Physical examination of the lumbar spine

Observation
- General; willingness to move/sit/change position
- Standing; asymmetry, spinal deformity, muscle tone/bulk
- (erector spinae, abdominals, quadriceps, hamstrings, calves)
- Lordosis/kyphosis/scoliosis, ASIS levels, skin changes
- Gait

Palpation
- Palpate for midline and paraspinal tenderness and muscle spasm

Active lumbar ROM
- Flexion, extension, lateral flexion, rotation

Neurological examination
- A thorough examination of muscle tone, power, reflexes and sensation should be performed and recorded accurately to enable monitoring of any neurological impairment or assessment of symptom progression.
- See below for requirements of a lower limb neurological examination.

Neural tests
- SLR
- Prone knee bend (femoral stretch test)

Quick screening tests of the hip joint
- Assess for fixed flexion deformity
- Hip IR/ER in 90 degrees hip flexion
- FABER test

Vascular assessment
- Observation of extremity, temperature
- Peripheral pulses, dorsalis pedis, posterior tibial
Lower limb neurological examination

Muscle tone including clonus

Muscle power
Test particular muscle groups that correspond to specific nerve root supply.

Myotomes:
- L2, L3: hip flexion
- L3, L4: knee extension
- L4, L5: ankle dorsiflexion
- L5, S1: great toe extension, ankle eversion
- S1, S2: ankle plantar flexion.

The Medical Research Council (MRC) has a recommended grading system for power:

MRC scale for muscle power:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>No muscle contraction is visible but there is no movement of the joint</td>
</tr>
<tr>
<td>1</td>
<td>Muscle contraction is visible but there is no movement of the joint</td>
</tr>
<tr>
<td>2</td>
<td>Active joint movement is possible with gravity eliminated</td>
</tr>
<tr>
<td>3</td>
<td>Movement can overcome gravity but not resistance from the examiner</td>
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<tr>
<td>4</td>
<td>The muscle group can overcome gravity and move against some resistance</td>
</tr>
<tr>
<td>5</td>
<td>Full and normal power against resistance</td>
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</tbody>
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Deep tendon reflexes (DTRs)

- Test the patellar (L3, L4) and achilles (S1, S2) reflexes.
- Reflexes can either be hyperactive (+++), normal (++), sluggish (+) or absent (-). ± is used when the reflex is only present on reinforcement.
- Plantar (Babinski) response: up-going/down-going?

Sensation

An assessment of light touch sensation aims to define any areas of hypesthesia or dysesthesia (see next page for illustration of dermatomal distributions). Regions of the leg that generally correlate with dermatomes include:

- L2: upper thigh
- L3: knee
- L4: medial aspect of the leg
- L5: lateral aspect of the leg, medial side of the foot
- S1: lateral aspect of the foot, the heel and most of the side
- S2: posterior aspect of the thigh
- S3-5: coccygeal rings around the anus, the outermost of which is S3.

Note: upper motor neuron pathology is suggested by findings of:
- spastic tone, clonus, increased DTRs and up-going plantar (Babinski) response.

For detailed explanation and notes on interpretation see www.patient.co.uk/showdoc/40000059/

Reference: Aids to examination of the peripheral nervous system, Brain, Bailliere Tindall, 1986.