G. SPINAL PAIN, SECTION 3: SPINAL AND RADICULAR PAIN SYNDROMES OF THE LUMBAR, SACRAL, AND COCCYGEAL REGIONS

N.B. For explanatory material on this section and on section D, Spinal and Radicular Pain Syndromes of the Cervical and Thoracic Regions, see pp. 11-16 of the list of Topics and Codes

GROUP XXVI: LUMBAR OR RADICULAR SPINAL PAIN SYNDROMES

In using this section, please refer back to the remarks upon Spinal and Radicular Pain Syndromes, pp. 11-16. Please note particularly the comments on coding at the top of sections IX and XXVI of the list of Topics and Codes, pp. 17 and 29.

Lumbar Spinal or Radicular Pain Attributable to a Fracture (XXVI-1)

Definition
Lumbar spinal pain occurring in a patient with a history of injury in whom radiography or other imaging studies demonstrate the presence of a fracture that can reasonably be interpreted as the cause of their pain.

Clinical Features
Lumbar spinal pain with or without referred pain.

Diagnostic Features
Radiographic or other imaging evidence of a fracture of one of the osseous elements of the lumbar vertebral column.

Schedule of Fractures
XXVI-1.1 (S)(R)
Fracture of a Vertebral Body
Code 533.X1aS/C  633.X1aR
XXVI-1.2(S)
Fracture of a Spinous Process
Code 533.X1bS
XXVI-1.3 (S)(R)
Fracture of a Transverse Process
Code 533.X1cS/C  633.X1cR
XXVI- 1.4(S)(R)
Fracture of a Superior Articular Process
Code 533.X1dS/C  633.X1dR
XXVI-1.5(S)(R)
Fracture of an Inferior Articular Process
Code 533.X1eS/C  633.X1e
XXVI-1.6(S)(R)
Fracture of a Lamina (pars interarticularis)
Code 533.X1fS  633.X1fR

Lumbar Spinal or Radicular Pain Attributable to an Infection (XXVI-2)
Definition
Lumbar spinal pain occurring in a patient with clinical and/or other features of an infection, in whom the site of infection can be specified and which can reasonably be interpreted as the source of their pain.

Clinical Features
Lumbar spinal pain with or without referred pain, associated with pyrexia or other clinical features of infection.

Diagnostic Features
A presumptive diagnosis can be made on the basis of an elevated white cell count or other serological features of infection, together with imaging evidence of the presence of a site of infection in the lumbar vertebral column or its adnexa. Absolute confirmation relies on histological and/or bacteriological confirmation using material obtained by direct or needle biopsy.

Schedule of Sites of Infection
XXVI-2.1(S)(R)
  Infection of a Vertebral Body (osteomyelitis)
  Code 532.X2aS/C    632.X2aR
XXVI-2.2(S)(R)
  Septic Arthritis of a Zygapophyseal Joint
  Code 532.X2bS/C    632.X2bR
XXVI-2.3(S)(R)
  Infection of a Paravertebral Muscle (e.g., psoas abscess)
  Code 532.X2cS/C    632.X2cR
XXVI-2.4(S)(R)
  Infection of an Intervertebral Disk (diskitis)
  Code 532.X2dS/C    632.X2dR
XXVI-2.5(S)(R)
  Infection of a Surgical Fusion-Site
  Code 532.X2eS/C    632.X2eR
XXVI-2.6(S)(R)
  Infection of a Retroperitoneal Organ or Space
  Code 532.X2fS/C    632.X2fR
XXVI-2.7(S)(R)
  Infection of the Epidural Space (epidural abscess)
  Code 532.X2gS/C    632.X2gR
XXVI-2.8(S)(R)
  Infection of the Meninges (meningitis)
  Code 502.X2*S/C    602.X2cR
XXVI-2.9(S)(R)
  Acute Herpes Zoster
  Code 503.X2*S/C (low back)
  Code 603.X2dR (leg)
XXVI-2.10(S)(R)
  Postherpetic Neuralgia
  Code 503.X2bS/C (low back)
  Code 603.X2bR (leg)

Lumbar Spinal or Radicular Pain Attributable to a Neoplasm (XXVI-3)

Definition
Lumbar spinal pain associated with a neoplasm that can reasonably be interpreted as the source of the pain.

**Clinical Features**
Lumbar spinal pain with or without referred pain.

**Diagnostic Features**
A presumptive diagnosis may be made on the basis of imaging evidence of a neoplasm that directly or indirectly affects one or other of the tissues innervated by lumbar spinal nerves. Absolute confirmation relies on obtaining histological evidence by direct or needle biopsy.

**Schedule of Neoplastic Diseases**

XXVI-3. I (S)(R)
- Primary Tumor of a Vertebral Body
  Code 533.X4aS/C  633.X4aR

XXVI-3.2(S)(R)
- Primary Tumor of Any Part of a Vertebra Other than Its Body
  Code 533.X4bS/C  633.X4bR

XXVI-3.3(S)(R)
- Primary Tumor of a Zygaphysial Joint
  Code 533.X4cS/C  633.X4cR

XXVI-3.4(S)(R)
- Primary Tumor of a Paravertebral Muscle
  Code 533.X4dS/C  633.X4dR

XXVI-3.5(S)(R)
- Primary Tumor of Epidural Fat (e.g., lipoma)
  Code 533.X4eS/C  633.X4eR

XXVI-3.6(S)(R)
- Primary Tumor of Epidural Vessels (e.g., angioma)
  Code 533.X4fS/C  633.X4fR

XXVI-3.7(S)(R)
- Primary Tumor of Meninges (e.g., meningioma)
  Code 503.X4aS/C  603.X4aR

XXVI-3.8(S)(R)
- Primary Tumor of a Spinal Nerve (e.g., neurofibroma, schwannoma, neuroblastoma)
  Code 503.X4bS/C  603.X4bR
  Code 503.X4cS/C  603.X4cR

XXVI-3.9(S)(R)
- Primary Tumor of Spinal Cord (e.g., glioma)
  Code 533.X4gS/C  633.X4gR

XXVI-3.10(S)(R)
- Metastatic Tumor Affecting a Vertebral
  Code 533.X4hS/C  633.X4hR

XXVI-3.11 (S)(R)
- Metastatic Tumor Affecting the Vertebral Canal
  Code 533.X4iS/C  633.X4iR

XXVI-3.12(S)(R)
- Other Infiltrating Neoplastic Disease of a Vertebra (e.g., lymphoma)
  Code 533.X4jS/C  633.X4jR
Lumbar Spinal or Radicular Pain Attributable to Metabolic Bone Disease (XXVI-4)

Definition
Lumbar spinal pain associated with a metabolic bone disease that can reasonably be interpreted as the source of the pain.

Clinical Features
Lumbar spinal pain with or without referred pain.

Diagnostic Features
Imaging or other evidence of metabolic bone disease affecting the lumbar vertebral column, confirmed by appropriate serological or biochemical investigations and/or histological evidence obtained by needle or other biopsy.

Schedule of Metabolic Bone Diseases
XXVI-4.1(S)(R)
   Osteoporosis of Age
   Code 532.X5aS/C  632.X5aR

XXVI-4.2(S)(R)
   Osteoporosis of Unknown Cause
   Code 532.X5bS/C  632.X5bR

XXVI-4.3(S)(R)
   Osteoporosis of Some Known Cause Other than Age
   Code 532.X5cS/C  632.X5cR

XXVI-4.4(S)(R)
   Hyperparathyroidism
   Code 532.X5dS/C  632.X5dR

XXVI-4.5(S)(R)
   Paget’s Disease of Bone
   Code 532.X5eS/C  632.X5eR

XXVI-4.6(S)(R)
   Metabolic Disease of Bone Not Otherwise Classified
   Code 532.X5fS/C  632.X5fR

Lumbar Spinal or Radicular Pain Attributable to Arthritis (XXVI-5)

Definition
Lumbar spinal pain associated with arthritis that can reasonably be interpreted as the source of the pain.

