Leg Pain

Spinal Clinical Reasoning 2

Just physio.

Subjective Examination

HPC, PMH, Primary Symptom Driver, Aggs and Eases

PC

69 year old male presented with L buttock and leg pain. Pt attended the FCP clinic after being referred by GP

Primary Symptom Driver

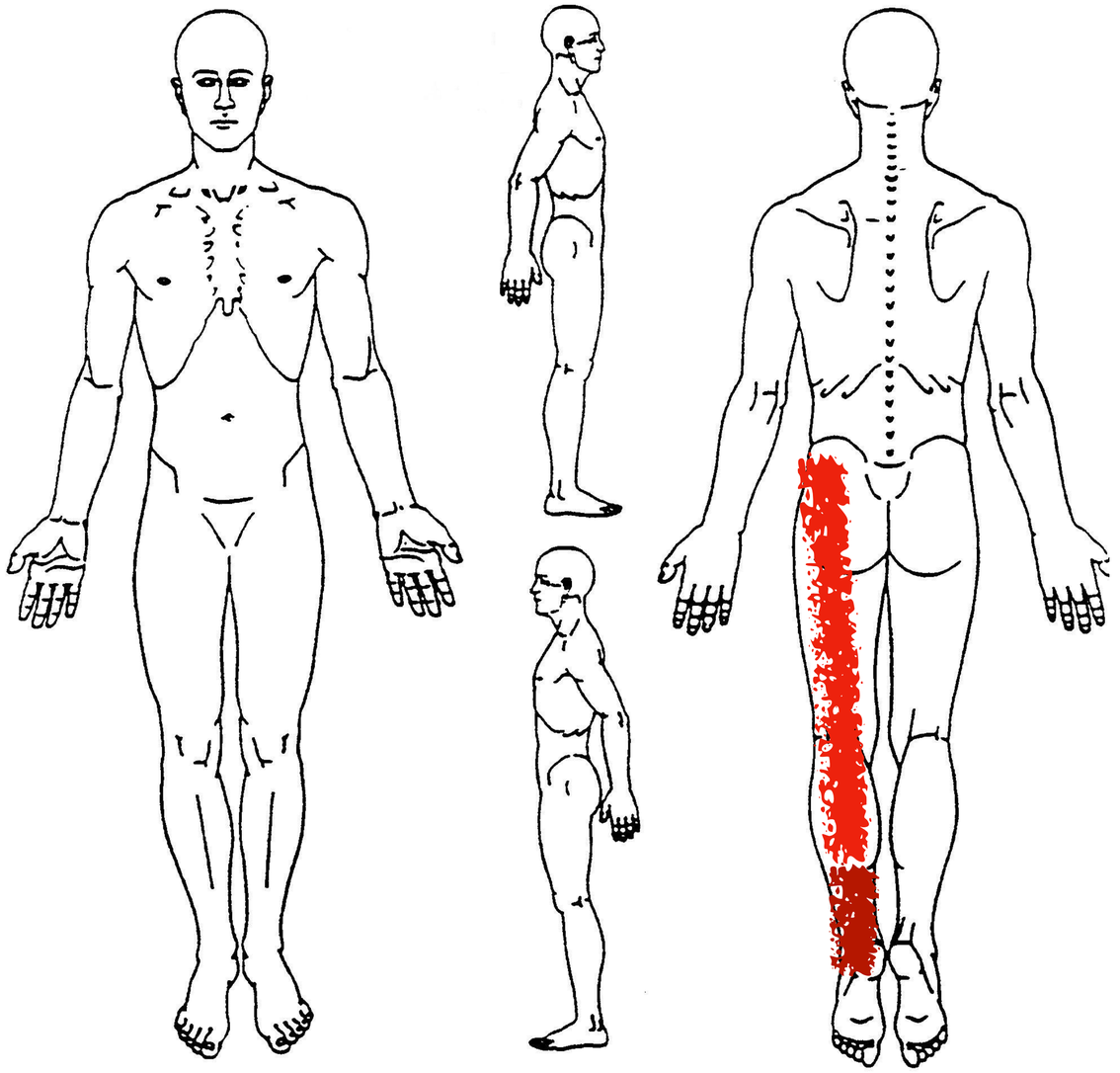
Pt mentioned that both buttock and leg are equally painful.

HPC

10 months ago, gradual onset of leg numbness. Numbness started after walking for 45 minutes with grandchildren. Nil falls/ trauma. Worsens 2 months ago where numbness starts after walking for 20 minutes. Spoke to GP and referred to FCP. Pt also reports bladder incontinence for the past month and did mention it to GP

Body Chart

- Red: Intermittent diffused burning pain on buttock. Intermittent numbness from buttock to ankle
- Maroon: Intermittent numbness but more intense. P&N
- Woken up by the numbness at night, usually 1st half of the night and able to sleep back after walking around.
- Slight stiffness in the morning but eases in 20 minutes after a warm bath



Subjective Examination continued…

Aggravating factors

Standing 5 minutes

Lying down for a few minutes

Walking after 20 minutes

Easing factors

Sitting for 15 minutes

Gabapentin

Cocodamol

Past Medical History

Previous angina

Previous colectomy 20 years ago

Total L Hip Replacement 3 years ago

Social History

Retired

Loves to walk

Lives with wife in a bungalow

Patient Belief and Expectation

Think there is something wrong with his prosthetic hip

What is your working diagnosis?

Questions to answer

Answer space on next slide

- Any further subjective questions?
- What test would you do to confirm/ refute your diagnosis?
- SIN levels?
- What are your working diagnosis?
- How did you come to that conclusion?
- What goals would you set for this patient?

State 3 working diagnosis and justify why

1.

Reason

2.

Reason

3.

Reason

Further Sub Q?

- _____
- _____

What test would you do to confirm/ refute your diagnosis?

- _____
- _____
- _____

SIN levels? Justify your answer.

_____

_____

Clinical Reasoning

Most likely diagnosis

Neurogenic claudication ?degenerative lumbar stenosis

Evidence from each section

PC

Age > 60 years old with complain of buttock and leg pain

HPC

Nil trauma or MOI

Red flag screening for CES is warranted with relatively recent bladder incontinence

Clinical Reasoning

Just physio.

Body Chart

Neurogenic claudication usually presents buttock pain and distal-to-proximal symptoms, with distal symptoms worse than proximal.

Quality of pain like burning, shooting pain and numbness increases the suspicion of neurogenic claudication rather than a vascular claudication

Early morning stiffness eases within 30 - 45 minutes reduces the suspicion of any inflammatory condition and might just indication degenerative changes.

Aggs and eases

Aggravating factors like extension-based movement ie lying and standing increases the suspicion of stenotic-related lumbar pathology. Flexion based movement (Shopping cart sign) as the easing factor also supports the working diagnosis of neurogenic claudication

Time to ease the symptoms is usually prolonged (>10minutes)

PMH

Nil

Further Reading

Articles, guidelines and further resource

- The reliability of differentiating neurogenic claudication from vascular claudication based on symptomatic presentation (Nadeau et al 2013)
- Spinal Stenosis And Neurogenic Claudication (Munakomi et al 2021)
- Current concepts and recent advances in understanding and managing lumbar spine stenosis (Bagley et al 2019)
- Lumbar spinal stenosis (Andaloro 2019)
- Nonoperative treatment for lumbar spinal stenosis with neurogenic claudication (Ammendolia et al 2013)
- Infographic. xercise for intermittent claudication (Tew et al 2020)