

Spine injury, with or without neurological deficits, must always be considered in patients with multiple injuries. Approximately 5% of patients with brain injury have an associated spinal injury, whereas 25% of patients with spinal injury have at least a mild brain injury. Approximately 55% of spinal injuries occur in the cervical region, 15% in the thoracic region, 15% at the thoracolumbar junction, and 15% in the lumbosacral area. Up to 10% of patients with a cervical spine fracture have a second, noncontiguous vertebral column fracture.

In patients with potential spine injuries, excessive manipulation and inadequate restriction of spinal motion can cause additional neurological damage and worsen the patient's outcome. At least 5% of patients with spine injury experience the onset of neurological symptoms or a worsening of preexisting symptoms after reaching the emergency department (ED). These complications are typically due to ischemia or progression of spinal cord edema, but they can also result from excessive movement of the spine. If the patient's spine is protected, evaluation of the spine and exclusion of spinal injury can be safely deferred, especially in the presence of systemic instability, such as hypotension and respiratory inadequacy. Spinal protection does not require patients to spend hours on a long spine board; lying supine on a firm surface and utilizing spinal precautions when moving is sufficient.

Excluding the presence of a spinal injury can be straightforward in patients without neurological deficit, pain or tenderness along the spine, evidence of intoxication, or additional painful injuries. In this case, the absence of pain or tenderness along the spine virtually excludes the presence of a significant spinal injury. The possibility of cervical spine injuries may be eliminated based on clinical tools, described later in this chapter.

However, in other patients, such as those who are comatose or have a depressed level of consciousness, the process of evaluating for spine injury is more complicated. In this case, the clinician needs to obtain the appropriate radiographic imaging to exclude a spinal injury. If the images are inconclusive, restrict motion of the spine until further testing can be performed. Remember, the presence of a cervical collar and backboard can provide a false sense of security that movement of the spine is restricted. If the patient is not correctly secured to the board and the collar is not properly fitted, motion is still possible.

Although the dangers of excessive spinal motion have been well documented, prolonged positioning of patients on a hard backboard and with a hard cervical collar (c-collar) can also be hazardous. In addition to causing severe discomfort in conscious patients, serious decubitus ulcers can form, and respiratory compromise

can result from prolonged use. Therefore, long backboards should be used only during patient transportation, and every effort should be made to remove patients from spine boards as quickly as possible.

▶ ANATOMY AND PHYSIOLOGY

The following review of the anatomy and physiology of the spine and spinal cord includes the spinal column, spinal cord anatomy, dermatomes, myotomes, the differences between neurogenic and spinal shock, and the effects of spine injury on other organ systems.

SPINAL COLUMN

The spinal column consists of 7 cervical, 12 thoracic, and 5 lumbar vertebrae, as well as the sacrum and coccyx (■ **FIGURE 7-1**). The typical vertebra consists of an anteriorly placed vertebral body, which forms part of the main weight-bearing column. The vertebral bodies are separated by intervertebral disks that are held together anteriorly and posteriorly by the anterior and posterior longitudinal ligaments, respectively. Posterolaterally, two pedicles form the pillars on which the roof of the vertebral canal (i.e., the lamina) rests. The facet joints, interspinous ligaments, and paraspinal muscles all contribute to spine stability.

The cervical spine, because of its mobility and exposure, is the most vulnerable part of the spine to injury. The cervical canal is wide from the foramen magnum to the lower part of C2. Most patients with injuries at this level who survive are neurologically intact on arrival to the hospital. However, approximately one-third of patients with upper cervical spine injuries (i.e., injury above C3) die at the scene from apnea caused by loss of central innervation of the phrenic nerves. Below the level of C3, the spinal canal diameter is much smaller relative to the spinal cord diameter, and vertebral column injuries are much more likely to cause spinal cord injuries.

A child's cervical spine is markedly different from that of an adult's until approximately 8 years of age. These differences include more flexible joint capsules and interspinous ligaments, as well as flat facet joints and vertebral bodies that are wedged anteriorly and tend to slide forward with flexion. The differences decline steadily until approximately age 12, when the cervical spine is more similar to an adult's. (See Chapter 10: Pediatric Trauma.)

Thoracic spine mobility is much more restricted than cervical spine mobility, and the thoracic spine has additional support from the rib cage. Hence, the

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