Clinical Features
Lumbar spinal pain with or without referred pain.

Diagnostic Features
Imaging or other evidence of arthritis affecting the joints of the lumbar vertebral column.

Schedule of Arthritides
XXVI-5.1(S)(R)
   Rheumatoid Arthritis
   Code 534.X3aS/C  634.X3aR
**XXVI-5.2(S)(R)**
Ankylosing Spondylitis
Code 532.X8*S/C  632.X8*R

**XXVI-5.3 (S)(R)**
Osteoarthritis
Code 538.X6a/S/C  638.X6aR

**XXVI-5.4(S)(R)**
Seronegative Spondyloarthropathy Not Otherwise Classified
Code 532.X8b*S/C  623.X8bR

**Remarks**
Osteoarthritis is included in this schedule with some hesitation because there is only a weak relation between pain and this condition as diagnosed radiologically.
The alternative classification to “lumbar spinal pain due to osteoarthrosis” should be “lumbar zygapophysial joint pain” if the criteria for this diagnosis are satisfied (see XXVI-13) or “lumbar spinal pain of unknown or uncertain origin” (see XXVI-9).

Similarly, the condition of “spondylosis” is omitted from this schedule because there is no positive correlation between the radiographic presence of this condition and the presence of spinal pain. There is no evidence that this condition represents anything more than age-changes in the vertebral column.

**References**

**Lumbar Spinal or Radicular Pain Associated with a Congenital Vertebral Anomaly (XXVI-6)**

**Definition**
Lumbar spinal pain associated with a congenital vertebral anomaly.

**Clinical Features**
Lumbar spinal pain with or without referred pain.

**Diagnostic Features**
Imaging evidence of a congenital vertebral anomaly affecting the lumbar vertebral column.

**Remarks**
There is no evidence that congenital anomalies per se cause pain. Although they may be associated with pain, the specificity of this association is unknown. This classification should be used only when the cause of pain cannot be otherwise specified, but should not be used to imply that the congenital anomaly is the actual source of pain.

**Code**
523.XOaS/C 623.XOaR

**Pseudarthrosis of a Transitional Vertebra (XXVI-7)**
**Definition**
Lumbar spinal or radicular pain stemming from a pseudarthrosis formed by a transitional vertebra.

**Clinical Features**
Lumbar, lumbosacral, or sacral spinal pain.

**Diagnostic Criteria**
The pseudarthrosis must be evident radiographically, and must be shown to be symptomatic by having the pain relieved upon selective anesthetization of the pseudarthrosis, provided that the local anesthetic injected does not spread to affect other structures that might constitute an alternative source of the patient’s pain.

**Pathology**
Periostitis as a result of repeated contact between the two bones, progressing to sclerosis of the contact sites of the two bones.

**Remarks**
The majority of pseudarthroses between transitional vertebrae are asymptomatic. Consequently, the radiographic presence of a pseudarthrosis in a patient with spinal pain is insufficient grounds alone to justify the diagnosis. The pseudarthrosis must be shown to be symptomatic.

**Reference**

**Code**
523.XObS/C
623.XObR

**Pain Referred From Abdominal Viscera or Vessels and Perceived as Lumbar Spinal Pain (XXVI-8)**

**Definition**
Lumbar spinal pain associated with disease of an abdominal viscus or vessel that reasonably can be interpreted as the source of pain.

**Clinical Features**
Lumbar spinal pain with or without referred pain, together with features of the disease affecting the viscus or vessel concerned.

**Diagnostic Features**
Reliable evidence of the primary disease affecting an abdominal viscus or vessel.

**Schedule of Diseases**

- XXVI-8.1 Aortic Aneurysm (See also XVII-7)
  Code 522.X6
- XXVI-8.2 Gastric Ulcer (See also XXI-4)
  Code 555.X3a
- XXVI-8.3 Duodenal Ulcer (See also XXI-5)
  Code 555.3Xb
- XXVI-8.4 Mesenteric Ischemia (See also XXI-8)
Lumbar Spinal Pain of Unknown or Uncertain Origin (XXVI-9)

**Definition**
Lumbar spinal pain occurring in a patient who has not previously undergone surgery for that pain whose clinical features and associated features do not enable the cause and source of the pain to be determined, and whose cause or source cannot be or has not been determined by special investigations.

**Clinical Features**
Lumbar spinal pain with or without referred pain.

**Diagnostic Features**
Lumbar spinal pain for which no other cause has been found or can be attributed.

**Pathology**
Unspecified.

**Remarks**
This definition is intended to cover those complaints that for whatever reason currently defy conventional diagnosis. It does not encompass pain of psychological origin. It presupposes an organic basis for the pain but one that cannot be or has not been established reliably by clinical examination or special investigations, such as imaging techniques or diagnostic blocks.

This diagnosis may be used as a temporary diagnosis. Patients given this diagnosis could in due course be accorded a more definitive diagnosis once appropriate diagnostic techniques are devised or applied. In some instances, a more definitive diagnosis might be attainable using currently available techniques, but for logistic or ethical reasons these may not have been applied.

Upper Lumbar Spinal Pain of Unknown or Uncertain Origin (XXVI-9.1)

**Definition**
As for XXVI-9 but the pain is located in the upper lumbar region.

**Clinical Features**
Spinal pain located in the upper lumbar region.

**Diagnostic Features**
As for XXVI-9, save that the pain is located in the upper lumbar region.

**Pathology**
As for XXVI-9.

**Remarks**
As for XXVI-9.
Lower Lumbar Spinal Pain of Unknown or Uncertain Origin (XXVI-9.2)

**Definition**
As for XXVI-9 but the pain is located in the lower lumbar region.

**Clinical Features**
Spinal pain located in the lower lumbar region.

**Diagnostic Features**
As for XXVI-9, save that the pain is located in the lower lumbar region.

**Pathology**
As for XXVI-9.

**Remarks**
As for XXVI-9.

Lumbosacral Spinal Pain of Unknown or Uncertain Origin (XXVI-9.3)

**Definition**
As for XXVI-9 but the pain is located in the lumbosacral region.

**Clinical Features**
Spinal pain located in the lumbosacral region.

**Diagnostic Features**
As for XXVI-9, save that the pain is located in the lumbosacral region.

**Pathology**
As for XXVI-9.

**Remarks**
As for XXVI-9.

Lumbar Spinal or Radicular Pain after Failed Spinal Surgery (XXVI-10)

**Definition**
Lumbar spinal pain of unknown origin either persisting despite surgical intervention or appearing after surgical intervention for spinal pain originally in the same topographical location.

**Clinical Features**
Lumbar spinal pain occurring alone or in association with referred pain or radicular pain.

**Diagnostic Criteria**
As for lumbar spinal pain of unknown origin with the exception that the patient’s history now includes an unsuccessful attempt at treating the pain in the same region by surgical means.

**Pathology**
Unknown.

**Remarks**
This diagnosis has been formulated as an entity distinct from lumbar spinal pain of unknown origin to accommodate beliefs that the failed attempt at surgical therapy complicates the patient’s condition pathologically, psychologically, or both.

Conjectures may be raised as to the possible origin of this form of pain, such as neuroma formation, deafferentation, epidural scarring, etc., but until reliable diagnostic techniques are developed whereby these or similar conditions can be confirmed objectively, any attempt at diagnosis can only be presumptive.

