Thoracic spine fracture

The spine is composed of small bones (vertebrae) stacked on top of each other, creating the natural curves of the back. Among the vertebrae are flat, round and rubber-eraser pads (intervertebral discs) that act as shock absorbers and allow the back to flex or bend. Muscles and ligaments that connect the vertebrae allow movement, providing support and stability to the spine and upper body. Each vertebra has an opening (forame) in the center and these align to form the spinal canal. Protected by vertebrae, spinal cord and other nerve roots travel through the spinal canal. Nerves branch out of the spine through vertebral openings, carrying messages between the brain and muscles. The facet joints align at the back of the spine, joining the vertebrae and allowing rotation and movement. Like all joints, cartilage covers the surface where the facet joints meet. The spine contains three segments: lumbar, thoracic and cervical. The lumbar spine consists of five vertebrae located in the lower back; Lumbar vertebrae are larger because they carry more of the body weight. The thoracic spine consists of 12 vertebrae and begins in the upper thorax, extending to the middle back wards and connecting to the rib cage. The cervical spine includes the neck and consists of seven small vertebrae, starting at the base of the skull and ending in the upper thorax. The discs in the lumbar spine are composed of a thick outer cartilage ring (annulus) and an internal gel-like substance (nucleus). In the cervical spine, the discs are similar but smaller in size. Description The most common spinal fractures occur in the thoracic (midback) and lumbar (lumbar) spines, or where the two connect (thoracic junction). A spinal fracture is a serious injury, typically caused by a car accident, fall from height or another high-speed accident. The energy required to severely fracture the spine can also cause spinal cord injury or other damage that requires additional treatment. Men experience fractures in the thoracic or lumbar spine four times more often than women, and the elderly who have the bone weakened due to osteoporosis are also at greater risk. Causes Chest and lumbar spine fractures are commonly caused by high-energy trauma, such as a car accident, high-rise fall, sports accident, or a violent act, such as a gunshot wound. Osteoporosis, tumors or other underlying conditions that weaken the bone can also cause fracture of a vertebra, even during normal and daily activities. There are several types of thoracic and lumbar fractures, and the classification is based on the pattern of injury and whether the spinal cord has also been injured. Identifying the type of fracture can help the doctor determine the most Symptoms The primary symptom of chest and lumbar fracture is moderate to severe back pain that worsens with movement. If the spinal cord is involved, numbness, tingling, weakness or dysfunction may also occur. After a high-energy trauma (such as a car accident), the patient may have a brain injury and experience loss of consciousness, and in some cases, back pain can be burdened by the pain of other injuries (disturbing injuries). In these cases, first responders should proceed under the assumption that a fracture in the spine is present. Emergency stabilization During initial evaluation, it may be difficult to assess the extent of lesions in patients with fractures in the thoracic and lumbar spine. At the crash site, EMS first responders will determine whether the patient is conscious and check for vital signs, including heart rate and breathing ability. Once stabilized, bleeding and injuries requiring immediate attention will be addressed. The patient should be immobilized on a cervical collar (neck) and backboard before being transported to the hospital emergency room, where a full evaluation will be performed. Diagnosis An emergency room doctor will perform a thorough examination of the head, chest, abdomen, pelvis, limbs and spine. The neurological state will be determined by evaluating the patient's ability to move, feel and feel the position of all limbs, and testing the patient's reflexes will help determine if there has been any spinal cord injury or individual nerves. After physical examination, a radiological evaluation is required. Depending on the extent of the lesions, this may include X-rays, CT scan, and multiple-area MRI, including the thoracic and lumbar spine. Once all other fatal injuries have been stabilized, the doctor will identify the fracture pattern and determine the appropriate treatment plan. What is the best treatment and whether surgery is required will depend on the fracture pattern and the treatment required for any other injuries suffered. Compression fracture of the flexion fracture pattern — While the front (anterior) of the vertebra breaks and loses height, the back (posterior) does not; is usually stable and rarely associated with neurological problems. Axial rupture fracture — The vertebra loses height on both the front and rear sides; it is