# Cervical disc herniation classification

- Classification of endoscopic spine procedures
- Integrating multidimensional data analytics for precision diagnosis of chronic low back pain
- The Association of Modic Changes and Disc-Endplate-Bone Marrow Complex Classification in Patients With Cervical Degenerative Disc Disease
- The Impact of Proton Pump Inhibitor Use on Fusion Rates Following Single-level Anterior Cervical Discectomy and Fusion
- Anterior Cervical Discectomy and Fusion Associated with Increased Home Discharge Rates in Geriatric Patients with Cervical Disc Herniation Compared to Posterior Cervical Decompression and Fusion: A Propensity-Matched Analysis
- Exploration of the correlation between facet joints cross-sectional area asymmetry and cervical disc herniation
- Comparison of the Outcomes of Anterior Cervical Discectomy and Fusion and Cervical Disc Replacement for Cervical Disc Disease
- Incidence and risk factors of heterotopic ossification after cervical Baguera C disc arthroplasty

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Cervical disc herniation is divided into three types concerning the intraspinal location of the herniated mass: median, paramedian, and lateral herniations. Median herniation presses the spinal cord against the lamina and deforms it into a boomerang shape in a cross-section, thereby giving rise to myelopathy of the central cord syndrome or transverse lesion syndrome, according to Crandall's classification. Paramedian herniation presses the spinal cord unilaterally and deforms it into a comma shape. The symptoms and signs produced are not always those of the Brown-Sequard syndrome. Radiculopathy is produced by compression of a root in patients with a wide spinal canal in which the spinal cord is thereby able to avoid compression. Lateral herniation presses a nerve root at the anterolateral corner of the spinal canal to the inlet of the foramen, thereby giving rise to radiculopathy. Of our 202 patients with myelopathy, 36% had median herniation and 64% had paramedian herniation. Of our 24 patients with radiculopathy, 12% had paramedian herniation and 88% had lateral herniation. Other matters pertinent to the management of patients are described [1)].

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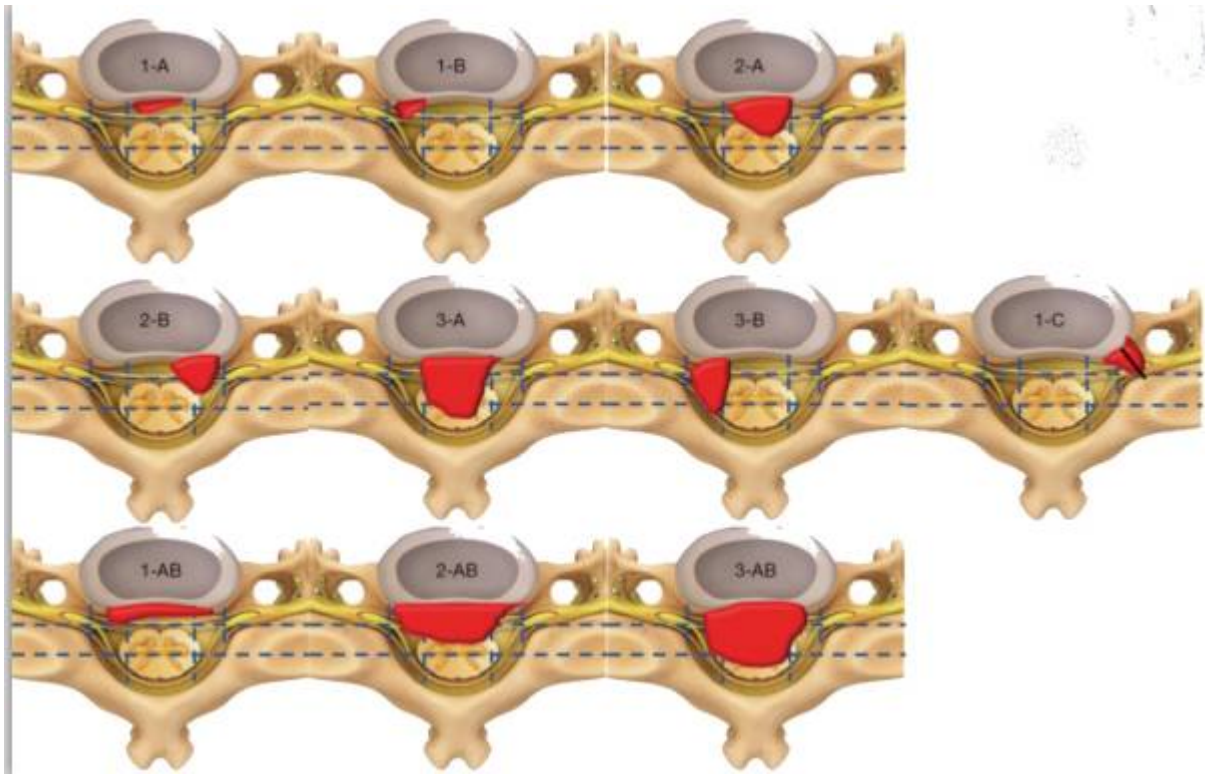


