# Spinal stenosis

- Wild-Type Transthyretin Amyloid Depositions in the Subcutaneous Fat and Skeletal Muscles of a Nonagenarian Who Had Heart Failure With Preserved Ejection Fraction and No Myocardial Technetium-99m-Labeled Pyrophosphate Uptake
- Clinical evaluation and finite element analysis of bone cement-augmented anterolateral screw fixation versus percutaneous bilateral pedicle screw fixation co-applied with oblique lumbar interbody fusion for single-level lumbar degenerative diseases with osteoporosis
- Laminectomy with fusion for cervical spondylotic myelopathy is associated with higher early morbidity and risk of perioperative complications compared with laminectomy alone: a retrospective study in the United States
- Positioning and clinical application of the inflection point of the uncinate process in anterior cervical discectomy and fusion (ACDF): a retrospective study
- Garré stricture: An unusual cause of intestinal obstruction: A case report
- Arterial and Venous Thromboembolism Associated With Whippet-Induced Vitamin B12 Deficiency
- Plantar Dermal Deposition of Wild-Type Transthyretin Amyloid (ATTR): A Case Report of a Unique and Challenging Histopathological Manifestation of Cutaneous ATTR Amyloidosis
- Thoracic anterior controllable antedisplacement fusion for thoracic ossification of the posterior longitudinal ligament: A case report

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Narrowing of the spinal canal or foramina is a common finding in spine imaging of the elderly.

## Epidemiology

Epidemiological data suggest an incidence of 1 case per 100 000 for cervical spine stenosis and 5 cases per 100 000 for lumbar spine stenosis. Cervical myelopathy in patients over 50 years of age is most commonly due to cervical spine stenosis. Symptomatic spinal narrowing can be congenital, or, more frequently, acquired. The latter may be the result of systemic illneses, namely endocrinopathies (such as Cushing disease or acromegaly), calcium metabolism disorders (including hyporarthyroidism and Paget disease), inflammatory diseases (such as rheumathoid arthritis) and infectious diseases. Physical examination is more often abnormal in cervical spondylotic myeloptahy whereas in lumbar spinal stenosis it is typically normal.

## Classification

see Cervical spinal stenosis

see Degenerative lumbar spinal stenosis

Foraminal stenosis

# Diagnosis

Only when symptoms of neurogenic claudication and/or cervical myelopathy are present is a spinal stenosis diagnosis made, either of the lumbar spine, cervical spine or both (only very rarely is the thoracic spine involved).

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Diagnosis relies on the clinical picture corresponding to conspicuous causative changes identified by imaging techniques, most importantly CT and MRI. Other ancillary diagnostic tests are more likely to be yielding for establishing a differential diagnosis, namely vascular claudication. Most patients have a progressive presentation and are offered non operative management as first treatment strategy.

# Treatment

Surgery is indicated for progressive intolerable symptoms or, more rarely, for the neurologically catastrophic initial presentations. Surgical strategy consists mainly of decompression (depending on the anatomical level and type of narrowing: laminectomy, foraminotomy, discectomy, corporectomy) with additional instrumentation should spinal stability and sagittal balance be at risk. For cervical spine stenosis the main objective of surgery is to halt disease progression. There is class 1b evidence that surgery is of benefit for lumbar stenosis at least in the short term [1)].

1)
Melancia JL, Francisco AF, Antunes JL. Spinal stenosis. Handb Clin Neurol. 2014;119:541-9. doi: 10.1016/B978-0-7020-4086-3.00035-7. PubMed PMID: 24365318.