a bit off topic. But Claire has asked whether, you know, if thermal imaging is used for diagnosis of injuries in humans, because it's apparently quite popular in animals,

Bob Chatterjee
thermal in thermal imaging, yeah, not quite, sort of hasn't really sort of gained a huge, all you can see with thermal imaging in humans really is you can you can see areas of relative high metabolism. Or sometimes you can see evidence of localized trauma because of the heat that's generated from it. So it's good at picking up inflammation and trauma, I suppose the problem that we have is, it doesn't tell you so much about what

causes it. And so it hasn't really gained an awful lot of popularity. I've seen it used in in sort of, sort of more sort of human location things in sort of, you know, mountain rescues and so forth. But that's not so much to do with treatment of the problem, but more more location of lots of people.

Steven Bruce
Final question, Robin says, Are there any tests or any other methods by which we can improve our diagnosis of kidney stones?

Bob Chatterjee
So, there are a few things to say so often, you will probably not so easy for you to do. And we often give them a shot of something called glucagon. And what it does is it significantly improves kidney stone pain, but it doesn't improve anything else. But obviously, you won't be able to get hold of that. In terms of the examination. What you tend to find is that they don't have any neurological issues a bit beyond the fact that they're not muscle water very well. They're actually more due to pain rather than anything else. There's a common phrase that they say that they often feel like they're they're passing water razor blades, it feels that that shot, be on painful. It's a deep seated, discovered really in the loins, and there usually isn't any specific areas of tenderness. So the examination is quite different, actually. Somebody's got musculoskeletal back pain, you'll find that you know, with muscle tissue back then you can put them in certain positions and it will ease off of your symptoms, whereas kidney pain is fairly unremitting. So they're different in many ways.

Steven Bruce
Well, thank you very much. We're slightly over time, and I'm very grateful to you for doing that. I think I dropped out in the middle of this. I thought it was your signal that had gone but I think I dropped out. I missed a little bit of what you said myself. I'll catch that up on the recording. Great to have you on the show. Hopefully, we'll get you on again. Future predicts in London, easily findable through the internet, but also we'll share that with the presentation for you after the show.