**Commentary**
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# Lumbar Lordosis

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## Description

Lordosis is the lumbar spine's inward curve (just above the buttocks). A minor amount of lordosis is normal. Swayback occurs when there is too much curving. Perhaps the best way to understand lumbar spinal stenosis is as a clinicopathologic disorder: the condition is characterised by a narrowing of the lumbar spinal canal and the nerve root canals, which is typically caused by osteoarthritis. This narrowing cause's compression of the contents of the canals with the neural and vascular structures which results in neurologic symptoms that are intermittent, typically triggered by ambulation, and typically positional. A smaller group of adults in their third and fourth decades are also afflicted, and in most cases, their lumbosacral spines are congenitally narrowed. As evidence of the primary aetiology of the stenosis, some patients with the congenital form of spinal stenosis exhibit achondroplastic dwarfism and present at a relatively young mean age of 38. Patients have a gradual onset of widespread symptoms that are frequently symmetrical, reflecting the fact that the underlying disease process frequently affects multiple spinal levels and is bilateral in nature [1-5].

Low back pain and morning stiffness that are eased by activity are typically the initial signs of lumbar spinal stenosis. As time goes on, there is frequently low back, buttock, thigh, and calf discomfort, which is frequently described as a cramping, burning sensation. Numbness and tingling in the legs and thighs may also occasionally be present. In the early stages of the ailment, the symptoms may be moderate and brought on by prolonged standing or walking, but as time goes on, many patients' conditions appear to reach a longer plateau phase. In very severe cases, patients may not walk more than a few feet without experiencing excruciating sensations. In response, they instinctively assume a stooped or anthropoid posture, which is thought to help the lumbar spinal canal widen [2,3].

The cauda equina, which is made up of several nerve roots that descend to their individual neural foramena and provide egress from the lumbosacral spinal canal, continues the spinal cord in adults at the top border of the L1 vertebral body. Congenital and acquired lumbar spinal stenosis are the two main subtypes. Short pedicles, thicker lamina and facets, and severe scoliotic or lordotic curves are the main congenitally occurring causes of restricted lumbar canals. The risk of developing clinically significant lumbar spinal stenosis in patients with these congenital anatomical alterations is slightly reduced, and this risk can be exacerbated by later-onset, superimposed degenerative joint changes that lead to additional canal narrowing [4,5].

Congenital spinal stenosis in achondroplastic dwarfism results from defects in cellular metabolism that slow cartilaginous growth and cause irregular intracartilagenous bone formation. This condition causes a significant narrowing of the spinal canal in all of its dimensions, particularly in the upper lumbar regions because of shortened pedicles, hypertrophied zygapophyseal joints, and thickened laminae. The occurrence of neurogenic claudication, the primary symptom of lumbar spinal stenosis, is explained by three theories. The postural, ischemic, and venous stasis hypotheses are their names. According to the postural theory, when the lumbar spine is stretched and lordosis is highlighted, either at rest or in the erect posture, symptoms are explained by temporary compression of the cauda equina by degenerative intervertebral discs and thickened ligamenta flava. In the assessment of individuals thought to have lumbar spinal stenosis, neuroimaging using MRI takes centre stage among diagnostic testing modalities. With its multiplanar imaging capability, this noninvasive test offers the most thorough evaluation of the lumbosacral spine's anatomy. It also allows for clear visualisation of the spinal cord, cauda equina, exiting nerve roots, and their relationships to the different components of the spinal canal, such as the ligaments, epidural fat, subarachnoid space, and intervertebral discs. Numerous conservative measures can be taken. Gentle leg and back strengthening exercises and mobility training can be given as part of physical therapy to help lower the risk of falling. Utilizing an exercise bike and taking quick strolls are examples of exercises [1,2].

Patients should also refrain from performing lumbar extension exercises, think about using lumbar bracing on occasion, and start a weight loss programme if they are obese. The use of nonsteroidal anti-inflammatory medicines, muscle relaxants, transcutaneous nerve stimulation, ultrasound therapy, and periodic epidural corticosteroid injection courses are some further unproven or anecdotal treatments [4].

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## Conflict of Interest

The authors reported no potential conflict of interest.

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