# Learning from Litigation:
# Cauda Equina Syndrome (CES) – 2nd Edition

This information is designed to provide CSP members with key messages that relate to high quality practice from an indemnity perspective, and to signpost members to more detailed resources. This page does not set out to be a definitive clinical guide to CES, or act as a guide for members on how to perform clinical examination and/or treatment.

This 2nd Edition updates the 1st edition of this CSP document which was published in 2014 and has now been archived.

**Background**

- The cauda equina comprises of the peripheral nerve roots that emerge from the spinal cord below L1.
- CES is challenging to diagnose and manage in a timely manner. Timely diagnosis is essential to avoid life-changing outcomes relating to ongoing bladder, bowel and sexual dysfunction.
- The incidence of CES in the UK is estimated to a complication in approximately 2% of all herniated discs.

**Diagnosis & Decision-Making**

- All patients presenting with low back pain +/- leg pain should have a detailed subjective examination of their clinical history. The timing of onset of symptoms is crucial information and must be clearly established through the subjective history to enable appropriate management planning.
- In all settings, if subjective symptoms of CES are identified a comprehensive neurological examination must be conducted which must include subjective questioning on saddle sensation.
- In secondary care settings, if subjective symptoms of CES are identified a comprehensive neurological examination must be conducted which must include saddle sensory testing and an examination of anal tone by digital rectal examination.
- Seeking the opinion of a more experienced clinician may be appropriate to determine if the clinical presentation requires emergency or urgent action.
- A diagnosis of CES cannot be confirmed without appropriate imaging examination that identifies nerve root compression.

**Clinical Challenge**

- Physiotherapists see many patients with back pain, a large number of whom may come directly to see a physiotherapist without seeing a doctor first. As autonomous and accountable diagnostic practitioners, physiotherapists of all levels of experience need to be able to identify those patients who need urgent medical review and act accordingly.

- Telephone triage must be able to highlight red flags. Timing is critical and in some circumstances emergency referral and management may be required on the basis of a subjective examination alone, particularly reports of altered saddle sensation +/- altered bladder control, rather than delay the onward management pathway.
- Documented examination needs to demonstrate a clinical reasoning and decision-making process [(1).]
- All clinicians must know their local referral pathways and, in an emergency, sending the patient immediately to A&E may be the most appropriate action.

**CES and Litigation**

- CES is one of the most litigious spinal conditions in the UK.
- Other differential diagnoses can have symptoms resembling CES red flags. Pain, medication and functional mechanisms of symptom production may also contribute to masquerading symptoms.
- Patients pursuing litigation claims may challenge what the clinical notes record, in particular that they under-record the actual presentation.
- The basis for the claim may be that the practitioner failed to: examine the patient properly; act on 'red flags' present, refer on or investigate with sufficient urgency.
- The extent of CES litigation involving physiotherapists is a highly stressful experience for those involved. Physiotherapists may be unprepared for being involved in litigation, unaware of the processes involved or who to go to for support [(2).]

**Key messages for members**

- Do a thorough clinically reasoned subjective and objective (physical) examination of the patient.
- Document carefully the actual time symptoms occurred / events happened.
- Record both positive AND negative neurological examination findings and clearly document this.
- Check your 'red flag' questions thoroughly.
- Provide clear safety-netting advice to patients at risk of CES and provide a CES card.
- Objective examination of saddle sensation +/- sphincter tone may be required depending on the clinical setting, undertaken by an appropriately trained clinician.
- Make sure you act on 'red flag' findings in a timely manner.
- Make sure you act to 'refer-on' immediately by phone to either a more senior colleague, a doctor or A&E if you have a suspicion a patient is presenting with CES. Timing is critical.

**References**


1. The Chartered Society of Physiotherapy. Record keeping guidance. https://www.csp.org.uk/publications/record-keeping-guidance [accessed 23 Feb 2023]

2. Yeowell, G, Leech, R, Greenhalgh, S, Selfe, J et al (2022) Medico-legal litigation of UK physiotherapists in relation to cauda equina syndrome: a multimethods study https://bmjopen.bmj.com/content/12/7/e060023 [accessed 23 Feb 2023]

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