

The More Intensive the Diagnostic Workup, the More Likely It Is That the Cause of Coccygodynia Can Be Clarified

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Letter to the Editor¹

We read with interest Galanakos et al's article about a 64-year-old male with coccygodynia and perianal numbness secondary to a coccygeal prolapse between S6 and S7 (1). With intensive conservative measures over three months, the patient's symptoms disappeared completely (1). It was concluded that imaging is of great importance in elucidating the cause of coccygodynia (1). The study is impressive, but several points require discussion. The major limitation of the study is that various alternative causes of coccygodynia were not sufficiently considered and excluded. Spondylosis, spondylarthrosis, chondrosis, osteochondrosis, foraminal stenosis, uncovertebral arthrosis, vertebral stenosis, osteoporosis, rheumatological disease (rheumatoid arthritis, polyarthritits, Sjögren syndrome, psoriatic arthropathy), immune or infections radiculitis, hypermobile os coccygis, SARS-CoV-2 infection, and varicositas spinalis were not excluded.

Since lumbar spine degeneration is one of the major causes of coccygodynia and since figure 1 shows chondrosis L4/L5, height reduction of the disc L4/5 and L3/L4, listhesis L4/L5, it is imperative to rule out degenerative lumbar disease as the cause of coccygodynia. Another argument

in favour of lumbar degenerative disease as the cause of coccygodynia is that physiotherapy was beneficial. A second limitation is that MRI was performed in only one plane. To assess whether prolapse or other pathology actually occurred, it is imperative to also provide images of the axial and coronal planes. In addition, there is no contrast medium. MRI is mandatory to rule out spondylodiscitis, radiculitis, paravertebral abscess, or other causes of inflammation, vasculitis, or a vascularised tumour. A third limitation is that perianal numbness has not been adequately studied. Perianal numbness suggests that sensory functions in this region were impaired, either at the level of the receptors or the level of centripetal signaling to the central nervous system. It is unlikely that central nervous system disease is the cause of coccygodynia and perianal numbness, as this has not previously been described as a CNS manifestation and clinical neurological examination did not provide evidence of CNS disease. A fourth limitation is that no cerebrospinal fluid (CSF) studies have been performed. To rule out radiculitis (e.g. Elsberg syndrome), myelitis, discitis, SARS-CoV-2 infection, or malignant disease, it is imperative to examine the CSF for infectious or immunological disease or malignancies. A fifth limitation is that extravertebral causes of coccygodynia have not been adequately ruled out. The patient did not

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undergo urological examination to rule out benign prostatic hyperplasia, prostatitis, or prostate carcinoma. The results of colonoscopy, rectoscopy, or sigmoidoscopy are not mentioned. A sixth limitation is that no dynamic imaging studies and provocative discography were performed. It would have made sense to carry out the MRI or CT in a laying, sitting, and upright position.

In summary, the excellent study has limitations that should be addressed before drawing final conclusions. Clarifying the weaknesses would strengthen the conclusions and could improve the

study. Unless all possible differential causes of coccygodynia have been adequately ruled out in the index patient, coccygodynia should not be attributed to coccygeal prolapse.

References

1. Galanakis SP, Karakousis ND, Bablekos G, Fontara S. Coccygeal Disc Disease as a Possible Cause of Coccygodynia. *Acta Med Acad.* 2023 Aug 1. doi: 10.5644/ama2006-124.418. Epub ahead of print.