The diagnosis does not apply if a patient presents with spinal pain that is not associated both topographically and temporally with the spinal surgery. In that case, the spinal pain should be accorded a separate diagnosis; the previous spinal pain treated surgically should be considered only as part of the patient’s general medical history.

**Code**
533.XlgS/C
632.X1hR

**Lumbar Discogenic Pain (XXVI-11)**

**Definition**
Lumbar spinal pain, with or without referred pain, stemming from a lumbar intervertebral disk.

**Clinical Features**
Spinal pain perceived in the lumbar region, with or without referred pain to the lower limb girdle or lower limb.

**Diagnostic Criteria**
The patient’s pain must be shown conclusively to stem from an intervertebral disk by demonstrating either (1) that selective anesthetization of the putatively symptomatic intervertebral disk completely relieves the patient of the accustomed pain for a period consonant with the expected duration of action of the local anesthetic used;

or (2) that selective anesthetization of the putatively symptomatic intervertebral disk substantially relieves the patient of the accustomed pain for a period consonant with the expected duration of action of the local anesthetic used, save that whatever pain persists can be ascribed to some other coexisting source or cause;

or (3) provocation diskography of the putatively symptomatic disk reproduces the patient’s accustomed pain, but provided that provocation of at least two adjacent intervertebral disks clearly does not reproduce the patient’s pain, and provided that the pain cannot be ascribed to some other source innervated by the same segments that innervate the putatively symptomatic disk.

**Pathology**
Unknown, but presumably the pain arises as a result of chemical or mechanical irritation of the nerve
endings in the outer anulus fibrosus, initiated by injury to the anulus, or as a result of excessive stresses imposed on the anulus by injury, deformity, or other disease within the affected segment or adjacent segments.

**Remarks**
Provocation diskography alone is insufficient to establish conclusively a diagnosis of discogenic pain because of the propensity for false-positive responses either because of apprehension on the part of the patient or because of the coexistence of a separate source of pain within the segment under investigation. If analgesic diskography is not performed or is possibly false-negative, criterion (3) must be explicitly satisfied. Otherwise, the diagnosis of “discogenic pain” cannot be sustained, whereupon an alternative classification must be used.

**Code**
- 533.X1IS  Trauma
- 533.X6aS  Degenerative
- 533.X7cS  Dysfunctional

**References**


**Internal Disk Disruption (XXVI-12)**

**Definition**
Lumbar spinal pain, with or without referred pain, stemming from an intervertebral disk, caused by internal disruption of the normal structural and biochemical integrity of the symptomatic disk.

**Clinical Features**
Lumbar spinal pain, with or without referred pain in the lower limb girdle or lower limb; aggravated by movements that stress the symptomatic disk.

**Diagnostic Criteria**
The diagnostic criteria for lumbar discogenic pain must be satisfied, and in addition, CT-diskography must demonstrate a grade 3 or greater grade of anular disruption as defined by the Dallas diskogram scale.

**Pathology**
The pathology of internal disk disruption is believed to be due to enzymatic degradation of the internal disk matrix. Initially, the degradation is restricted to the nucleus pulposus, but eventually it progresses in a centrifugal pattern along radial fissures into the anulus fibrosus. Biochemically the process involves activation of enzymes such as proteinases, cathepsin, and collagenase. Biophysically the process is characterized by denaturation and deaggregation of proteoglycans and diminished water-binding capacity of the nucleus pulposus.
The causes of disk degradation are still speculative but possibly involve disinhibition of proteolytic enzymes systems endogenous to the disk as a result of impaired nutrition to the disk or injuries to the vertebral endplate.

Pain arises as a result of chemical or mechanical stimulation of the nerve endings located in the outer third or outer half of the anulus fibrosus, and is aggravated by any movements that stress these portions of the anulus.

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<tr>
<td>533.X7*fS</td>
<td>Dysfunctional</td>
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**References**


**Lumbar Zygaphophysial Joint Pain (XXVI-13)**

**Definition**

Lumbar spinal pain, with or without referred pain, stemming from one or more of the lumbar zygapophysial joints.

**Clinical Features**

Lumbar spinal pain with or without referred pain.

**Diagnostic Criteria**

No criteria have been established whereby zygapophysial joint pain can be diagnosed on the basis of the patient’s history or by conventional clinical examination. The condition can be diagnosed only by the use of diagnostic, intraarticular zygapophysial joint blocks. For the diagnosis to be declared, all of the following criteria must be satisfied.

1. The blocks must be radiologically controlled.
2. Arthrography must demonstrate that any injection has been made selectively into the target joint, and any material that is injected into the joint must not spill over into adjacent structures that might otherwise be the actual source of the patient’s pain.
3. The patient’s pain must be totally relieved following the injection of local anesthetic into the target joint.
4. A single positive response to the intraarticular injection of local anesthetic is insufficient for the diagnosis to be declared. The response must be validated by an appropriate control test that excludes false-positive responses on the part of the patient, such as:
   - no relief of pain upon injection of a nonactive agent;
   - no relief of pain following the injection of an active local anesthetic into a site other than the target joint; or
   - a positive but differential response to local anesthetics of different durations of action
injected into the target joint on separate occasions.

Local anesthetic blockade of the nerves supplying a target zygapophysial joint may be used as a screening procedure to determine in the first instance whether a particular joint might be the source of symptoms, but the definitive diagnosis may be made only upon selective, intraarticular injection of the putatively symptomatic joint.

Pathology
Still unknown. May be due to small fractures not evident on plain radiography or conventional computerized tomography, but possibly demonstrated on high-resolution CT, conventional tomography, or stereoradiography. May be due to osteoarthrosis, but the radiographic presence of osteoarthritis is not a sufficient criterion for the diagnosis to be declared. Zygapophysial joint pain may be caused by rheumatoid arthritis, ankylosing spondylitis, septic arthritis, or villo-nodular synovitis.

Sprains and other injuries to the capsule of zygapophysial joints have been demonstrated at post mortem and may be the cause of pain in some patients, but these types of injuries cannot be demonstrated in vivo using currently available imaging techniques.

Remarks
See also XXVI-17, Lumbar Segmental Dysfunction.

Code
Trauma  533.X1kS/C  633.X1*R
Degenerative  533.X6oS/C  633.X6aR

References


**Lumbar Muscle Sprain (XXVI-14)**

**Definition**
Lumbar spinal pain stemming from a lesion in a specified muscle caused by strain of that muscle beyond its normal physiological limits.

**Clinical Features**
Lumbar spinal pain, with or without referred pain, associated with tenderness in the affected muscle and aggravated by either passive stretching or resisted contraction of that muscle.

**Diagnostic Criteria**
The following criteria must all be satisfied.

1. The affected muscle must be specified.
2. A history of activities consistent with the affected muscle having been strained.
3. The muscle is tender to palpation.
4. (a) Aggravation of the pain by any clinical test that can be shown to selectively stress the affected muscle, or
   (b) Selective infiltration of the affected muscle with local anesthetic completely relieves the patient’s pain.

**Pathology**
Rupture of muscle fibers, usually near their myotendinous junction, that elicits and inflammatory repair response.

**Remarks**
This nosological entity has been included in recognition of its frequent use in clinical practice, and because “muscle sprain” is readily diagnosed in injuries of the limbs. However, in the context of spinal pain this entity is only presumptive, since no clinical test for spinal muscle sprain has been validated.

**Code**
533.X11S

**References**


**Lumbar Trigger Point Syndrome (XXVI-15)**

**Definition**
Lumbar spinal pain stemming from a trigger point or trigger points in one or more of the muscles of the lumbar spine.

