Single photon emission computed tomodraphy (SPECT) scanning for adolescent back pain. A sine qua non?

Malcolm T. F. Read MA MRCGP
60 Woodbridge Road, Guildford, Surrey, UK and London Bridge Clinic, London, UK

Nine cases of adolescent back pain show that a diagnosis of spondylolysis cannot be made on physical examination alone and that single photon emission computed tomography (SPECT) scanning revealed pars interarticularis stress lesions undiagnosable on planar technetium-99 bone scan. As management of spondylolysis differs from other lumbar dysfunctional problems SPECT scanning of children should be a sine qua non in extension related back pain with a normal radiograph and planar bone scintigraphy.

Keywords: SPECT, single photon emission computed tomography, bone scan, children, adolescent, spondylolysis, back pain

Results
Apart from case 2, who was pain free until ‘demon’ fast bowling, all cases had extension related back pain. Case 5 had sclerosis of the right pedicle on radiography. ‘Specific tests’ such as the spondylolysis swing and Fitch catch were not pathognomonic for spondylolysis but did increase extension pain. All cases had negative PBS but five cases had a positive lesion on SPECT scanning that would fit with a pars interarticularis stress lesion.

Management
To reduce the amount of radiation the patients were not radiographed (unless previously investigated) and went straight to SPECT scanning. Those cases with a negative SPECT scan were treated actively with manipulation, mobilization and short wave/interferential diathermy and returned to activities within 2–4 weeks.

Because it was felt that active mobilization might make the stress lesion worse, the SPECT positive cases were rested from sport until pain free daily living was established and then returned to sport without extension elements: bat, slow bowl, field for cricket; ground strokes and volley for tennis; pommel horse, balancing and conditioning for gymnastics. Extension manoeuvres were gradually introduced, but the number of repetitions of these elements was limited, i.e. one fast ball per over, 40 overs per week.

Discussion
Fredrickson et al. reported a 4.4% incidence of spondylolysis in 5-year-old children and perhaps adolescents doing extension and rotation related sports should have pre-participation screening for pars interarticularis lesions and spina bifida with its increased incidence of pars lesions. Weber and Woodall in their review of the literature suggested that gymnasts present with reliable signs, especially pain on the one legged hyperextension test (spondylolysis swing), but the cases presented here indicate that this test and other recommended tests are not specific for spondylolysis. One cannot, for clinical management’s sake, assume that all extension pains are from spondylolysis as manipulative treatment of
the facet joint may be rapidly curative and the child returned early to sport. Equally, manipulation may convert the stress related pars defect into a frank fracture, and too early a return to sport may create an unstable spondylolisthesis, which can affect the child for life. This paper and others' show that in extension related vertebral pain the SPECT scan is the most sensitive indicator of bony stress lesions. Bellah et al. recommend SPECT scanning in adolescent back pain but this paper suggests that SPECT scanning should be a sine qua non in extension vertebral back pain with negative radiograph obliques and PBS, and if used as a first line investigation would reduce radiation.

References

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