Degenerative cervical myelopathy

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What you need to know

Consider degenerative cervical myelopathy in patients over 50 with progressive neurological symptoms, such as pain and stiffness in the neck or limbs, imbalance, numbness, loss of dexterity, frequent falls, and/or incontinence

Perform a full neurological assessment as early symptoms are subtle and non-specific

A magnetic resonance imaging (MRI) scan is essential to detect degenerative changes in the cervical spine and cord compression

**Time is Spine:** Refer patients with suspected DCM promptly to a specialist for consideration of spinal surgery, as delayed diagnosis can lead to residual symptoms and functional disability

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A 54 year old man presents with neck stiffness for about a year. He complains of numbness in his fingers and difficulty buttoning up his shirt, which has not improved following surgery for carpal tunnel syndrome. Of late, he has experienced unsteadiness and has started to use a walking stick after sustaining falls. He sees a neurologist who identifies hyperreflexia in his arms and legs. An MRI scan shows multilevel cervical spondylosis and disc herniation causing cord compression. He is diagnosed with degenerative cervical myelopathy and referred to spinal surgery for operative decompression.

**What is degenerative cervical myelopathy?**

Degenerative cervical myelopathy (DCM), earlier referred to as cervical spondylotic myelopathy, involves spinal cord dysfunction from compression in the neck. Patients report neurological symptoms such as pain and numbness in limbs, poor coordination, imbalance, and bladder problems. Owing to its mobility, the vertebral column of the neck is particularly prone to degenerative changes such as disc herniation, ligament hypertrophy or ossification, and osteophyte formation. These changes are more common with age and are often collectively termed *spondylosis*.

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**Why is it missed?**

Non-specific and subtle early features that overlap with other neurological conditions can delay the diagnosis. Incomplete neurological assessment by professionals with a poor awareness of the disease further contributes to delay. A retrospective
study of medical records of 42 patients in Israel who underwent surgery for DCM noted an average delay of 2.2 years (range 1.7 months to 8.9 years) from initiation of symptoms to diagnosis. On average, 5.2 ±3.6 consultations were required before a diagnosis was made.\textsuperscript{10} Forty three per cent of these patients had symptoms of numbness and pain in hands, and were initially diagnosed and sometimes treated for carpal tunnel syndrome.\textsuperscript{10} In our clinical experience, the diagnosis of carpal tunnel syndrome, especially when diagnosed bilaterally, is often incorrect and DCM usually accounts for these symptoms.

**Why does this matter?**

Spinal cord compression results in progressive neurological decline and affects quality of life.\textsuperscript{12} Left untreated, it can lead to tetraplegia and wheelchair dependence (data on how many patients with DCM progress in this way are unavailable). Surgical decompression can halt the disease progression, however, the regenerative capacity of the spinal cord is limited and any damage is often permanent. Delayed treatment leads to poorer outcomes and lifelong disability. Findings from the AOSpine series (746 patients with DCM) indicate that treatment within six months of symptoms offers the best chance of recovery,\textsuperscript{13} but this time frame is some way from current average diagnosis times.\textsuperscript{10}

**How is it diagnosed?**

Detecting early DCM can be challenging. A high index of suspicion, alongside a comprehensive neurological examination is advised. Boxed Text on page 2

### Box 2

**Commonly reported symptoms and examination findings in DCM\textsuperscript{9}**

#### Symptoms

- Neck pain/stiffness
- Unilateral or bilateral limb/body pain
- Upper limb weakness, numbness, or loss of dexterity
- Lower limb stiffness, weakness, or sensory loss
- Paraesthesia (tingling or pins and needles sensations)
- Autonomic symptoms such as bowel or bladder incontinence, erectile dysfunction, or difficulty passing urine
- Imbalance/unsteadiness
- Falls

#### Examination findings

- Motor signs
  - Pyramidal weakness (Upper limb; extensors more than flexors. Lower limb: flexors more than extensors)
  - Limb hyperreflexia
  - Spasticity (eg, clasp knife sign)
  - Clonus, especially Achilles tendon
  - Hoffman’s sign (thumb adduction/flexion+/− finger flexion after forced flexion and sudden release of a finger, distally)
  - Babinski’s sign (upgoing plantar)
  - Segmental weakness (corresponding to the level of compression)
- Sensory loss (limb and/or trunk)
- Lhermitte’s sign (electric shock sensation down the spine, or into the limbs, on neck flexion or extension, present in severe cases)
- Gait disturbance

