Spinal Injuries Notes

- The cervical spine is very mobile = 55% of spinal injuries are cervical
- Males > females
- C4 and above injury = phrenic N. injury causing respiratory depression
- The atlas does not have a body. The axis has an odontoid process (dens) which is held against the ant. arch of the atlas with the strong transverse ligament

Interspinous ligaments connect spinous

processes, whereas the supraspinous



Injury mechanism:

- Hyperflexion = wedge fractures or post. ligamentous injuries
- Hyperextension

ligaments connect their tips

- Compression (vertical force) = burst fractures
- Axial loading, direct injury
- Penetrating

Management in the field:

- 1- Immobilize
- 2- Check consciousness = if awake then keep immobilized, if not, patient might need CPR
- 3- Maintain active bleeding, BP, and oxygenation
- 4- Brief motor exam

• Management in the hospital:

- 1- Immobilization.
- 2- Systemic measures: CVS, RS, GIT, bladder and temp.
- **3-** Detailed neuro evaluation.
- 4- Radiological evaluation.
 - Most important and first Xray should be done for the thorax
 - AP/lateral = for any fractures or dislocations
 - Schwimmer's view = for C7-T1 (most imp.)
 - CT scan
 - MRI is done after admission to visualize soft tissue structures (disc prolapse, bleeding)
- **5-** Steroids; 5-10% get worse after arriving the E/R; due to edema, ischemia, or inadequate immobilization
- **6-** Spinal instrumentations
- 7- Rehabilitation

Classifications:

- Significance
- **1-** Minor = processes
- **2-** Major = body / dislocation
- Stability
- 1- Stable, e.g. wedge fracture
- 2- Unstable (injury to 2 columns), e.g. burst (ant, mid)

• Neural involvement

- **1-** Intact cord and roots
- 2- Damaged
 - a- Complete cord transection:
 - Quadriplegia with upper and lower extremity areflexia; anesthesia below the affected level.
 - Neurogenic shock (i.e. hypothermia + hypotension without compensatory tachycardia).
 - Loss of rectal and bladder sphincter tone.
 - Respiratory insufficiency: phrenic N. may be injured if the damage is at C4 or above.
 - b- Incomplete
 - Ant. spinal cord syndrome (caused by trauma or prolapse)
 - Post. spinal cord syndrome
 - Central spinal cord syndrome (most common):

In patients with cervical spondylosis who sustained a **severe hyperextension** injury: dissociated sensory loss (mostly pain and temp) and weakness more prominent in UL (cape-like)

- Brown-Sequard syndrome
- Cauda equina syndrome:

Only the cauda equina = polyradiculopathy with pain, radicular sensory changes, asymmetric LMN–type leg weakness, and then, sphincter disturbances.

Only the conus medullaris = early disturbance of bowel/bladder function first

- Complications:
 - Recurrent chest infections, DVT, UTI, urinary stones, hypoproteinemia, bed sores, depressions, painful spasms, contractures, dysreflexia, loss of temp. control.

Management as in the book:

Туре	Cause	Management
Stable, - Neuro deficits	 Spinous process Fx Transverse process Fx Wedge Fx <50% 	- Bed rest - Analgesia - Physiotherapy
Unstable, - Neuro deficits	 Cervical dislocation Wedge Fx >50% Including 2 columns 	- Reduction & maintenance (using screws)
Stable, + Neuro deficits	 Temporary dislocation Injury to spondylotic spine Bone or disc compression 	 Conservative first Cord damage = methylprednisolone IV High cervical injury = ventilation (tracheostomy) Urine retention = catheter DVT = pneumatic LL compression and anti-thrombotic Surgery in case of compression is detected or pt deteriorated due to edema or hematoma
Unstable, + Neuro deficits	-	 Same as above Surgery of reduction and maintenance