**Clinical Features**
Lumbar spinal pain, with or without referred pain, associated with a trigger point in one or more muscles of the lumbar vertebral column.

**Diagnostic Criteria**
The following criteria must all be satisfied.
1. A trigger point must be present in a muscle, consisting of a palpable, tender, firm, fusiform nodule oriented in the direction of the affected muscle’s fibers.
2. The muscle must be specified.
3. Palpation of the trigger point reproduces the patient’s pain and/or referred pain.
4. Elimination of the trigger point relieves the patient’s pain. Elimination may be achieved by stretching the affected muscle, dry needling the trigger point, or infiltrating it with local anesthetic.

**Pathology**
Unknown. Trigger points are believed to represent areas of contracted muscle that have failed to relax as a result of failure of calcium ions to sequestrate. Pain arises as a result of the accumulation of algogenic metabolites.

**Remarks**
For the diagnosis to be accorded, the diagnostic criteria for a trigger point must be fulfilled. Simple tenderness in a muscle without a palpable band does not satisfy the criteria, whereupon an alternative diagnosis must be accorded, such as muscle sprain, if the criteria for that condition are fulfilled, or spinal pain of unknown origin.

**Schedule of Trigger Point Sites**
XXVI-15.1(5)
  - Multifidus
    - Code 532.X1aS
XXVI-15.2(S)
  - Longissimus Thoracis
    - Code 532.X1bS
XXVI-15.3(S)
  - Iliocostalis Lumborum
    - Code 532.X1cS
XXVI-15.4(5)
  - Lumbar Trigger Point Not Otherwise Specified
    - Code 532.X1*S

**References**


**Lumbar Muscle Spasm (XXVI-16)**

**Definition**
Lumbar spinal pain resulting from sustained or repeated involuntary activity of the lumbar spinal muscles.

**Clinical Features**
Lumbar spinal pain for which there is no other underlying cause, associated with demonstrable sustained muscle activity.
**Diagnostic Features**
Palpable spasm is usually found at some time, most often in the paravertebral muscles.

**Pathology**
Unknown. Presumably sustained muscle activity prevents adequate wash-out of algogenic chemicals produced by the sustained metabolic activity of the muscle.

**Remarks**
While there are beliefs in a pain-muscle spasm-pain cycle, clinical tests or conventional electromyography have not been shown to demonstrate reliably the presence of sustained muscle activity in such situations. The strongest evidence for repeated involuntary muscle spasm stems from sleep-EMG studies conducted on patients with low-back pain, but although it is associated with back pain a causal relationship between this type of muscle activity and back pain has not been established.

**Code**
- 532.X1tS  Trauma
- 532.X2hS  Infection
- 532.X4aS  Neoplasm
- 532.X6aS  Degenerative
- 532.X7dS  Dysfunctional
- 532.X8fS  Unknown

**References**


**Lumbar Segmental Dysfunction (XXVI-17)**

**Definition**
Lumbar spinal pain ostensibly due to excessive strains imposed on the restraining elements of a single spinal motion segment.

**Clinical Features**
Lumbar spinal pain, with or without referred pain, that can be aggravated by selectively stressing a particular spinal segment.

**Diagnostic Criteria**
All the following criteria should be satisfied.
1. The affected segment must be specified.
2. The patient’s pain is aggravated by clinical tests that selectively stress the affected segment.
3. Stressing adjacent segments does not reproduce the patient’s pain.
Pathology
Unknown. Presumably involves excessive strain imposed by activities of daily living on structures such as the ligaments, joints, or intervertebral disk of the affected segment.

Remarks
This diagnosis is offered as a partial distinction from spinal pain of unknown origin in so far as the source of the patient’s pain can at least be narrowed to a particular offending segment. Further investigation of a patient accorded this diagnosis might result in the patient’s condition being ascribed a more definitive diagnosis such as discogenic pain or zygapophysial joint pain, but the diagnosis of segmental dysfunction could be applied if facilities for undertaking the appropriate investigations are not available, if the physician or patient does not wish to pursue such investigations, or if the pain arises from multiple sites in the same segment rendering investigation futile or meaningless.

For this diagnosis to be sustained it is critical that the clinical tests used be shown to be able to stress selectively the segment in question and to have acceptable interobserver reliability. To date, no studies have established validity for any techniques purported to demonstrate segmental dysfunction.

Code
533.X1hS
533.X7eS

Lumbar Ligament Sprain (XXVI-18)

Definition
Lumbar spinal pain stemming from a lesion in a specified ligament caused by strain of that ligament beyond its normal physiological limit.

Clinical Features
Lumbar spinal pain, with or without referred pain, aggravated by active or passive movements that strain the affected ligament.

Diagnostic Criteria
All the following criteria should be satisfied; otherwise the diagnosis can only be presumptive.
1. The affected ligament must be specified.
2. A history of an acute or chronic mechanical disturbance of the vertebral column which would be expected to have strained the specified ligament.
3. Aggravation of the pain by any clinical test that has been shown to stress the specified ligament selectively, or
   (b) Aggravation of the pain by a combination of clinical tests each of which stresses several ligaments or other structures but which have only the specified ligament in common, or
   (c) Selective infiltration of the putatively symptomatic ligament with local anesthetic under radiographic control completely relieves the patient’s pain.

Pathology
Unknown and unstudied. Presumably partial rupture of the collagen fibers of the ligament at a microscopic or macroscopic level causes inflammation of the injured part. May involve sustained strain of the ligament at the limit of its physiological range at a length short of partial failure but sufficient to elicit nociceptive stimulation consistent with impending damage to the ligament.

Remarks
Any clinical tests or local anesthetic infiltration of the ligament must be shown to be specific for that ligament. Any conventional or otherwise established clinical tests must have been shown to have good interobserver reliability.

Ligament sprain is an acceptable diagnosis in the context of injuries of the joints of the appendicular skeleton because the affected ligament is usually accessible to palpation for tenderness and because the ligament can be selectively stressed by passive movements of the related limb segments. However, this facility does not pertain to the lumbar spine. Lumbar ligaments are either impalpable or difficult to stress selectively. Hence the diagnosis is somewhat conjectural.

**Code**
533.XlmS

**Sprain of the Anulus Fibrosus (XXVI19)**

**Definition**
Lumbar spinal pain arising from a lesion in the anulus fibrosus of an intervertebral disk caused by excessive strain of the anulus fibrosus.

**Clinical Features**
Lumbar spinal pain, with or without referred pain, aggravated by movements that stress an anulus fibrosus, associated with a history compatible with singular or cumulative injury to the anulus fibrosus.

**Diagnostic Criteria**
The following criteria must be fulfilled.
1. The affected anulus fibrosus must be specified.
2. A history of activities or injury consistent with the affected anulus fibrosus having been strained.
3. (a) Aggravation of the pain by clinical tests that selectively stress the affected anulus fibrosus, or
   (b) Relief of the patient’s pain upon selectively infiltrating the affected anulus fibrosus with local anesthetic.

**Pathology**
Analogous to ligament sprain. Partial or complete tears of the anulus fibrosus in a location consistent with the nature of the precipitating stress; typically: circumferential tears of the outer layers of the anulus fibrosus caused by excessive combined flexion and rotation of the affected segment. Pain arises either as a result of an inflammatory repair response to the injured collagen fibers or as a result of excessive strain imposed by activities of daily living on the remaining, intact collagen fibers of the anulus fibrosus, which alone are insufficient to sustain these loads within their accustomed, normal physiological limits.