**Clinical**

Pain is a common reason to seek treatment. Musculoskeletal pain might be present in the neck, while neuropathic pain can affect upper and lower limbs and occasionally the trunk. Patients often report neck stiffness, at times without pain. A textbook case would describe gait dysfunction and bilateral hand impairment. Frequently not all symptoms are present. For example, pain might be absent and symptoms can be unilateral and vary in severity, even on a daily basis.\textsuperscript{9} Atypical symptoms such as headaches and muscle cramps are also reported.\textsuperscript{9}

The more consistent feature of DCM is the evolution of symptoms. Most patients describe symptoms that have been ongoing for months and getting worse.\textsuperscript{7} The rate of progression varies; in some individuals symptoms remain mild over extended periods of time, while in others disease progression accelerates. Functional decline can be insidious, and patients might mistakenly attribute these symptoms to “getting older.” Typical features include loss of dexterity (difficulty doing up buttons, using keys, mobile phones, or writing) or mobility (use of walking aids or frequent falls).

Symptoms might precede objective examination findings.\textsuperscript{9,14} As in focal central nervous system disorders, examination features in DCM have a low sensitivity—that is, a normal finding does not exclude the disease—but high specificity—that is, an abnormal finding is highly suggestive of the disease.\textsuperscript{9,14} Features can be mild and difficult to elicit in the initial stages of disease.
Investigations

Request an MRI scan of the cervical spine to detect cord compression (fig 1) in suspected DCM. An urgent MRI is required for patients with progressive disease and/or symptoms that substantially affect quality of life. In patients with mild symptoms, a non-urgent MRI might be requested. Bear in mind that the extent of spinal cord compression and signal changes in the cord on the MRI scan do not correlate well with the severity of symptoms. Even mild compression can account for severe disease.

The pathway to diagnosis varies depending on local services. In the UK, for example, many primary care physicians do not have direct access to MRI imaging and referral to neurology might be warranted.

How is it managed?

Often cord compression is an incidental finding and at least initially does not cause symptoms. Reassure the patient that no further management is required at this stage but advise them to report any symptoms promptly in the future.

Guidelines from AOSpine—an international community of spine surgeons advise that all patients with DCM should be assessed by a specialist surgeon, who might fall under the remit of neurosurgery or orthopaedics. The guidelines use the modified Japanese Orthopaedic Association score, which classifies patients as having mild or severe symptoms based on arm, leg, and bladder function. Surgery is recommended in patients with moderate or severe DCM and in those with disease progression. Treatment of symptoms (for pain, for example) and regular follow-up might be offered for patients with mild, stable DCM.

The AOSpine series showed that decompressive surgery can halt disease progression and enable meaningful, albeit limited, recovery across a range of measures including pain, function, and quality of life. The optimal timing of surgery is debatable because the progression of disease is poorly understood. Preoperative physiotherapy should only be advised by specialist services; neck manipulation is strictly contraindicated as it might cause further damage.

It is not possible to predict the long term outcome of surgery. Maximal recovery occurs at around 6-12 months. Residual symptoms beyond this are likely to be permanent and should be managed appropriately. Functional deficits are common, and include falls and reduced mobility, incontinence, depression, sleep deficits, and struggles with self-care, and often the most troublesome symptom is pain. Discuss with your patient that the complete resolution of pain is unlikely. Neuropathic analgesia and anti-spasticity medication can be offered to manage the pain. Early referral to specialist pain clinics is often helpful.

Ask patients to report any worsening or new symptoms or signs as untreated levels of the cervical spine might further degenerate and cause spinal cord compression.

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**Figure**

**Fig 1** Pathology of DCM. (A) Anatomy of an initially healthy spine (C2 level), with examples of the potential pathological changes that can occur and cause DCM (shown at lower spinal levels; C3-7). (B) Sagittal section from a T2-weighted MRI scan showing multilevel degenerative changes in the cervical spine. The spinal cord is compressed at C3/4 by a disc prolapse (white arrow) and at C5/6 by spondylosis, thickening of the posterior longitudinal ligament, and a disc-osteophyte complex (white star). However, this is not associated with high signal changes in the cord on MRI (Figure reproduced with permission from Michael G Fehlings, University of Toronto).