evidence based guidelines

VERTEBRAL COMPRESSION FRACTURES

Diagnosis

Signs and symptoms

2/3 of vertebral compression fractures are silent or occur chronically
- Often found incidentally on another imaging study
- Clinical exam may suggest loss of height, thoracic kyphosis, or gradual neurologic compromise

Pain can be either sharp or dull and is usually centralized (T8-L4) but may refer laterally
Pain is often worse while upright and reduced when reclined
Movement and changes in position worsen the pain
Percussion over spinous process may elicit localized pain

Imaging

Begin with plain film X-ray
Pursue MRI, CT, and/or bone scan for atypical cases
- Concern for cancer (abnormal labs, weight loss, atypical fracture pattern)
- Patient is at low risk for osteoporosis (esp. young age)
- Presence of neurologic symptoms (may suggest spinal canal compromise)
- Symptoms not improving as expected

Acute Treatment

Low to Moderate pain:

Acetaminophen and Non-steroidal anti-inflammatories
Topical lidocaine patches
Nasal calcitonin
Physical therapy

Severe pain: (unable to participate in PT or remain upright for most of the day)

Consider risks/benefits of opiate use – See "Pain Management" guideline
Consider Percutaneous Vertebral Augmentation (Vertebroplasty, Kyphoplasty, etc)
- Will need MRI or SPECT scan to assess acuity and anatomy
- Hold anti-coagulants using "Spinal anesthesia" column on "Management of Anticoagulants – Interruption for Elective Surgery" guideline.
- Contact any of the following providers: Dr. Easa, Brain + Spine, Michigan Pain Consultants, Shoreline Orthopaedics

Chronic Treatment

Treat pain using "Pain Management" guideline

If low-impact fracture (fall from stand) in a post-menopausal woman or man ≥ 50yo

Obtain Bone Mineral Density
Consider work-up for secondary causes of osteoporosis
Initiate medical management for osteoporosis <u>(even if BMD is NOT ≤ -2.5)</u>
- See "Osteoporosis Fracture Prevention" guideline

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