Conference
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Title
Incomplete Spinal Cord Injury Missed at Initial Inpatient Evaluation and Diagnosed During Routine Physiatry Consult

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Case Diagnosis
Traumatic incomplete spinal cord injury with C3-5 myelomalacia

Case Description
A 72-year-old male presented to the hospital with altered mental status secondary to benzodiazepine withdrawal. Physiatry was consulted for rehabilitation evaluation.

Previously independent, he had a significant decline in mobility and activities of daily living (ADLs) since a motor vehicle crash (MVC) 5 months prior. Initial evaluation after MVC only revealed a left humeral head fracture, and he was discharged home but was quickly readmitted due to inability to ambulate, urinary retention, L4 fracture and small bowel obstruction. He was transferred to subacute rehabilitation where he made little progress, requiring assistance for all mobility and ADLs.

On exam, the patient had weakness on elbow extension and finger abduction, hyperreflexia, hypophonia, bilateral intrinsic hand muscle wasting, retropulsion, and poor truncal balance concerning for C-spine pathology. C-spine MRI revealed severe cervical stenosis from C3-5 with cord signal changes. The patient underwent C3-C5 posterior cervical decompression and fusion.

Discussion
Due to a missed diagnosis at initial assessment after his MVC, multiple preventable acute hospital and rehabilitation facility admissions ensued in subsequent months. Five months later, on routine consultation a physiatrist identified a suspected incomplete cervical spinal cord injury. After undergoing cervical decompression and extensive rehabilitation, he made a dramatic improvement and is now independent with mobility and ADLs.

Conclusions
Extensive history and physical exam are crucial in recognizing undiagnosed incomplete spinal cord injuries. When a patient is not progressing as expected following an injury, it is necessary to assimilate all clinical information in order to identify potential missed diagnoses.