PREMIER NEUROSURGERY

Spine Insights

A QUARTERLY CLINICAL BRIEF FOR PRIMARY CARE
ISSUE 01 · MAY 2026

THIS ISSUE · CERVICAL SPINE

Cervical myelopathy: *the diagnosis hiding in plain sight.*

Dear Colleague,

It is my pleasure to share the inaugural edition of the Premier Neurosurgery newsletter, and to personally thank you for the trust you place in our practice.

As a spine-focused neurosurgeon serving Contra Costa County, I am committed to helping patients navigate complex spinal conditions through thoughtful, individualized treatment plans and advanced surgical techniques — without ever losing sight of the human experience behind each diagnosis.

This newsletter is one way we hope to stay connected: sharing clinical insight, practice updates, and resources that support you in caring for your patients.

— **Brandon McCutcheon, MD, FAANS**

THE CLASSIC SYMPTOM TRIAD

1 HAND DEXTERITY LOSS
Difficulty buttoning shirts, dropping objects, declining handwriting. Often the earliest symptom — and the most easily overlooked.

2 GAIT INSTABILITY
Subtle balance problems, wide-based gait, or a new tendency to hold handrails. Patients often attribute this to "getting older."

3 BOWEL / BLADDER CHANGES
Urinary urgency, frequency, or hesitancy. A late finding that signals significant cord compression. Don't wait for this one.

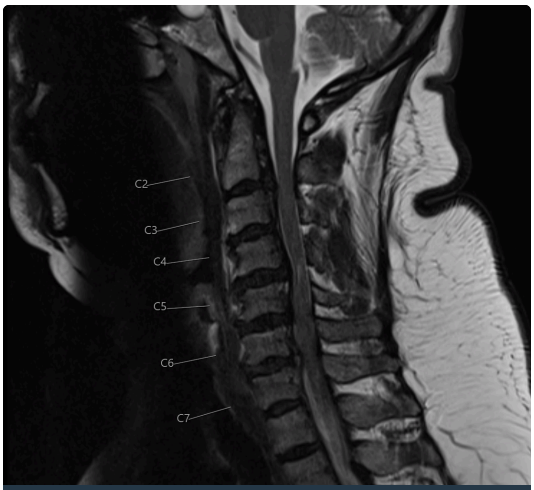

FIGURE 1 · SAGITTAL T2 CERVICAL MRI
Advanced canal stenosis at C2/3 and C4–C7, with T2 cord signal at C4/5.

CLASSIC EXAM FINDINGS

- **HOFFMANN SIGN**
  Flick the distal phalanx of the middle finger; involuntary flexion of the thumb or index finger suggests upper motor neuron pathology.
- **HYPERREFLEXIA**
  Brisk reflexes in the upper extremities or at the patellar tendon suggest upper motor neuron involvement.
- **WIDE-BASED GAIT**
  Broad stance or spastic pattern. Ask the patient to walk heel-to-toe — myelopathy makes tandem gait difficult.

Referral algorithm

01	**SCREEN**	Any component of the symptom triad or classic exam findings? If positive or suspicious, proceed to imaging.
02	**IMAGE**	MRI cervical spine without contrast is the study of choice. Consider adding CT cervical without contrast and cervical flexion/extension radiographs if surgery is anticipated.
03	**REFER**	ROUTINE Mild symptoms with imaging-confirmed cord stenosis. Expect an appointment within two weeks.
04	**URGENT**	URGENT · 48H Progressive deficit, gait deterioration, new bowel/bladder symptoms, or significant cord signal change. Use the VIP line — seen within 48 hours. Acute myelopathy with rapid decline → ED.

Treatment options

Cervical myelopathy is a surgical disease.

Typical conservative measures including Physical Therapy and Epidural Steroid Injections, while useful for axial neck pain or radiculopathy, are not effective when there is spinal cord compression and myelopathy symptoms. The key to preventing symptom progression is achieving **decompression** and **stabilization** of the stenotic segment — delivered either through an anterior or posterior approach.

ANTERIOR APPROACH

Anterior cervical discectomy & fusion

ACDF

Cord decompressed from the front by removing the offending disc, osteophytes, and compressive PLL. Interbody graft restores disc height; plate achieves fusion.

Smaller incision, minimal muscle disruption, direct access to ventral pathology.

BEST SUITED FOR:

One- to three-level disease with predominantly ventral compression.

POSTERIOR APPROACH

Laminectomy & fusion

POSTERIOR DECOMPRESSION & FUSION

Cord decompressed from behind by removing lamina over affected levels. Instrumented fusion with lateral-mass or pedicle screws restores alignment and prevents post-laminectomy kyphosis.

Addresses long-segment stenosis; accommodates poor cervical lordosis or ossified ligamentum.

BEST SUITED FOR:

Multi-level disease, dorsal pathology, or congenitally narrow canals.

THE VIP REFERRAL LINE

Direct line to our clinical team.

For urgent referrals and complex cases. Your call reaches our clinical coordinator directly — no phone tree, no voicemail. We confirm an appointment before you hang up.

925.430.5754

MON–FRI · 9A–4P

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Premier Neurosurgery
323 Lennon Lane · Walnut Creek, CA 94598

Brandon McCutcheon, MD, FAANS
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