The foramen facet spinal (FFS) classification based on MRI Japanese Orthopedic Association (JOA) scores and the incidence of complications were evaluated and analyzed, and follow-up outcomes were assessed.

Results: Areas 2-A, 2-B, and 1-C had high motor function scores, areas 2-A, 3-A, and 2-AB had high sensory scores, but areas 3-AB and 3-A had low bladder function scores. Areas 3-AB had the most severe symptoms and the lowest scores. Area 1-C showed neurogenic abnormal sensation and higher visual analog scale (VAS) scores. A good/excellent outcome as indicated by the JOA score was 94.70% at 3 months and 92.35% at 1 year in 170 patients. The complication rate was 9.41%. The diagnostic coefficient of the FFS classification was 0.888, P<0.001.

Conclusions: The FFS classification is an objective scoring system that can be applied similarly by multiple examiners and is correlated with clinical symptoms. [2].

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Soft cervical disc herniation

Hard disc cervical disc herniation

High cervical disc herniation.

Traumatic cervical disc herniation

Cervical intradural disc herniation (IDH) is a rare condition with very few case reports in the literature.

All patients with a cervical IDH reported in the literature have a traumatic etiology.

Only one patient with a spontaneous cervical IDH has been reported [3].

C3-C4 cervical disc herniation

C4-C5 cervical disc herniation

C5-C6 cervical disc herniation

C6-C7 cervical disc herniation

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Rectification of physiological cervical lordosis. Osteophytic formations at the anterosuperior and anteroinferior margins of the vertebral bodies in the C3-C6 segment, as well as loss of signal on T2 of the discs in this segment related to degenerative disc dehydration. Level C2-C3: Mild diffuse disc bulge. Level C3-C4: Left paracentral and foraminal disc protrusion that impinges on the arachnoid space, causing mild canal stenosis (8mm) without signs of myelopathy, as well as mild left foraminal stenosis. Level C4-C5: Diffuse disc bulge causing mild canal stenosis (8mm) and slight biforaminal stenosis. Level C5-C6: Diffuse disc bulge impinging on the arachnoid space, resulting in moderate canal stenosis (6mm) without clear signs of myelopathy, and mild foraminal stenosis. Level C6-C7: Diffuse disc bulge impinging on the arachnoid space, causing moderate canal stenosis (6mm) without signs of myelopathy, and mild to moderate left foraminal stenosis. No morphological and/or signal intensity alterations at the bone level suggesting the presence of fracture or contusion foci are identified. No evidence of demyelinating spinal cord lesions. No pathological masses or collections are observed at the epidural or subdural level.

DIAGNOSTIC IMPRESSION: Mechanical changes in the C3-C6 segment and signs of disc dehydration. Multilevel diffuse disc bulges resulting in moderate canal stenosis from C5 to C7 without signs of myelopathy and mild to moderate foraminal stenosis (see study description).

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2)
Wang S, Zhao T, Han D, Zhou X, Wang Y, Zhao F, Shi J, Shi G. Classification of cervical disc herniation myelopathy or radiculopathy: a magnetic resonance imaging-based analysis. Quant Imaging Med Surg. 2023 Aug 1;13(8):4984-4994. doi: 10.21037/qims-22-1387. Epub 2023 May 29. PMID: 37581078; PMCID: PMC10423346.
3)
Warade AG, Misra BK. Spontaneous cervical intradural disc herniation. J Clin Neurosci. 2013 Aug 23. pii: S0967-5868(13)00448-7. doi: 10.1016/j.jocn.2013.06.011. [Epub ahead of print] PubMed PMID: 24210799.