**Remarks**
Any clinical test used to diagnose sprain of the anulus fibrosus should be shown to be valid and reliable. To date, no such test has been developed. Consequently, until this is done this entity must remain conjectural. Such clinical tests as have been advocated for this condition (Farfan 1985) have not been assessed for validity.

**Code**
533.XlnS

**Reference**
Interspinous Pseudarthrosis (Kissing Spines, Baastrup’s Disease) (XXVI-20)

Definition
Lumbar spinal pain stemming from a pseudarthrosis formed between consecutive lumbar spinous processes.

Clinical Features
Lumbar, lumbosacral, or sacral spinal pain associated with midline tenderness over the affected interspinous space, the pain being aggravated by extension of that segment of the vertebral column.

Diagnostic Criteria
The pseudarthrosis must be evident radiographically and must be shown to be symptomatic by having the pain relieved upon selective anesthetization of the pseudarthrosis, provided that the local anesthetic injected does not spread to affect other structures that might constitute an alternative source of the patient’s pain.

Pathology
Periostitis as a result of repeated contact between the two bones, progressing to sclerosis of the contact sites of the two bones.

Remarks
The radiographic presence of a pseudarthrosis in a patient with spinal pain is insufficient grounds alone to justify the diagnosis. The pseudarthrosis must be shown to be symptomatic. Relief of pain following infiltration of local anesthetic into the lesion is not necessarily attended by relief following surgical treatment.

Code
533.X10S

Reference

Lumbar Instability (XXVI-21)

Definition
Lumbar spinal pain ostensibly due to excessive or abnormal motion of lumbar motion segment that exhibits decreased stiffness (Pope and Panjabi 1985) or an increased neutral zone (Panjabi et al. 1989).

Clinical Features
Lumbar spinal pain, with or without referred pain, that can be aggravated by movements that stress the affected spinal segment, accompanied by radiographic evidence of instability.

Diagnostic Criteria
No universally accepted criteria exist for the clinical or radiographic diagnosis of instability, but for this classification to be used, one of the sets of criteria proposed in the literature must be satisfied, such as those of Posner et al. (1982), Kalebo et al. (1990), or Nachemson (1991).

Pathology
Loss of stiffness in one or more of the elements of a lumbar motion segment that resist translation, rotation, or both. The pain presumably arises as a result of excessive stresses being imposed by movement.
on structures such as the ligaments, joints, or anulus fibrosus of the affected segment.

**Remarks**
No studies have revealed exactly what the source of pain is in unstable lumbar motion segments nor what the mechanism of pain production is. This diagnosis is, therefore, offered only as one of association between lumbar spinal pain and demonstrable movement abnormalities. No studies have vindicated any clinical test for instability. Consequently, the diagnosis can be sustained only if the radiographic criteria are strictly satisfied. At the time of writing, although such criteria have been enunciated, reservations have also been raised about the internal and external reliability of measurements made on radiographs of the type used to demonstrate instability (Shaffer et al. 1990).

**Code**
533.X7jS

**References**


**Spondylolysis (XXVI-22)**

**Definition**
Lumbar spinal pain arising from a painful pars interarticularis defect.

**Clinical Features**
Lumbar spinal pain, with or without referred pain, in association with a radiographically demonstrable pars interarticularis defect that has been shown to be the source of the patient’s pain.

**Diagnostic Criteria**
The patient’s pain should be fully or substantially relieved upon anesthetization of the pars interarticularis defect using a procedure that ensures that no other structure is anesthetized that might alternatively be the source of the patient’s pain.

**Remarks**
This classification should not be used unless the diagnostic criterion is satisfied. The presence of a pars interarticularis defect on radiographs or nuclear scans in a patient with lumbar spinal pain is not sufficient evidence to justify this diagnosis, because pars interarticularis defects occur in about 7% of asymptomatic individuals (Moreton 1966) and therefore may be only a coincidental finding in a patient with lumbar spinal pain. For this classification to be used evidence must be brought to bear that the observed defect is not asymptomatic.
References

Prolapsed Intervertebral Disk (XXVI-23)

Code
502.X1cS/C
602.X 1 aR
GROUP XXVII: SACRAL SPINAL OR RADICULAR PAIN SYNDROMES

Sacral Spinal or Radicular Pain Attributable to a Fracture (XXVII-1)

Definition
Sacral spinal pain occurring in a patient with a history of injury in whom radiography or other imaging studies demonstrate the presence of a fracture that can reasonably be interpreted as the cause of pain.

Clinical Features
Sacral spinal pain with or without referred pain.

Diagnostic Features
Radiographic or other imaging evidence of a fracture of the sacrum.

Code
533.X21S/C

Sacral Spinal or Radicular Pain Attributable to an Infection (XXVII-2)

Definition
Sacral spinal pain occurring in a patient with clinical and/or other features of an infection, in whom the site of infection can be specified and can reasonably be interpreted as the source of the pain.

Clinical Features
Sacral spinal pain with or without referred pain, associated with pyrexia or other clinical features of infection.

Diagnostic Features
A presumptive diagnosis can be made on the basis of an elevated white cell count or other serological features of infection, together with imaging evidence of the presence of a site of infection in the sacrum or its adnexa. Absolute confirmation relies on histological and/or bacteriological confirmation using material obtained by direct or needle biopsy.

Schedule of Sites of Infection

XXVII-2.1(S)(R)
   Infection of the Sacrum (osteomyelitis)
   Code 533.X2aS/C   633.X2aR

XXVII-2.2(S)
   Septic Arthritis of the Sacroiliac Joint
   Code 533.X2bS

XXVII-2.3(S)
   Infection of a Paravertebral Muscle (psoas abscess)
   Code 533.X2cS

XXVII-2.4(S)
   Infection of a Surgical Fusion-Site
   Code 533.X2dS

XXVII-2.5(S)
   Infection of a Retroperitoneal Organ or Space
   Code 533.X2eS

XXVII-2.6(S)(R)
Infection of the Epidural Space (epidural abscess)
Code 533.X2fS/C  633.X2bR
XXVII-2.7(S)(R)
Infection of the Meninges (meningitis)

Sacral Spinal or Radicular Pain Attributable to a Neoplasm (XXVII-3)

Definition
Sacral spinal pain associated with a neoplasm that can reasonably be interpreted as the source of the pain.

Clinical Features
Sacral spinal pain with or without referred pain.

Diagnostic Features
A presumptive diagnosis may be made on the basis of imaging evidence of a neoplasm that directly or indirectly affects one or other of the tissues innervated by sacral spinal nerves. Absolute confirmation relies on obtaining histological evidence by direct or needle biopsy.

Schedule of Neoplastic Diseases
XXVII-3. 1 (S)(R)
   Primary Tumor of the Sacrum
   Code 533.X4tS/C  633.X4kR
XXVII-3.2(S)
   Primary Tumor of the Sacroiliac Joint
   Code 533.X4kS
XXVII-3.3 (S)(R)
   Primary Tumor of a Parasacral Muscle
   Code 533.X4mS
XXVII-3.4(S)(R)
   Primary Tumor of Epidural Fat (e.g., lipoma)
   Code 533.X4nS/C  633.X41R
XXVII-3.5(S)(R)
   Primary Tumor of Epidural Vessels (e.g., angioma)
   Code 533.X4oS/C  633.X4mR
XXVII-3.6(S)(R)
   Primary Tumor of Meninges (e.g., meningioma)
   Code 503.X4dS/C  603.X4dR
XXVII-3.7(S)(R)
   Primary Tumor of a Spinal Nerve (e.g., neurofibroma, schwannoma, neuroblastoma)
   Code 533.X4eS/C  603.X4eR
XXVII-3.8(S)(R)
   Metastatic Tumor Affecting the Sacrum
XXVII-3.9(S)(R)
   Metastatic Tumor Affecting the Sacral Canal
   Code 533.X4qS/C  633.X4oR
XXVII-3.10
   Other Infiltrating Neoplastic Disease Affecting the Sacrum (e.g., lymphoma)
   Code 533.X4rS/C  633.X4pR
Sacral Spinal or Radicular Pain Attributable to Metabolic Bone Disease (XXVII-4)

Definition
Sacral spinal pain associated with a metabolic bone disease that can reasonably be interpreted as the source of the pain.

