MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Saddle or perineal numbness

Structured history, interpretation & clinical review

Symptom 29 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

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> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

Saddle or perineal numbness is assessed urgently with bladder, bowel, sexual, back-pain, leg-motor, and reflex findings because cauda-equina compression is time-sensitive.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person’s usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. “Not sure” is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for Saddle or perineal numbness

1A. Immediate safety screen

Is there new urinary retention, loss of bladder or bowel control, saddle numbness, or new sexual dysfunction?

☐ No ☐ Yes ☐ Not sure

If Yes: Go to an emergency department now for cauda-equina assessment; do not wait for routine imaging.

Is there rapidly progressing weakness in one or more limbs, a sensory level, or new inability to walk?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now for possible spinal-cord compression or another acute cord process.

Is there fever, immune suppression, recent spinal procedure, injection-drug use, cancer, or severe unremitting night pain?

☐ No ☐ Yes ☐ Not sure

If Yes: Arrange same-day assessment; fever or progressive neurological deficits require emergency care.

Did significant trauma precede the pain, or is there new deformity or immediate neurological loss?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now and avoid unnecessary movement of the spine.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

How did the symptom begin?

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months ☐ Longstanding or since childhood ☐ Not sure

Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.

What is the overall course?

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable ☐ Currently resolved

Has this exact pattern been assessed before?

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

1C. Discriminating features

Which bladder change is present?

☐ Difficulty starting, incomplete emptying, or inability to pass urine ☐ New loss of control or reduced awareness ☐ No bladder change ☐ Not sure

Is there new leg weakness, numbness, or loss of reflex-like function?

☐ Both legs ☐ One leg ☐ No leg symptoms ☐ Not sure

Is there severe low-back pain or radiation into one or both legs?

☐ Yes ☐ No ☐ Not sure

Is this acute/progressive, or longstanding and previously evaluated?

☐ New or rapidly changing ☐ Stable after a previous evaluation ☐ Not sure

1D. Associated findings

Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?

☐ Yes ☐ No ☐ Not sure

Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?

☐ Yes ☐ No ☐ Not sure

How much does this affect daily activity?

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

1E. Clinical context

Who is being assessed?

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

Could a medicine, substance, withdrawal, or recent dose change be relevant?

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.

Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?

☐ No known relevant condition ☐ Yes ☐ Not sure

What prior information is available?

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person’s baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Saddle symptoms with bladder dysfunction

Which bladder change is present? Difficulty starting, incomplete emptying, or inability to pass urine / New loss of control or reduced awareness

Emergency warning pattern — Now

Saddle numbness with new bladder dysfunction requires emergency cauda-equina assessment.

Differential to review:

- Cauda equina or conus compression

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 2: Saddle symptoms with leg deficits or severe pain

Is there new leg weakness, numbness, or loss of reflex-like function? Both legs / One leg
Is there severe low-back pain or radiation into one or both legs? Yes

Emergency warning pattern — Now

Saddle sensory loss with leg deficits or severe radiating back pain is an emergency spinal presentation.

Differential to review:

- Cauda equina or conus compression
- Spinal-cord, demyelinating, or inflammatory process

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 3: New isolated saddle numbness

Is this acute/progressive, or longstanding and previously evaluated? New or rapidly changing
Which bladder change is present? No bladder change

Urgent assessment pattern — Same day

New saddle numbness remains a same-day spinal assessment even without reported bladder change.

Differential to review:

- Cauda equina or conus compression
- Sacral plexus or peripheral sacral-nerve disorder

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Pattern 4: Stable previously evaluated saddle finding

Is this acute/progressive, or longstanding and previously evaluated? Stable after a previous evaluation
Which bladder change is present? No bladder change
Is there new leg weakness, numbness, or loss of reflex-like function? No leg symptoms

Prompt clinical review pattern — Promptly

A stable documented finding can be reviewed against prior records, but any change reopens the emergency pathway.

Differential to review:

- Chronic post-surgical, pelvic, or functional sensory change

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Unresolved-information pathway: New saddle numbness needs urgent spinal assessment.

Emergency warning pattern — Now

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Cauda equina or conus compression

Discriminating features: Saddle sensory loss with retention, sphincter/sexual change, bilateral sciatica, or leg weakness.

Logical investigations: Emergency lumbosacral MRI and surgical/neurological assessment; bladder scanning may support but does not exclude the diagnosis.

3.2 Sacral plexus or peripheral sacral-nerve disorder

Discriminating features: Perineal sensory loss without the full compression pattern, sometimes after pelvic injury, surgery, infection, or diabetes.

Logical investigations: Careful sacral reflex/sensory/sphincter examination; pelvic, plexus, or electrodiagnostic evaluation as indicated.

3.3 Spinal-cord, demyelinating, or inflammatory process

Discriminating features: A sensory level, upper-motor signs, or other central features broadens beyond cauda-equina disease.

Logical investigations: Urgent spinal and sometimes brain imaging with clinician-directed inflammatory testing.

3.4 Chronic post-surgical, pelvic, or functional sensory change

Discriminating features: Stable documented findings after prior disease may persist, but new progression must not be attributed to old disease.

Logical investigations: Compare prior records and examination; repeat urgent imaging for new retention, weakness, or progression.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. National Institute for Health and Care Excellence. (2019, updated 2023). *Suspected neurological conditions: recognition and referral (NG127)*. https://www.nice.org.uk/guidance/ng127
2. National Institute for Health and Care Excellence. (2016, updated 2020). *Low back pain and sciatica in over 16s: assessment and management (NG59)*. https://www.nice.org.uk/guidance/ng59