exiting root at the level of the disc prolapse. The right image shows a block of the exiting root at the level below. Steroids were used on both occasions, yet in neither case did the injection address the presumed pathology directly.

There are at least two important implications, which we highlighted in our discussion. First, if an injection was used as a diagnostic procedure, it is essential to know where it was placed. This is especially true if, for instance, as a clinician you refer your patients for a diagnostic procedure to be performed by staff from another specialty, such as radiology, as you need to know how to interpret the result. Second, in reviewing the literature, particularly in relation to those studies on the role of steroids, ask yourself whether you know at which level the injection was given in relation to the pathology. Have the authors made it clear in their paper? If not, then we suggest that the conclusions of that study should be treated with some caution. This is the message of our paper, which we hope encourages further debate on this subject.

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Computed tomography of the lumbar spine

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COMMENT ON

Ahmad Z, Mobasheri R, Das T *et al.*

How to interpret computed tomography of the lumbar spine. *Ann R Coll Surg Engl* 2014; **96**: 502–507
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I read with interest the article by Ahmad *et al.* It describes the role of computed tomography (CT) in assessing stability of fractures of the lumbar spine. While I agree that CT is a very valuable tool for looking at bony anatomy and much information can be gleaned from it, I think it is important to emphasise that in most situations when looking at spinal pathology, magnetic resonance imaging (MRI) is the investigation of choice.

The paper describes CT in terms of a trauma situation and spinal stability. Most polytrauma protocols around the UK do now include whole-body CT (including the spine) for the rapid triage of patients. In trauma, however, we recognise increasingly that a combination of physical examination, CT and often MRI is required to assess spinal stability thoroughly. The role of the posterior soft tissue structures of the spine, not to forget disc injuries, has moved us away from the three-column system as described in this paper to classification systems based on mechanisms of injury such as the Magerl classification,¹ the Thoracolumbar Injury Severity Score,² and the Thoracolumbar Injury Classification and Severity Score.⁵

CT certainly is an important diagnostic tool for spinal bony anatomy. It is often the investigation of choice when looking for spondylolysis, be it acute or chronic, but it is important to remember that the combination of physical examination, CT, MRI and mechanisms of injury are often more important when establishing stability and treatment options in trauma.

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