Clinical Features
Sacral spinal pain with or without referred pain.

Diagnostic Features
Imaging or other evidence of metabolic bone disease affecting the sacrum, confirmed by appropriate serological or biochemical investigations and/or histological evidence obtained by needle or other biopsy.

Schedule of Metabolic Bone Diseases
XXVII-4.1(S)(R)
Osteoporosis of Age
Code 532.X5gS/C 632.X5gR
XXVII-4.2(S)(R)
Osteoporosis of Unknown Cause
Code 532.X5hS/C 632.X5hR
XXVII-4.3(S)(R)
Osteoporosis of Some Known Cause Other than Age
Code 532.X5iS/C 632.X5iR
XXVII-4.4(S)(R)
Hyperparathyroidism
Code 532.X5jS/C 632.X5jR
XXVII-4.5(S)(R)
Paget’s Disease of Bone
Code 532.X5kS/C 632.X5kR
XXVII-4.6(S)(R)
Metabolic Disease of Bone Otherwise Not Classified
Code 532.X51S/C 632.X51R

Sacral Spinal or Radicular Pain Attributable to Arthritis (XXVII-5)

Definition
Sacral spinal pain associated with arthritis that can reasonably be interpreted as the source of the pain.

Clinical Features
Sacral spinal pain with or without referred pain.

Diagnostic Features
Imaging or other evidence of arthritis affecting the sacroiliac joints.

Schedule of Arthritides
XXVII-5.1(S)
Rheumatoid Arthritis of the Sacroiliac Joint
Code 534.X3bS
XXVII-5.2(S)
Ankylosing Spondylitis
XXVII-5.3(S)(R)
Seronegative Spondylarthropathy Otherwise Not Classified
Code 523.X8aS/C 623.X8aR

XXVII-5.4(S)
Sacroiliitis (evident on bone-scan)
Code 532.X8gS

XXVII-5.5(S)
Osteitis Condensans Ilii
Code 532.X8uS

Reference

**Spinal Stenosis: Cauda Equina Lesion (XXVII-6)**

**Definition**
Chronic pain usually experienced in the buttocks and legs, at times extremely severe. Usually deep and aching with “heaviness and numbness” in the leg from buttock to foot, associated with narrowing of the vertebral canal.

**Site**
Low back, buttocks, and lower extremities.

**System**
Musculoskeletal system.

**Main Features**
Patients usually have a long history of gradually increasing lumbar spinal with referred pain in the buttocks or lower limbs, with or without radicular pain, aggravated by extension of the lumbar spine, or by sustained postures that involve accentuation of the lumbar lordosis (like prolonged standing), and by walking. Walking also produces overt or subtle neurological features in the lower limbs that range from sensations of heaviness or clumsiness to paresthesias, numbness, weakness, and temporary paralysis of the lower limbs. The onset of these neurological features may be measured in terms of a “walking distance,” which diminishes as the condition progresses in severity.

**Associated Symptoms**
There may be paresthesias and bowel or bladder disturbance, or impotence.

**Aggravating Factors**
Walking, standing.

**Signs and Laboratory Findings**
X-rays usually demonstrate diffuse severe degenerative disease with facet hypertrophy and a shallow anteroposterior diameter of the lumbar canal. Cystometrogram may be helpful in diagnosis. Myelography and CT scanning are helpful in showing narrowing of the spinal canal. Magnetic resonance imaging and electrdiagnostic studies can also be helpful in demonstrating the areas involved. The dilemma posed by this condition is the discrepancy between physical signs, which are usually not great, and the subjective complaints.
Etiology
Congenital factors, (e.g., lumbar spondylosis, lumbar spondylolisthesis; degenerative disease, osteoarthritis).

Pathology
Encroachment upon and narrowing of the vertebral canal as a whole or of multiple lateral recesses thereof by osteophytes of the zygapophysial joints or syndesmophytes of the intervertebral disks. Congenital narrowing of the vertebral canal may predispose to this condition insofar as symptoms may arise in the face of osteophytes and syndesmophytes that in other individuals would not cause significant encroachment. The mechanism of the neurological features is unknown but may involve constriction of the dural sac with obstruction of flow of the cerebrospinal fluid, or obstruction of venous blood flow in the vertebral canal, or direct compression of spinal nerve roots.

Radicular pain may arise as a result of compression or other compromise of one or more nerve roots but there is no evidence that the constrictive effects of spinal stenosis cause spinal pain and referred pain. These latter forms of pain ostensibly arise from the disorders of one or more of the disks or zygapophysial joints whose osteophytic overgrowth coincidentally causes the stenosis.

Spinal stenosis is characterized by an essentially global distribution of neurological symptoms in the lower limbs, and in this respect should be distinguished from radicular pain due to foraminal stenosis, in which the pathology is restricted to a single intervertebral foramen and as such does not encroach upon the vertebral canal as a whole.

Treatment
Surgical decompression.

Differential Diagnosis
Peripheral vascular claudication, sciatic nerve compression, osteoarthritis of hip or knee, retroperitoneal tumors, other tumor or abscess, prolapsed lumbar disk.

Code
533.X6*S/C  Back
633.X6*R  Legs

Sacral Spinal or Radicular Pain Associated with a Congenital Vertebral Anomaly (XXVII-7)

Definition
Sacral spinal pain associated with a congenital vertebral anomaly.

Clinical Features
Sacral spinal pain with or without referred pain.

Diagnostic Features
Imaging evidence of a congenital vertebral anomaly affecting the sacrum.

Remarks
There is no evidence that congenital anomalies per se cause pain. Although they may be associated with pain, the specificity of this association is unknown. This classification should be used only when the cause of pain cannot be otherwise specified, but should not be used to imply that the congenital anomaly
is the actual source of pain.

**Code**
533.X0*S/C
533.X0*R
633.X0*R

**Pain Referred from Abdominal or Pelvic Viscera or Vessels Perceived as Sacral Spinal Pain (XXVII-8)**

**Definition**
Sacral spinal pain associated with disease of an abdominal or pelvic viscus or vessel that reasonably can be interpreted as the source of pain.

**Clinical Features**
Sacral spinal pain with or without referred pain, together with features of the disease affecting the viscus or vessel concerned.

**Diagnostic Features**
Imaging or other evidence of the primary disease affecting an abdominal or pelvic viscus or vessel.

**Schedule of Diseases**
XXVII-8.0 Classified elsewhere:
- Dysmenorrhea (see XXIV-2 and XXIV-3)
- Endometriosis (see XXIV-4)
- Posterior Parametritis (see XXIV-5)
- Retroversion of the Uterus (see XXIV-7)
- Carcinoma of the rectum (see XXIX-5.1)

XXVII-8.1 Irritation of Presacral Tissues by Blood
Code 533.X6aS/C

XXVII-8.2 Irritation of Presacral Tissues by Contents of Ruptured Viscera
Code 533.X6bS/C

**Sacral Spinal Pain of Unknown or Uncertain Origin (XXVII-9)**

**Definition**
Sacral spinal pain occurring in a patient whose clinical features and associated features do not enable the cause and source of the pain to be determined, and whose cause or source cannot be or has not been determined by special investigations.

