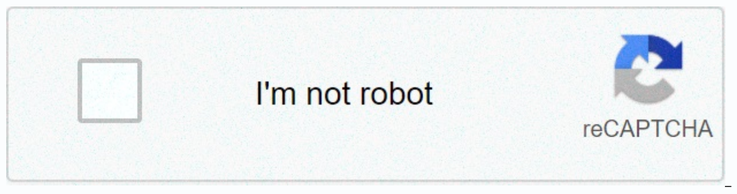

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Scottie dog sign fracture

Spondylolysis is defined as the defect through pars interarticularis, which is located between a narrow strip of bone during the lamina and lower joint process, and above the pedicle and excellent joint process. This can happen unilaterally or bilaterally. It is most common in the L5 vertebral segment. Fibrous tissue that fills the defect contains free nerve endings, so the defect itself can be a source of pain. His etiology or cause is unclear, but three theories are assumed. These are: This is a congenital defect; or It is a direct consequence of trauma, resulting in a non-unifying fracture; or It is the direct result of excessive or indirect trauma, leading to stress fracture. More evidence, recently, to support the third theory, is that spondylolysis is due to fatigue fracture. This is probably due to the fact that the pars interarticularis is subjected to extra stress, as it acts as a pivot between the body's vertebra and facet joints. This stress is further enhanced by the curvature of the lumbar spine, that is, lordosis. In a study of 32,600 asymptomatic adults, 7.2% had spondylolysis. Studies have shown that the incidence of spondylolysis is higher in the sports population than in the general population. Although always present in the younger, sports population, the incidence of spondylolysis also increases with age. Biomechanically, many factors may predispose you to spondylolysis, but often with aging, the elongation range of the hip decreases, which in turn can cause more stress to pars interarticular, resulting in stress fractures. In the sports population, this is quite a common occurrence. This can be seen in particular in the Australian rules for footballers, gridiron players, high jumpers, tennis players, rowers, weightlifters, gymnasts and cricketers (a sport often played in Commonwealth countries). It's interesting to note that in cricket, the bowling action seen in fast bowlers involves rotation and extension, often leading to stress fracture/spondylolysis on the other side of that bowling arm. X-rays should not be used to diagnose symptomatic spondylolysis. The condition occurs too often in asymptomatic individuals to take a proper test. When present, the smooth x-rays, often visible in lateral view X-rays, but can be accurately and clearly visible oblique views. These views are often referred to as Scotty Dog views (Figure 1).Figure 1: Oblique X-ray view of the lumbar spine (Scotty Dog view). In the lower segment, a fracture (or spondylolysis) through the pars show up as a black collar on the dog's neck. Interestingly, however, in radiological examination, sometimes no fracture is seen, but presents as an elonstic pars interarticular. This is thought to be the stress of the bone repeated, the resulting microfresses, bone healing, ultimately elongation of the bone. If a person suspects that there is a stress reaction in the lumbar spine and x-rays do not show pathology, the most accurate method of assessment for symptomatic pars interarticularis is bone scanning with SPECT. It always shows early stress fracture. Examinations within one year of a suspected fracture show initial fractures (stress reactions), recent fractures and healing fractures. They can all occur in the absence of any changes in smooth x-ray. During physical examination, the extension of movement is often painful and rigid. The pain is also triggered by allowing the patient to stand on one leg and then lead to the extension. Narrow hamstrings are not uncommon, however, these features are present for other causes of lower back pain. This condition can be asymptomatic, as spondylolysis is otherwise found, e.g. x-rays are taken as part of a screening program and there are no symptoms. On the other hand, symptoms can vary from central lower back pain, to unilateral (unilateral) lower back pain, to radiant buttock pain or radiant leg pain. Spondylolysis is not able to produce nerve cord compression, so signs of nerve cord indicate additional pathology, for example, croup plate prolapse. In children, only 13% of people with spondylolysis have symptoms. It completely depends on whether the symptoms actually stem from spondylolysis. If there is a link between spondylolysis and symptoms, treatment is contraindicated, from the rest of the aggravating activity to the gentle mobilization of the spine (always aware that in this type of pathology, an increase in the range of movement may be contraindicated), to braces/corsets, exercises - especially dynamic lumbar stabilization exercises aimed at supporting the lumbar spine and controlling lordosis. It is possible that if the acute phase settles with fibrous or bony healing, the condition disappears. If this is repeated every time the person returns from aggravating activity or sports, account should be taken of the change in activity or sport. This may require a change in style or technique, e.g. bowling action in cricket or in the sport. In spondylolysis, there is usually no need for surgical intervention. Spondylolisthesis is defined as a slide forward from one vertebra to the lower, adjacent vertebra. The most commonly affected vertebral segment is L5, which slides forward on the first major segment (S1). There are varying degrees of slippage, classified