



LUMBARSPONDYLOLYSIS: A REVIEW

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ABSTRACT

The main aim of the review was to provide knowledge in physiopathology, diagnosis and management of spondylolysis.

Spondylolysis represents a weakness or stress fracture in one of the bony bridges that connect the upper with the lower facet joints of the vertebra. It is the most common cause of low back pain in young athletes. One half of all paediatric and adolescent back pain in athletic patients is related to various disturbances in the posterior elements including spondylolysis. The most common clinical presentation of spondylolysis is low back pain.

This is aggravated by activity and is frequently accompanied by minimal or no physical findings. A pars stress fracture or early spondylolysis are common and a misdiagnosis is often made.

Plain radiography with posteroanterior (P - A), lateral and oblique views have proved very useful in the initial diagnostics of low back pain, but imaging studies such as Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scans are more sensitive in the establishment of the diagnosis.

Several treatment options are available. Surgical treatment is indicated only for symptomatic cases when conservative methods fail. The fact that early and multiple imaging studies may have a role in the diagnosis of pars lesions and the selection of the optimal treatment approaches is also highlighted. Hippokratia 2010; 14 (1): 17-21

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INTRODUCTION

Spondylolysis is generally defined as the defect in the pars interarticularis of the vertebral arch. It is the weakness or stress fracture in one of the bony bridges which connects the upper with the lower facet joints. This problem can be associated with lower back pain (LBP) or can be asymptomatic. 6% of populations have this kind of although the aetiology of this lesion is still unclear, it has been shown to have both hereditary and acquired risk factors, with an increased prevalence in men and athletes participating in certain high-risk sports. Spondylolysis is indeed, a common cause of low back pain in preadolescent and adolescent athletes (50%) and it particularly presents a clinical problem in this population. (2).

It occurs with higher frequency in people engaged in certain activities that appear to put unusual stress on their lower spine. Gymnasts, football linemen, weightlifters, wrestlers, dancers, and drivers are the most commonly affected individuals. However, primary care practitioners should be familiar with its frequency and the possibility of progression

from a pars interarticularis stress fracture to spondylolysis and/or to spondylolisthesis (3-5.) The vast majority of spondylolitic defects occur at the L5 level (85 - 95%), with L4 being the second most commonly involved level (5 - 15%) whereas higher lumbar areas are rarely affected. This defect is seen relatively often in plain radiographic studies with posteroanterior and lateral views, although dynamic and oblique views seem to determine the vertebral stability and lead to the diagnosis (7). Spondylolisthesis occurs in a significant proportion of individuals with bilateral spondylolysis.

It appears that approximately 50 - 81% of people suffering from spondylolysis have associated spondylolisthesis. This is defined as: the complete bilateral fractures of the pars interarticularis resulting in the anterior slippage of the vertebra. Predicting risk factors for progression of the slip to Spondylolisthesis has proven to be difficult (6,8). Unfortunately, since a misdiagnosis of spondylolysis is often made, an early recognition of this entity is essential. A complicating factor in the early stages of the disease that leads to a misdiagnosis is the fact that plain radiographs, even with oblique films, may not be helpful at the stress fracture stage. Other imaging techniques, such as bone scan possibly with single photon emission computed tomography (SPECT) or

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magnetic resonance image (MRI) should be used early in the diagnostic process. In the primary care setting, an early diagnosis of posterior element involvement related to low back pain either at the stage of pars stress fracture or early spondylolysis can prevent progression of the disease and obviate the need for an aggressive intervention of a more significant defect (9, 10).

Spondylolysis is broadly divided into 5 categories : they are dysplastic, isthmic, degenerative, traumatic, and pathological each of it representing distinct considerations and characteristics for all healthcare providers.(3,9,) .Dysplastic conditions involve congenital abnormalities (attenuated pars)isthmic conditions are lesions in the pars interarticularis resulting from stress fractures or acute fractures; - Degenerative conditions are related to segmental instability and alterations of the articular processes due to degeneration of the intervertebral discs; - traumatic spondylolysis results from acute fractures in various areas of the neural arch, other than the pars. Finally, pathological conditions involve various bone diseases, tumours or infections and their complications. (Table 1).

Type of spondylolysis	Pathogenesis
Dysplastic	Congenital abnormalities
Isthmic	Stress fractures in the pars interarticularis
Degenerative	Degeneration of the intervertebral discs
Traumatic	Acute fractures in areas other than pars
Pathological	Bone diseases, tumours or infections.

Clinical presentation

Most of the cases of spondylolysis are asymptomatic. They are often identified incidentally. The major complain of the individuals who are symptomatic is focal low back pain. This radiates into the buttock or proximal lower limb. The onset of pain is acute or gradual, after an intense athletic activity (lumbar spinal rotation or extension). Some patients may also report a recent or old history of local trauma. The pain is intense and restricts everyday activities. Symptoms typically worsen acutely after a particular stressful event(5,6,) Based on the pertinent literature, the only possible pathognomonic finding during physical examination, is the reproduction of pain by performing the one legged hyperextension manoeuvre (the patient stands on one leg and leans backwards). Interestingly, unilateral lesions often produce pain when standing on the ipsilateral leg (8,15)

