Cauda Equina: Tells & Tales About the "Horse's Tail"

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Cauda equina syndrome is a rare and severe type of spinal stenosis. A narrowing of the spinal canal causes the nerves in the lower back to become severely compressed. Typically, but not exclusively, it results from a prolapsed disc bulge. The condition requires urgent hospital admission and timely surgery (usually decompression of the disc). The longer it goes untreated, the greater the chance it will result in permanent paralysis and incontinence.

On that account, it leads to claims for clinical negligence, notably in respect of delayed diagnosis, whether against hospital or GP. On that account too, such claims have latterly given rise to a number of decisions by the higher courts. The purpose of this blog is to review three of them.

Red Flags

Reference to the NICE Guidelines will be the corner-stone to any claim. I consider them briefly first as the back-drop to the case-law addressed below.

The NICE Guidelines (last revised in December 2020) include the following so-called, 'red flags':

- Bilateral sciatica.
- Severe or progressive bilateral neurological deficit of the legs, such as major motor weakness with knee extension, ankle eversion, or foot dorsiflexion.
- Difficulty initiating micturition or impaired sensation of urinary flow, if untreated this may lead to irreversible urinary retention with overflow urinary incontinence.
- Loss of sensation of rectal fullness, if untreated this may lead to irreversible faecal incontinence.
- Perianal, perineal or genital sensory loss (saddle anaesthesia or paraesthesia).
- Laxity of the anal sphincter.

In bold type are those new flags that were added when the guidelines were updated in 2018. The addition of bilateral sciatica had the effect of lowering, to a material degree, the threshold for urgent investigation. The same is true as regards urinary issues because the previous guidelines required either urinary retention or incontinence. By revising them to include lesser symptoms of difficulty initiating micturition (i.e. urination) or impaired sensation of urinary flow, there is an enhanced onus on front line medical practitioners to obtain, with care, a comprehensive enough history to rule out those more subtle degrees of symptomology.

As cauda equina syndrome involves step deteriorations, there are the following recognised phases, depending on the extent of nerve damage: Suspected (CES-S), Incomplete (CES-I), Retention (CES-R) and Complete (CES-C). All patients with CES experience a deterioration, but the rate of it varies between patients. Sometimes the deterioration is complete within hours. Other patients' CESI never reaches CESR. In general, on the balance of probabilities, the outcome of surgery for patients with CES-I tends to be good, whereas it tends to be poor for patients with CES-R.

It is therefore vital, once a clinician suspects CES, that an MRI scan is done as soon as reasonably possible, and that, if CES is found, the patient has decompression surgery as soon as possible (or as soon as is reasonably possible). What outcomes may eventuate from being at the cusp of CES-R is perhaps most contentious or, in litigation terms, most fact-specific.

Shaw v Stead [2019] EWHC 520 (QB)

This was a case decided by Yip J made difficult by what the GP notes did not record. Did the lack of red flags recorded in the notes mean they were not there, or was their very omission evidence of breach? Was the GP seeking to make a virtue of his own alleged vice in not taking a careful history?

The findings of fact reached by the Judge were that:

- On Day 1 of presentation, by reference to the notes available to the GP, the Claimant had bilateral leg pain;
- On the morning of Day 2, after difficulty urinating, the Claimant suffered a urinary accident on the way back to bed;
- On the afternoon of Day 2 the Claimant reported bilateral numbness and tingling in her legs which was within the GP notes;
- When she left home to go to the surgery on that second day she had difficulty walking because her legs were weak and felt like Bambi;
- She attended in a wheelchair and a straight leg raise could not be undertaken on either side due to the level of pain the claimant was in.

The judge rejected the suggestion that the Claimant would not have reported her symptoms if questioned appropriately. Her Ladyship concluded that the red flags were there to be found but were alas negligently missed. A lot may be learned from slight alterations in condition – hence the need for special care in history taking.

Hewes v West Hertfordshire Hospitals NHS Trust [2020] EWCA Civ 1523

The Court of Appeal made clear that, precisely because cauda equina cases turn on their own specific facts, once those facts were found by the first instance tribunal, setting sail on the appellate seas – island-hopping from selected quote to quote – in the quest of a reversal of those findings, or more general guidance, was ever likely to be doomed.

As Davis LJ put matters at [96]:

> *"We were told that, so far as is known, this was the first case directly relating to the treatment of CES which has come before the Court of Appeal. But that does not mean that it raises issues of principle of general application. In fact an appellate court, a court of law, often may need to be careful to avoid making generalised pronouncements on the obligations of doctors in medical situations. What is ordinarily required, in each case, is consideration of whether the responses and procedures actually undertaken in a given medical situation fall outwith the range of reasonableand logically justifiable responses and procedures, applying the Bolam/Bolitho principles, on the facts of the individual case".* [Emphasis added.]

This involved a proper understanding of context, both in terms of what was the subject condition (namely a highly challenging, developing one) and where the patient was being treated. Both those considerations were regarded as pertinent in assessing breach and causation.

In terms of breach, a critique of each minute stage of managing the condition was not seen as the right course when assessing reasonableness. The premise of the *Bolam* test on breach of duty is that there may not be one right answer on the facts found, but a range of reasonable answers.

As to factual causation, the appellant Claimant argued, on factual causation, that had the respondent Defendant not been negligent, the Claimant would have had decompression surgery earlier, and his prognosis would have been much better. The Defendant's case was that this was unrealistic given the resources of a District General Hospital. Further, as to legal causation, the Defendant's case was that, on the timings, the Claimant was already in retention whereby earlier surgery would not have made a difference to condition and prognosis.

