Patients were compared for the study. CES was defined as an acute onset of cauda equina syndrome presenting within 72 hours and clinically concerning for malignant spinal compression. Surgical versus conservative management was randomly assigned to patients. A 4-point Likert scale was used for both probability of malignancy and likelihood of benefit from treatment. Agreement was measured using the Cohen’s kappa statistic. The primary outcome was the degree of agreement between the two expert radiologists in the interpretation of the postero-anterior radiographs. Results: The kappa statistic for agreement between the two radiologists was 0.72 (95% CI 0.61–0.83) for malignancy and 0.69 (95% CI 0.56–0.82) for likelihood of benefit from treatment. The agreement was higher among radiologists with more experience in spinal imaging. Conclusion: Further research is needed to improve the accuracy of radiological diagnosis of cauda equina syndrome. Keywords: Cauda equina syndrome, Magnetic resonance imaging, MRI, Needle biopsy, Neurosurgery, Oncology.
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**Objective**

To characterize interrater and intrarater agreements of diagnostic cut-off values for magnetic resonance imaging (MRI) findings in the lumbar spine, significant variability across degenerative conditions.

**Methods**

A retrospective, comparative cohort study of 51 biopsy-proved or clinically confirmed cases of lumbar discitis-osteomyelitis was undertaken with a panel of two musculoskeletal radiologists and two orthopedic spine surgeons. Images were assessed using standardized and pilot-tested imaging protocols with a mix of both contrast-enhanced and noncontrast examinations. This study was designed to closely represent the cohort that MRI assessment criteria used in the study at our institution may not be the same as seen in other centers. The MRI assessment criteria used in the study were developed in collaboration with orthopedic spine surgeons and musculoskeletal radiologists at our institution and may not be representative of current clinical practice or the standards of care used during the initial study. Variations in individual institutional guidelines in some patients, the clinical diagnosis and imaging protocols with a mix of both contrast-enhanced and noncontrast examinations.

**Results**

Of 1226 participants, 18.6% received early MRI. Most (77.9%) had no hospitalization following the imaging. This could contribute to the low rate of early imaging for back pain. Of the 51 cases, 21.6% (11/51) were determined to have discitis-osteomyelitis. The sensitivity of MRI for discitis-osteomyelitis when compared to histology or clinical follow-up for a total of 10 lumbar degenerative findings and 11 interrater and intrarater agreements were determined. The overall absolute and interrater agreement was 66.7% and 83.3%, respectively. The absolute and intrarater agreement was 83.3% and 96.7%, respectively. The overall absolute and intrarater agreement was 83.3% and 96.7%, respectively. The overall absolute and intrarater agreement was 83.3% and 96.7%, respectively. The overall absolute and intrarater agreement was 83.3% and 96.7%, respectively.

**Conclusion**

Our study illustrates the importance of standardizing imaging protocols and optimizing the performance of musculoskeletal imaging in the evaluation of degenerative conditions. This is particularly true for degenerative conditions, where significant variability in the interpretation of MRI findings exists across centers.

**References**

1. Jarvik JG, et al. Early imaging for noninfectious causes of back pain. Our early imaging was not associated with an increased risk of long-term disability at 1 year, and the rate of recovery 1 year after injury. The Roland-Morris Disability Questionnaire (RDQ) consists of 24 yes/no items to assess the physical impact of back pain. The RDQ has been validated as a unique outcome measure.

**Low Back Pain Mid-Level Evidence Table**

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