Matters arising

Cervical mobility in the production of spondylotic myelopathy

Sir: The paramount importance of mobility of the cervical spine as a factor in the causation of spondylotic myelopathy has been clearly brought out in the article on this subject by Barnes and Saunders.¹ The existence of even marked narrowing of the spinal canal does not seem by itself to be necessarily associated with progressive clinical deterioration.

Their findings were the result of careful assessment of degrees of reduction in canal diameter related to the range of flexion and extension of the neck. I would like to recall that similar conclusions, although not evaluated quantitatively were drawn some years ago as a result of observations during myelographic studies in such patients.² We often found that although there was an apparent free flow rostrally of contrast medium through the cervical canal with the neck in flexion or in a neutral position, complete myelographic block could be obtained at the level of the spondylotic ridge if the neck was then retroflexed. We were also able to confirm previous related observations,³ namely the production of manometric block by employing the same manoeuvre during lumbar puncture.

Your contributors refer to theories of pathogenesis based on interference with blood supply⁴ and perhaps these would fit in well with the above observations pointing to the effect of spinal mobility, possibly due to intermittent compression of the anterior spinal artery.

Incidentally all investigators accustomed to following the upward flow of contrast material during cervical myelography are frequently impressed by evidence of gross concomitant osteophytic indentation of the column in the lumbar area, in patients who have no related neurological symptoms or signs. It may well be that this apparent anomaly also is related to the range of local spinal mobility.

References

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