**Clinical Features**
Sacral spinal pain with or without referred pain.

**Diagnostic Features**
Sacral spinal pain for which no other cause has been found or can be attributed.

**Pathology**
Unspecified.

**Remarks**
This definition is intended to cover those complaints that for whatever reason currently defy conventional
diagnosis. It does not encompass pain of psychological origin. It presupposes an organic basis for the pain but one that cannot be or has not been established reliably by clinical examination or special investigations, such as imaging techniques or diagnostic blocks.

This diagnosis may be used as a temporary diagnosis. Patients given this diagnosis could in due course be accorded a more definitive diagnosis once appropriate diagnostic techniques are devised or applied. In some instances, a more definitive diagnosis might be attainable using currently available techniques, but for logistic or ethical reasons these may not have been applied.

**Code**
5XX.X8*S

**Sacroiliac Joint Pain (XXVII-10)**

**Definition**
Spinal pain stemming from a sacroiliac joint.

**Clinical Features**
Pain perceived in the region of the sacroiliac joint with or without referred pain into the lower limb girdle or lower limb itself.

**Diagnostic Criteria**
The following criteria should all be fulfilled.
1. Pain is present in the region of the sacroiliac joint.
2. Stressing the sacroiliac joint by clinical tests that are selective for the joint reproduces the patient’s pain, or
3. Selectively infiltrating the putatively symptomatic joint with local anesthetic completely relieves the patient of the pain.

**Pathology**
Unknown. Presumably the pain is caused by excessive stresses being imposed on the ligaments of the sacroiliac joint as a result of some structural fault in the joint itself or as a result of the joint as a whole being subject to inordinate stresses.

**Remarks**
This category does not encompass sacroiliitis, ankylosing spondylitis, or seronegative spondylarthropathies that may be demonstrated by radionuclide imaging other forms of imaging or diagnosed by other means. This category infers a mechanical disorder of the joint.

Mechanical disorders of the sacroiliac joint are the subject of controversy. While there are beliefs that such disorders can befall the sacroiliac joint, no clinical tests of laudable validity and reliability have been devised whereby this condition can be diagnosed. The presence of such a condition, however, in the absence of any overt inflammatory joint disease, is implied by a positive response to an intraarticular injection of local anesthetic. Until such time as appropriate clinical tests are demonstrated to be valid and reliable, any diagnosis of sacroiliac joint pain based exclusively on clinical examination must be held to be only presumptive.

**Code**
533.X6dS

**Reference**
GROUP XXVIII: COCCYGEAL PAIN SYNDROMES

Coccygeal Pain of Unknown or Uncertain Origin (XXVIII-1)

Definition
Coccygeal pain occurring in a patient whose clinical features and associated features do not enable the cause and source of the pain to be determined, and whose cause or source cannot be or has not been determined by special investigations.

Clinical Features
Coccygeal pain with or without referred pain.

Diagnostic Features
Coccygeal pain for which no other cause has been found or can be attributed.

Pathology
Unspecified.

Remarks
This definition is intended to cover those complaints that for whatever reason currently defy conventional diagnosis. It does not encompass pain of psychological origin. It presupposes an organic basis for the pain but one that cannot be or has not been established reliably by clinical examination or special investigations, such as imaging techniques or diagnostic blocks.

This diagnosis may be used as a temporary diagnosis. Patients given this diagnosis could in due course be accorded a more definitive diagnosis once appropriate diagnostic techniques are devised or applied. In some instances, a more definitive diagnosis might be attainable using currently available techniques, but for logistic or ethical reasons these may not have been applied.

Code
5XX.X8hS

Posterior Sacroccocygeal Joint Pain (XXVIII-2)

Definition
Pain perceived in the coccygeal region, stemming from one or both of the posterior sacroccocygeal joints.

Clinical Features
Pain in the sacroccocygeal region.

Diagnostic Criteria
Complete relief of pain upon infiltration of the putatively symptomatic joint or joints with local anesthetic, provided that the injection can be shown to have been selective in that it has not infiltrated other structures that might constitute the actual source of pain.

Pathology
Unknown, but presumably involves sprain of the capsule of the affected joint.

Code
533.X1pS Trauma
533.X6eS Degenerative
GROUP XXIX: DIFFUSE OR GENERALIZED SPINAL PAIN

Generalized Spinal Pain Attributable to Multiple Fractures (XXIX-1)

Definition
Generalized spinal pain occurring in a patient with a history of injury in whom radiography or other imaging studies demonstrate the presence of multiple fractures that can reasonably be interpreted as the cause of their pain.

Clinical Features
Generalized spinal pain with or without referred pain.

Diagnostic Features
Radiographic or other imaging evidence of multiple fractures throughout the vertebral column.

Code
933.X1*S/C
933.X1*R

Generalized Spinal Pain Attributable to Disseminated Neoplastic Disease (XXIX-2)

Definition
Generalized spinal pain associated with widespread neoplastic disease of the vertebral column or its adnexa that can reasonably be interpreted as the source of the pain.

Clinical Features
Generalized spinal pain with or without referred pain.

Diagnostic Features
Imaging or other evidence of neoplastic disease that directly or indirectly affects multiple regions of the vertebral column or its adnexa.

Schedule of Neoplastic Diseases
XXIX-2.1(S)(R)
Disseminated Primary Tumors Affecting the Vertebral Column or Its Adnexa (e.g., multiple myeloma)
Code 933.X4aS/C 933.X4aR

XXIX-2.2(S)(R)
Disseminated Metastatic Tumors Affecting the Vertebral Column or Its Adnexa
Code 933.X4bS/C 933.X4bR

XXIX-2.3(S)(R)
Infiltrating Neoplastic Disease of the Vertebral Column or Its Adnexa, Other than Primary or Metastatic Tumors (e.g., lymphoma)
Code 933.X4cS/C 933.X4cR

Generalized Spinal Pain Attributable to Metabolic Bone Disease (XXIX-3)

Definition
Generalized spinal pain associated with a metabolic bone disease that can reasonably be interpreted as the
source of the pain.

**Clinical Features**
Generalized spinal pain with or without referred pain.

**Diagnostic Features**
Imaging or other evidence of metabolic bone disease affecting multiple regions of the vertebral column.

**Schedule of Metabolic Bone Diseases**

XXIX-3.1(S)(R)
Osteoporosis of Age
Code 933.X5aS/C  933.X5aR

XXIX-3.2(S)(R)
Osteoporosis of Unknown Cause
Code 933.X5bS/C  933.X5bR

XXIX-3.3(S)(R)
Osteoporosis of Some Known Cause Other than Age
Code 933.X5cS/C  933.X5cR

XXIX-3.4(S)(R)
Hyperparathyroidism
Code 933.X5dS/C  933.X5dR

XXIX-3.5(S)(R)
Paget’s Disease of Bone
Code 933.X5eS/C  933.X5eR

XXIX-3.6(S)(R)
Metabolic Disease of Bone Not Otherwise Classified
Code 933.X5fS/C  933.X5fR

**Generalized Spinal Pain Attributable to Arthritis (XXIX-4)**

**Definition**
Generalized spinal pain associated with arthritis that can reasonably be interpreted as the source of the pain.

**Clinical Features**
Generalized spinal pain with or without referred pain.

**Diagnostic Features**
Imaging or other evidence of arthritis affecting the joints of multiple regions of the vertebral column.

