

In both cases, the majority of respondents would follow-up clinically or radiographically every 1-3 months, respectively. Conclusions: This study highlights consensus in Canadian practice patterns for the workup and management of asymptomatic eTVAl.

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Evaluating instability in Degenerative Lumbar Spondylolisthesis: objective variables versus surgeon impressions

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Background: The qualitative Degenerative Spondylolisthesis Instability Classification (DSIC) system defines pre-operative instability associated with degenerative lumbar spondylolisthesis (DLS) and facilitates surgical technique selection. **Objectives:** (1) propose a quantitative DSIC system; (2) compare objective measures to surgeon impressions of DLS-related instability. **Methods:** We conducted a multi-center prospective study of 408 adult patients undergoing surgery for DLS. Variables included in the quantitative classification were assigned point-values based on evidence quality. Scores were converted to DSIC Types: 0-2 points ("Stable"; Type I), 3 points ("Potentially Unstable"; Type II), 4-5 points ("Unstable"; Type III). Surgeons documented impressions of instability using the qualitative DSIC system. **Results:** Five variables were included in the quantitative DSIC: presence of facet effusion, preservation of disc height (<6.5mm), translation (>4mm), kyphotic or neutral disc angle in flexion, and presence of low back pain (LBP) (>5/10 intensity). Surgeons categorized higher degrees of instability than the preliminary quantitative DSIC system, in 130 patients (42%) ($P < 0.001$). Compared to procedures suggested by the quantitative DSIC system, more extensive surgical procedures were performed in 150 patients (57%) ($P < 0.001$). **Conclusions:** A quantitative DSIC system allowed DLS-related stability to be scored and categorized. Patients potentially received more extensive surgery than warranted based on quantitative assessments of stability.

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The nerve root sedimentation sign on MRI is not only correlated with neurogenic claudication: association with leg dominant mechanical pain

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Background: A correlation between the nerve root sedimentation sign (SedSign) and neurogenic claudication has been

demonstrated; though it did not account for leg-dominant pain. This study analyzed the utility of SedSign to diagnose leg-dominant pain using validated classification systems. **Methods:** We retrospectively reviewed prospective data from 367 patients with back or leg pain collected between January 1, 2012 to May 31, 2018. Baseline characteristics included SSPc (Saskatchewan Spine Pathway classification), Oswestry disability index (ODI), visual analogue pain scores (VAS), and EuroQol Group 5-Dimension Self-Report (EQ5D). Inter- and intra-rater reliability for SedSign was 73% and 91%. **Results:** SedSign was positive in 111 (30.2%) and negative in 256 (69.8%) patients. Univariate analysis showed a correlation between SedSign and age, male sex, ODI, EQ5D, cross-sectional area (CSA) of stenosis, antero-posterior diameter of stenosis, and leg-dominant pain; negative SedSign was correlated with back-dominant pain. Multivariate analysis revealed an association between SedSign and age, male sex, CSA stenosis, and ODI walking distance. The sensitivity, specificity, positive and negative predictive values of SedSign for leg-dominant pain were 33.5%, 83.2%, 77.0%, and 57.3%. **Conclusions:** SedSign has high specificity but low sensitivity for leg-dominant pain. Despite a similar correlation between SedSign and neurogenic claudication or sciatica, significance was lost on multivariate analysis.

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An exploration of the evolving perception of quality of life from the perspective of individuals living with a cervical spinal cord injury in Nova Scotia

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Background: Spinal cord injuries invoke enormous life changes for the individual, with impacts not just on physical functioning, but social and psychological well-being. Individuals learn to deal with these changes, and handle these new stressors in different ways. Extant literature suggest the majority of people eventually attain a quality of life (QoL) similar to able-bodied individuals. We sought to validate these observations in a contemporary cohort and specifically explore how patients' perceptions evolve over time. **Methods:** We conducted hour-long semi-structured interviews with 15 individuals living with cervical spinal cord injuries. Interviews took place over the telephone or virtually via MS Teams. Interview transcripts were then analyzed using an iterative coding process and thematic analysis (NVivo). **Results:** The over-arching journey that most participants described was a continuous evolution in QoL, as they learned to adapt and function with their injury. However, these trajectories were disparate and heavily reliant on personal supports and resources available, their psychosocial environment and inherent coping strategies. **Conclusions:** This study emphasizes the unique nature of each person's journey, and not all people attain a satisfactory QoL. Our approach needs to be individualized, adjusting to specific circumstances, in order to provide more inclusive and supportive care.