as the distance between the sliding vertebrae moving forward from the body to the vertebra below. The spondylolisthetic slip is the spondylolisthetic slip from 1 to 4. Figure 2, figure 2. It is thought that the anatomical direction of L5 on S1 (where there is a slope of about 30°) can be an important factor in the production of spondylolisthesis at this level, as constant downward shear force occurs when standing. If the rear support structures, i.e. pedicures and space joints, are incomplete, slippage may occur when the support structures are stretched due to gravitational forces. Spondylolisthesis can occur as a result of bilateral pars interarticular fractures, although the fracture of the pars is not always associated with the slippage of spondylolisthesis. It is not known why spondylolysis, in some people, becomes spondylolisthesis and in others it does not. However, it has been found that slippage is much more common among young people, with the majority under the age of 25. Like spondylolysis, sporting activities involving repeated load on the spine in bending and/or prolongation in combination with rotation threaten the lumbar spine with the risk of developing spondylolisthesis. There have been 5 types of spondylolisthesis described. These are: Congenital SpondylolisthesisUsually occurs most often in girls with some family predisposition and is associated with other congenital dysplasia e.g. spina bifida occult. This usually occurs with L5 in S1 and can be as severe as a grade 4, with a huge neurological deficit. Traumatic SpondylolisthesisA rare condition usually caused by severe trauma, resulting in both pars interarticular fractures. Falls from a height, or skydiving, have identified the possible cause of this type of spondylolisthesis. It should be emphasized, however, that there are many cases where spondylolisthesis is undiagnosed and asymptomatic, trauma is experienced, tests and spondylolisthesis are diagnosed. In this case, it is necessary to correctly identify symptomatic structures to determine whether spondylolisthesis causes symptoms, or other structures during trauma. In other cases, a person with spondylolysis may develop spondylolisthesis in case of trauma, or a person with spondylolisthesis may have an increased slippage as a result of trauma. Degenerative Spondylolisthesis Occurs most often in women (4:1), this type usually occurs in L4/5 and is usually more than 50 years old. It is thought to be secondary to increased mobility in the L4/5 segment, resulting in degenerative plate disease, segmental instability and degenerative facet joints that are prone to sublux. Spondylolytic SpondylolisthesisResponses as a result of bilateral pars interarticular fractures and the most common l5 in S1. Due to age-related structure and function changes, there are large delays children, while young adults have minor delays. Pathological SpondylolisthesisIt can occur in conditions such as Paget's disease, where there is a significant bony disease. This usually leads to the failure of the back bony hook, which consists of pedicules, neural arch and lower school year. See spondylolysis earlier on this site. Like spondylolysis, a spondylolisthetic patient can complain of diffuse general lower back pain, with or without leg pain. If leg pain is present, it can be one-sided or bilateral. Symptoms usually worsen with standing and eased sitting. The groin bending range may be limited unilaterally or bilaterally by tight hamstrings/dura. This is usually due to tightness in the L5 nerve roots. As a secondary, the patient may have an exaggerated lumiar lordosis, bilateral extensor muscle spasm. In more severe cases, a gap in the level of spondylolisthesis can be observed or palpable, and can be increased when the patient is placed in the extension. It is also possible radicular pain, with or without neurological symptoms and signs, to develop. These symptoms can be caused by related pathology, such as plate prolapse, or the tension effect on nerve roots. Like spondylolysis, it is essential to determine whether the symptoms come from spondylolisthesis. If not, the treatment will be symptomatic, directed at defective structures. On the other hand, if spondylolisthesis is defective, the purpose of treatment is to reduce symptoms, stabilize the spine and control the degree of lordosis. The child would need a radiological reassessment to monitor the extent of the delay. Mobilization (gentle) can be useful, as can groin traction, but manipulative or powerful techniques are contraindicated. Dynamic lumbar stabilization exercises are encouraged to control spinal movement, posture and lordosis, with braces or corsets being useful in the short term. Surgery is indicated for patients who:A. Failed conservative management; and/orB. There is a prolonged history of back pain and/or isia; and/orC. There is evidence of spinal canal narrowing; and/orD. Evidence of cauda equina compression or progressive lower motor neuron deficiency; and/orE. Progression to warp 3 or 4, indicating severe instability. Spinal fusion +/- decompression lamitomy may also be indicated in these patients, depending on the symptoms. The concepts presented here are entirely the author's own (unless explicitly stated) and do not represent the thoughts or ideas of any other person. Person.

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