**Schedule of Arthritides**

XXIX-4. 1 (S)(R)
Rheumatoid Arthritis
Code 932.X3aS/C  932.X3aR

XXIX-4.2(S)(R)
Ankylosing Spondylitis
Code 932.X3bS/C  932.X3bR

XXIX-4.3(S)(R)
Osteoarthritis
Code 932.X8*S/C  932.X8*R

XXIX-4.4(S)(R)
Ankylosing Spondylitis (XXIX-4.2)

Definition
Aching low back pain and stiffness of gradual development due to chronic inflammatory change of unknown origin.

Site
Low back.

System
Musculoskeletal system.

Main Features
Prevalence in 1-2% of the population. Males nine times more common than females. Peak onset in the third or fourth decades. More common in Caucasian populations, but some other ethnic groups, e.g., Haida Indians, have unusually high prevalence rates. Chronic, persistent low back pain of insidious onset, aching discomfort, and stiffness while sleeping that forces the patient to get up and move around; morning stiffness is usually greater than half an hour in duration, and stiffness occurs also after periods of inactivity ("gelling phenomenon").

Associated Symptoms
Peripheral joint disease in 20% of patients, conjunctivitis and iritis in 25% of patients, chronic pulmonary fibrosis and cardiovascular disease.

Aggravating Features
Inactivity.

Signs
Depressed spinal mobility and chest expansion with chest involvement.

Laboratory Findings
None specific; 90% of patients are HLA-B27 positive, but 8-10% of normal populations also are HLA-B27 positive.

Radiographic Findings
Bilateral symmetric sacroiliitis; syndesmophytes of lumbar thoracic spines.

Usual Course
Chronic lumbar pain often with acute exacerbations intermittently; pain diminishes as spine fuses.

Relief
Some severe morning stiffness or pain abates with activity. A good response to nonsteroidal anti-inflammatory drugs.

Complications
Spinal immobility, fracture of fused spine. Higher spinal disease may cause vertical odontoid subluxation or penetration with brain-stem compression.
Etiology
Unknown; may be immunological, with possible environmental factors, along with apparent genetic susceptibility.

Essential Features
Chronic aching lumbar pain and stiffness with “gelling” and with characteristic X-ray changes as described.

Differential Diagnosis
Psoriatic spondylitis; Reiter’s spondylitis; mechanical back pain; discogenic back pain.

Code
932.X3bS/C
932.X3bR

Back Pain of Other Visceral or Neurological Origin Involving the Spine (XXIX-5)

Carcinoma of the Rectum (XXIX-5.1)

Code
Pelvic pain
753.X4*S/C  753.X4*R
Perineal pain
853.X4*S/C  853.X4*R

Tumor Infiltration of the Lumbosacral Plexus (XXIX-5.2)

Definition
Progressively intense pain in the low back or hip with radiation into the lower extremity.

Site
Lower back and leg.

System
Nervous system (lumbosacral plexus).

Main Features
Lumbosacral plexopathy occurs most commonly in patients with genitourinary, gynecological, and colonic cancers as a result of local tumor extension. The local pain is pressure-like or aching in quality. The referred pain varies with the site of plexus involvement and can be burning, crampy, or lancinating. Upper lumbar plexus involvement produces pain in the anterior thigh and groin, whereas pain in the L5-S1 distribution radiates down the posterior aspect of the leg to the heel. The pain is often worse at night and is usually aggravated by movement of the hip joint.

Associated Symptoms
Typically, leg weakness and numbness occur three to five months after the onset of pain. Sphincter disturbance is uncommon.

Signs and Laboratory Findings
There may be tenderness in the region of the sciatic notch. There is usually limitation of both direct and reverse straight leg raising. Focal weakness and sensory loss with depressed deep tendon reflexes may be evident. The cardinal feature is progressive weakness in a pattern involving more than one nerve root. There may be pedal edema due to lymphatic obstruction.

An intravenous pyelogram may show hydronephrosis. A CT scan through the abdomen and pelvis is the definitive study. It may show a paralumbar or pelvic soft tissue mass and there may be bony erosion of the pelvic side wall. Myelography may be positive if there is epidural extension of disease.

**Usual Course**
The course is inexorably progressive and leads to a wheelchair- or bedridden existence.

**Summary of Essential Features and Diagnostic Criteria**
Low back and hip pain radiating into the leg is followed in weeks to months by progressive numbness, paresthesias, weakness, and leg edema. The physical findings indicate that more than one nerve root is involved. CT scan of the abdomen and pelvis is the study of choice.

**Differential Diagnosis**
Myelography and cerebrospinal fluid analysis should rule out epidural and meningeal metastatic disease, respectively. Other entities to consider are radiation fibrosis, lumbosacral neuritis, and disk disease.

**Code**
502.X4dS/C
502.X4dR

**Tumor Infiltration of the Sacrum and Sacral Nerves (XXIX-5.3)**

**Definition**
Dull aching sacral pain accompanied by burning or throbbing pain in the rectum and perineum.

**Site**
Sacrum, rectum, and perineum.

**Systems**
Skeletal and nervous systems.

**Main Features**
Pain in a sacral distribution usually occurs in the fifth, sixth, and seventh decades as a result of the spread of bladder, gynecological, or colonic cancer. There is dull aching midline pain and usually burning or throbbing pain in the soft tissues of the rectal and perineal region. The pain is usually made worse by sitting and lying. The rectal and perineal component of the pain may respond poorly to analgesic agents.

**Associated Symptoms**
With bilateral involvement, sphincter incontinence and impotence are common.

**Signs and Laboratory Findings**
There may be tenderness over the sacrum and in the region of the sciatic notches. Sometimes there is limitation of both direct and reverse straight leg raising. Involvement of S1 and S2 roots will produce weakness of ankle plantar flexion, and the ankle jerks may be absent. There is usually sensory loss in the perianal region and in the genitalia, and this may be accompanied by hyperpathia. CT scan of the pelvis usually shows sacral erosion with a presacral mass.
Usual Course
The pain and sensory loss may be unilateral initially with progression to bilateral sacral involvement and sphincter disturbance.

Social and Physical Disability
The major disabilities are the results of intractable pain and loss of sphincter function. An in-dwelling urinary catheter may be required.

Summary of Essential Features Differential Diagnosis
The essential features are dull aching sacral pain with The differential diagnosis includes post-traumatic neuromas in patients with previous pelvic surgery, perineal burning or throbbing perineal pain. There is usually sac-romas in patients with previous pelvic surgery, pelvic ral sensory loss and sphincter incontinence. A CT scan abscess, radiation fibrosis, and tension myalgias of the of the pelvis may show sacral erosion and a presacral pelvic floor. soft tissue mass.

Differential Diagnosis
The differential diagnosis includes post-traumatic neuromas in patients with previous pelvic surgery, pelvic abscess, radiation fibrosis, and tension myalgias of the pelvic floor.

Diagnostic Criteria
1. Dull aching sacral pain.
2. Burning or throbbing perineal pain.
3. Perineal sensory loss and sphincter dysfunction.
4. CT scan of pelvis may show sacral erosion and presacral soft tissue mass.

Code
Nerve infiltration
702.X4*S/C  702.X4*R
Musculoskeletal deposits
732.X4*S/C  732.X4*R
GROUP XXX: LOW BACK PAIN OF PSYCHOLOGICAL ORIGIN WITH SPINAL REFERRAL

The frequency of low back pain due solely to psychological causes is unknown but probably relatively low compared with low back pain overall, which of course is very common. Psychological causes may play an important part in protracted low back pain in a large number of patients. They will, however, rarely be seen to be the sole cause of the pain, nor will the diagnosis emphasize them in the first instance.

Low Back Pain of Psychological Origin with Spinal Referral (XXX-1)
(See also 1-16)

Code
533.X7bS     Tension
51X.X9aS     Delusional
51X.X9bS     Conversion
51X.X9fS     Depression