Pausing there, on wider issues of causation pertinent to clinical negligence it should be noted that some reservations were expressed about *Wright v Cambridge Medical Group* [2013] QB 32. That 2011 Court of Appeal decision supports the proposition that *"if a defendant GP has been negligent in his treatment of a patient, he cannot rely on subsequent*

negligent treatment of the same patient by a hospital to escape liability". Although the point did not arise because the GP was not negligent, as Laing LJ put it at [74]:

> "*… it is not easy to tease a* ratio *from this decision as the two members of the court who allowed the appeal did so for different reasons. Further, it is clear from the judgment of Neuberger LJ that he was not articulating a legal rule that applies in all cases, in part, because the application of any such rule will depend on what damage was caused by each successive negligent act*".

Given the bouquets offered by the Court of Appeal to the first instance decision of Anne Whyte QC, sitting as Deputy Judge of the High Court, her judgment repays careful reading – it can be found at [2019] EWHC 1201 (QB) – in particular for its consideration of the passing from CES-I to CES-R.

Jarman v Brighton and Sussex University Hospitals NHS Trust [2021] EWHC 323 (QB)

Three months after *Hewes*, Jason Coppel QC sitting as a Deputy Judge of the Hight Court, handed down judgment in *Jarman*. At [2], he referenced *Hewes* and how "*once CES has been diagnosed, it is seen as an emergency, because unless the pressure on the nerves is released quickly, they can be damaged permanently. CES may be suspected following consideration of a patient's symptoms (as subjectively reported) and, following examination, of any objective physical signs of CES, but a diagnosis of CES can only be confirmed by an MRI scan*".

On the facts, context was again key – but focusing on when the events complained of happened. He noted at [41] that:

> "*it was common ground … that there is a trajectory towards increased numbers of scans, and that the threshold for scanning was, in general, higher in 2015 than it is today. In other words, whilst the precise approach adopted would differ between clinicians, the evidence of CES would have to have been stronger in 2015 in order to justify a scan than it would have to be today. That serves to support the approach of not scanning a patient for CES who presented with symptoms but no signs of CES in 2015, even if there is a greater likelihood that such a patient would be scanned on an emergency basis today*".

In reaching that conclusion, the Judge noted at [40] that this feature so far as guidelines are concerned, which practitioners will wish to bear in mind, as it provides something of a counter-point between the position of GPs and those working in a hospital setting:

> "*Such is the catastrophic damage commonly caused by CES that it is a common subject of medical negligence litigation. Guidelines have been issued by the National Institute for Clinical and Healthcare Excellence for primary care medical practitioners to assist them in identifying possible CES and referring patients to A&E on a timely basis. But there were in 2015 no equivalent guidelines for hospital care which would suggest that a patient with certain symptoms but no signs of CES must be scanned immediately, and nor have any been published subsequently. If that were indeed the position, there would be significant resource implications for hospitals, given the numbers of patients who present with symptoms but no signs of CES*".

As regards causation, two practical points emerge. First, the relative narrowness of the temporal window for achieving a better outcome. This was addressed at [53]:

> "*The parties' experts were agreed that the main determinant of success of outcome of decompression surgery to relieve CES is the neurological condition of the patient at the time of surgery. This was, for example, the clear view expressed by Mr Todd, the Claimant's neurosurgical expert. In his view, if the Claimant had been operated on within 48 hours of attending A&E she would have had a "very good outcome" but "once you have got beyond the 48-hour window in my opinion, we need to demonstrate, the claimant needs to demonstrate, neurological deterioration to succeed in saying the outcome would have been better.*"

Secondly, what the Judge had to say in terms of expectations that some medical literature would be deployed to buttress medical opinions or assertions made, as found at [70]:

> "*… evidence on causation was undermined in my estimation by being proffered by both experts as a high level view based on their own experience and without any evidential support in the way of published literature or even case*

> *studies of their own patients. Mr Maurice-Williams told me that "relying on the literature is difficult" because, in the case of CES, it is "vast" and also "I do not think that any paper has ever been published where somebody cannot find flaws in it" (14 December 2020, pp. 50-51). I have considerable difficulty accepting that proposition. The existence of a "vast" literature in CES made it more rather than less surprising that none was cited by him. I would have found his evidence much more persuasive if it had been supported in some concrete or objective way".*

The Defendant was able to produce some academic literature in support of its position. This requires to be borne in mind in the preparation of any case, partly because of the controversy around the passage from CES-I to CES-R and partly to guard against charges of merely asserting what actually requires to be proved and/or framing one's position to fit the primary, indeed necessary legal position.

Conclusion

What this trilogy of cases illustrate is that such claims are highly challenging, both in terms of breach of duty and causation with the following, main 'practitioner points' suggested:

1. Careful, contextual analysis is required – first by the medical practitioner taking the history, and (failing that) by the advising lawyer.
2. Keep the guidelines under review. They will themselves no doubt be the subject of periodic review – although the 2018 edition lower the threshold for seeking specialist advice and border on saying: 'you suspect CES, you must scan for it'. In that regard, the 2018 guidelines say MRI must be available at the hospital 24/7 (aspirational for some?) and make clear that 'MRI for ?CES must take precedence over routine cases'.
3. Remember there is an 'sliding scale', if you will, between breach and causation. For Claimants, the earlier in the so-called 'CES timeline', the harder will be the breach arguments, but the easier (relatively speaking) may be the causation arguments; the latter in that timeline, the converse becomes true.
4. At trial, the Courts will have an expectation of some literature being cited in support, including but not limited to what chances have (or have not) been lost.
5. To succeed, Claimants need to focus hard on identifying where the window of lost opportunity arises; and subject to breach of duty, Defendants on how narrow that window may be, assuming there was one there.