often caused by a fall from a height and landing on the feet. Non-surgical treatment — Most flexion lesions can be treated with or without a brace and activity modification for 6 to 12 weeks. By gradually increasing physical activity and doing rehabilitation exercises, most patients avoid post-injury problems. Surgery — Surgery is typically necessary for unstable fractures that have: significant comminution (fracture fragments); severe loss of vertebral body height; excessive forward bending or angulation at the site of the injury; or significant nerve injury due to parts of the vertebral body or disc pinching the spinal cord. Surgical treatment should include decompression (laminectomy) of the to remove remove or other structures pressing on the spinal cord and stabilization of the fracture. Flexion/distraction fracture of extension fracture pattern (chance) — The vertebra is literally separated (distraction); this can occur in accidents such as a head-on collision, where the upper body is thrown forward while the pelvis is stabilized by a seat belt. Treatment will depend on where the spine fails and whether or not the bones can be reinserted (reduction) using a strap or plaster. Non-surgical treatment — Extension fractures that occur only through the vertebral body can usually be treated nonurgically; these should remain in a brace or cast for 12 weeks, under close observation. Surgery — If there is an injury to the posterior ligaments (back) of the spine, surgery is typically necessary. If the fracture falls through the spinal discs, surgery will be required to stabilize it. Fracture of the standard transverse rotation fracture process — This unusual fracture that generally does not affect stability; rotation or extreme (lateral) curves. Fracture-dislocation — This can be an extremely unstable lesion involving bone and/or soft tissue in which a vertebra can move from an adjacent (displaced) vertebra as a result of high-energy trauma. These injuries often cause serious damage to the spinal cord or nerves. Non-surgical treatment — transverse process fractures are treated predominantly using a gradual increase in movement, with or without bracing, based on the level of comfort. Surgery — Fractures to the thoracic and lumbar spine require stabilization through surgery. The optimal timing of these surgeries is often complicated and can be postponed because of other serious and life-threatening injuries. Surgical Procedure The ultimate goal of surgical treatment for fracture of the thoracic and lumbar spine is to achieve adequate reduction (fit the bones, relieve pressure on the spinal cord and nerves, and allow early movement. Stabilizing the column may require the use of devices such as metal screws, rods, and cages. During surgery, the surgeon may use an anterior (frontal), lateral (lateral) or posterior (back) or a combination of the three, depending on what is most appropriate for his fracture pattern and individual situation. Complications There are several complications associated with fractures of the thoracic and lumbar spine, including pneumonia and pressure wounds. Among the most serious complications is a blood clot that develops in the legs due to the immobility of the patient. These clots can travel to the lungs, resulting in death (pulmonary embolism). Complications can be reduced by early treatment, mechanical methods (compression stockings in the lower leg) and medications to protect against clots, as well as appropriate surgical techniques and postoperative programs. surgical — As with any surgery, there are some risks, and these vary from person to person. Many are small treatable and unlikely to affect their final Specific complications for surgical treatment for fractures of the thoracic and lumbar spine, including: bleeding, infection, spinal fluid leaks, instrument failure, and non-fracture union. Discuss possible complications with your surgeon before surgery. In general, elderly patients have higher rates of surgery complications, as well as overweight patients, diabetics, smokers, or those suffering from multiple medical problems. General risks for cervical spine surgery include: infection, bleeding, nerve or spinal cord injury, reactions to anesthesia, rupture of the sac covering the nerves (dural rupture), need for additional surgery in the future and not alleviating symptoms. Rehabilitation Regardless of whether the patient receives non-surgical treatment or surgery, rehabilitation will be required after healing of the lesion and can be recommended in hospital and outpatient physiotherapy. The goals of rehabilitation are to reduce pain, regain mobility and return the patient to a lifestyle and activities as close as possible to those experienced before the injury. Issues with the potential to complicate these goals include: inadequate fracture reduction, neurological injury (paralysis), and progressive deformity. A spinal conditioning program or lumbar exercises may also be recommended. Recommended.

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