



Cauda Equina

Physiology:

The anatomical location of the cauda equina is distal to the cord and conus. Therefore, the pattern of injury can be very variable. The neuro urology is classified as either suprasacral or sacral depending on the severity of the injury, however complete sacral injuries are rare. The most common cause is a disc prolapse. Bladders can be reflexic or areflexic and the sphincter may or may not be functioning. Bladder overactivity, poor bladder emptying and urethral sphincter incompetence are common although any combination occurs. Do not assume compliance will be normal as sympathetic input may be affected. This is particularly important of stress incontinence procedure is offered

Management:

Patients with urinary symptoms secondary to damage to the cauda equina area of the spinal cord should be attached to their regional spinal unit. (LINK GIRFT cauda document). Spinal units should have appropriate bladder bowel and sexual dysfunction services for cauda equina patients so please contact your regional unit. However, this may not always be easy to access so please do the simple things to manage these patients optimally particularly if they have a urethral catheter in situ. The Spinal injuries association will be able to direct any queries about where services can be assessed, and they now encompass the cauda equina charity (<https://spinal.co.uk>) Assess bladder emptying and institute ISC if necessary. If an indwelling catheter is the only option, then consider insertion of suprapubic catheter as early as possible. Patients with cauda equina often have poor or no sensation around the perineal area so may not feel a urethral catheter increasing the likelihood of urethra damage which needs to be avoided.

Investigations:

Renal US and UE should be done as at baseline.

Video urodynamics will be necessary if there is ongoing urological problems in the longer term and if urological surgical intervention is required.

Overactive bladder symptoms should be managed down the standard pathway. If Botox is offered and they are not already doing ISC there is likely to be a higher chance of retention than in the non-neuropath so teach them

Bowel issues are a particular problem in this group, and they will need help



The British Association
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Special Considerations

These patients are spinally injured so should have the input from the cauda service of their spinal unit.

Pain and uncomfortable feelings in the perineal area can be very unpleasant. Feelings that there is something in the vagina or rectum can be neurological in origin so extreme caution managing what is considered to be a symptomatic prolapse. Only operate if there is an anatomical reason to do so

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