Diagnosis

Radiographic studies and other more detailed imaging modalities assist in the diagnosis of spondylolysis. Several imaging modalities may play a role in the identification of a symptomatic pars lesion. The radiographic visualisation of a pars lesion is essential in establishing the diagnosis of symptomatic spondylolysis (17). Plain radiographs of the spine are always performed, in symptomatic spondylolysis or not, mainly to rule out underlying specific diagnosis and to describe degenerative spine changes. Plain radiographs with posteroanterior and lateral views are useful in the initial investigation of low back pain, whereas dynamic and oblique views help in the

determination of vertebral stability(18,19) According to different studies, about 20% of pars defects seen on plain radiographs can be identified on oblique views only6. A common term used for the diagnostic description of the neural arch region defect, is the visualisation of “the collar on the Scottie dog”. The collar indicates the non displaced fracture of the pars interarticularis (6,17,) In the past, most studies have used plain conventional x-rays as the only diagnostic method to determine spondylolysis. It should be noted however that they represented an important diagnostic tool for a long time since the defect in isthmic spondylolysis is visualised as a lucency in the pars interarticularis (5). Standard radiographic examinations are still helpful in the diagnosis.

They can predict what the prognosis will be in terms of the evolution defect and more importantly indicate what treatment should be applied, according to the degree of the slippage, the slip angle etc. On the other hand, the most significant limitation of plain radiographs is the lack of orientation from the plane of the defect (5,15)

Over the past decades, other imaging modalities have been increasingly used for diagnosing of spondylolysis. These include the Computed Tomography (CT) scan, the Single Photon Emission Computed Tomography (SPECT) and the magnetic Resonance Imaging (MRI) 20. All the above methods have proven to be more sensitive, in identifying pars lesions allowing more complicated angles to be taken to accommodate the complex structure of the lower spine. These techniques can definitely lead with more accuracy to the diagnosis of spondylolysis. A bone scan is useful in the early stages of spondylolysis. In some studies, though, in early spondylolysis, changes in the MRI signal intensity in the pars interarticularis may be detected, even before fracture lines are visible on plain radiographs. Nevertheless, further studies are needed to validate MRI as the imaging modality of choice for the early diagnosis of spondylolysis. Although, the CT scan and in particular high definition multislice devices is the most accurate examination, MRI has also become an indispensable diagnostic tool6. At MRI, most of degenerative disc abnormalities are non-specific and are frequently found in the asymptomatic subjects. On fat-suppressed T2WI images, the presence of oedema in the end-plates in case of degenerative disc disease and in the posterior arches when facet arthropathy and spondylolysis are present is well-correlated to LBP. Such visualised oedema may be useful to direct the treatment approach in these patients. (19, 21). According to the pertinent literature, CT best demonstrates fracture size and extent, and is the most appropriate modality for the follow-up as a baseline for assessment of healing. MRI is limited in its ability to fully depict the cortical integrity of incomplete fractures in the pars interarticularis, but the presence of marrow oedema on fat-saturated T2-weighted sequences is a useful sign for diagnosing acute spondylolysis (9, 10)

Treatment

The lack of large controlled clinical trials focused on the diagnosis and management of spondylolysis renders the establishment of an optimal treatment algorithm difficult. Recent advances in imaging technology have proven to be useful in the diagnosis and the follow – up in symptomatic patients11. Conservative methods should be applied to all affected individuals. In fact, most symptomatic cases do well

with conservative care. Many pars lesions may heal if managed conservatively, particularly those with early stage defects. According to the classification of Standaert and Herring, pars lesions are divided in early, progressive and terminal stages. The likelihood to heal is much higher in early stage lesions with very few changes of healing or no healing in terminal stages (9,17,)

Pharmacological intervention includes the application of pain relief medications. The nonsteroidal anti – inflammatory drugs (NSAIDs) should not be ordinarily used because they slow down the bone growth and healing. If the patient is osteoporotic or osteopenic, alendronate sodium is a pharmacological alternative (6,15). Once pain levels are controlled, pulsed ultrasound and therapeutic isometric contractions of surrounding musculature may be initiated to promote additional blood flow, by increasing collagen, neovascular and myofibroblast production in the injured lesion. Through this way, the healing process is also facilitates. Moreover, the use of electrical bone stimulators (internals or externals) seems to promote healing (19,23,)

Surgical treatment is used only for symptomatic cases were all conservative methods failed to show any effect. Approximately 9-15% of cases of symptomatic spondylolysis undergo surgery. The main indications include intractable pain, progressive slip, development of neurological deficits and segmental spine instability. Surgical procedures typically attempt a direct repair of the pars which is sometimes accompanied by a fusion procedure. Specific surgical techniques, such as translaminar screw fixation, cerclage wiring loop and pediculolaminar hook screws, preserve segmental motion by repairing the isthmic defect (24). Although treating spondylolysis may seem complicated, an uneventful outcome may be experienced. Rehabilitation programmes are strongly recommended for symptomatic and post - surgical patients. It is imperative these programmes to be guided by patients' pain and tolerance and their objectives to be the promotion of bone healing, the relief of pain and the optimization of physical function (25-27)

CONCLUSIONS

So I can conclude that a prompt diagnosis is very important of symptomatic Spondylolysis so that disease can be treated properly. The clinical status and the results of diagnostic methods should be taken into consideration and then the treatment of spondylolysis must be done. The management guidelines have remained largely unchanged since earlier recommendations. Most cases are managed conservatively with success. However in special occasions surgery is indicated. The introduction of a bone growth stimulator in the management of challenging cases is promising for the future of this entity.

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