TRACTS OF SPINAL CORD
LEARNING OBJECTIVES

- White Matter - classification
- Tracts
  - Ascending Tracts
  - Descending Tracts
- Clinical Correlates
SECTION OF SPINAL CORD

Dorsal columns (white matter)

Dorsal horn (grey matter)

Ventral horn (grey matter)

Ventral columns (white matter)

Dorsal (posterior)

Dorsal nerve root (PNS)

Ventral (anterior)

Ventral nerve root (PNS)

Spinal nerve

Cervical

Thoracic

Lumbar

Sacral

Ventral
WHITE MATTER OF THE SPINAL CORD

Mixture of:

1. Nerve fibers,
2. Neuroglia,

- surrounds the grey matter
- white colour
- myelinated nerve fibres.
TYPES OF FIBRES

- Sensory
- Motor
- Association
DIVISIONS IN WHITE MATTER

Anterior white column (or funiculus)

Lateral white column (or funiculi)

Posterior white column (or funiculus)

Anterior white commissure.
TRACTS
Collection of nerve fibres with same Origin, Course, Termination
TRACTS OF SPINAL CORD

Ascending tracts
- Dorsal white column
- Fasciculus gracilis
- Fasciculus cuneatus
- Posterior spinocerebellar tract
- Anterior spinocerebellar tract
- Lateral spinothalamic tract
- Anterior spinothalamic tract
- Spino-olivary tract
- Spinoreticular tract
- Spinotectal tract

Descending tracts
- Anterior white comissure
- Lateral reticulospinal tract
- Lateral corticospinal tract
- Rubrospinal tract
- Medial reticulospinal tract
- Anterior corticospinal tract
- Vestibulospinal tract
- Tectospinal tract
- Descending autonomic tract

Key:
- Red: Descending tracts
- Blue: Ascending tracts

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ASCENDING TRACTS
# Ascending Tracts

<table>
<thead>
<tr>
<th>Tract</th>
<th>Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lateral Spinothalamic Tract</td>
<td>Pain, Thermal sensation</td>
</tr>
<tr>
<td><strong>Anterior Spinothalamic Tract</strong></td>
<td>Crude (Light) touch, (non-discriminative touch) Pressure Tickle, Itch</td>
</tr>
<tr>
<td>Dorsal Column</td>
<td>Fine touch (discriminative touch) Two point discrimination Vibration Conscious Proprioception</td>
</tr>
<tr>
<td>Fasciculus gracilis</td>
<td></td>
</tr>
<tr>
<td>Fasciculus cuneatus</td>
<td></td>
</tr>
<tr>
<td><strong>Anterior Spinocerebellar Tract</strong></td>
<td>Unconscious Proprioception Gross movements</td>
</tr>
<tr>
<td>Posterior Spinocerebellar Tract</td>
<td>Unconscious Proprioception Fine movements</td>
</tr>
</tbody>
</table>
**TRACTS OF SPINAL CORD**

**Ascending tracts**
- Dorsal white column
- Fasciculus gracilis
- Fasciculus cuneatus
- Posterior spinocerebellar tract
- Anterior spinocerebellar tract
- Spinotectal tract
- Spinoreticular tract
- Spino-olivary tract

**Descending tracts**
- Lateral reticulospinal tract
- Lateral corticospinal tract
- Rubrospinal tract
- Medial reticulospinal tract
- Anterior corticospinal tract
- Vestibulospinal tract
- Tectospinal tract

*Key:*
- Red: Descending tracts
- Blue: Ascending tracts

*Descending autonomic tract*
## Lateral spinothalamic tract

<table>
<thead>
<tr>
<th><strong>Destination</strong></th>
<th>Posterior central gyrus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3rd Order Neuron</strong></td>
<td>Ventral posterolateral nucleus of Thalamus</td>
</tr>
<tr>
<td><strong>Pathways</strong></td>
<td>Lateral spinothalamic, Spinal lemniscus? Spinotectal</td>
</tr>
<tr>
<td><strong>2nd Order Neuron</strong></td>
<td>? Substantia gelatinosa/ Rexed III-VII</td>
</tr>
<tr>
<td><strong>1st Order Neuron</strong></td>
<td>Posterior root ganglion</td>
</tr>
<tr>
<td><strong>Receptor</strong></td>
<td>Free nerve endings</td>
</tr>
</tbody>
</table>

[Decussation diagram]
### Anterior spinothalamic tract

<table>
<thead>
<tr>
<th><strong>Destination</strong></th>
<th>Posterior central gyrus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3rd Order Neuron</strong></td>
<td>Ventral posterolateral nucleus of Thalamus</td>
</tr>
<tr>
<td><strong>Pathways</strong></td>
<td>Anterior spinothalamic, Medial lemniscus</td>
</tr>
<tr>
<td><strong>2nd Order Neuron</strong></td>
<td>? Substantia gelatinosa/ Rexed III-VII</td>
</tr>
<tr>
<td><strong>1st Order Neuron</strong></td>
<td>Posterior root ganglion</td>
</tr>
<tr>
<td><strong>Receptors</strong></td>
<td>Pacinian Corpuscle</td>
</tr>
</tbody>
</table>
Posterolateral tract of Lissauer

1st order neuron enters posterior horn & divides into ascending and descending branches that travel for 1-2 segments, then terminate synapsing with 2nd order neurons in substantia gelatinosa.
TRACTS OF SPINAL CORD

Ascending tracts
- Dorsal white column
- Fasciculus gracilis
- Fasciculus cuneatus
- Spinocerebellar tract
- Anterior spinocerebellar tract
- Lateral spinothalamic tract
- Anterior spinothalamic tract
- Spinotectal tract
- Spinoreticular tract
- Spino-olivary tract

Descending tracts
- Anterior corticospinal tract
- Lateral corticospinal tract
- Lateral reticulospinal tract
- Rubrospinal tract
- Medial reticulospinal tract
- Vestibulospinal tract
- Tectospinal tract

Key:
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- Blue: Ascending tracts

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# Dorsal Column

<table>
<thead>
<tr>
<th>Destination</th>
<th>Posterior central gyrus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3rd Order Neuron</strong></td>
<td>Ventral posterolateral nucleus of Thalamus</td>
</tr>
<tr>
<td><strong>2nd Order Neuron</strong></td>
<td>Nuclei gracilis and cuneatus in medulla oblagata Few IV-VI</td>
</tr>
<tr>
<td><strong>Pathways</strong></td>
<td>Ipsilateral Fasciculi gracilis &amp; cuneatus Medial lemniscus</td>
</tr>
<tr>
<td><strong>1st Order Neuron</strong></td>
<td>Posterior root ganglion</td>
</tr>
<tr>
<td><strong>Receptors</strong></td>
<td>Meissner's corpuscles, Pacinian corpuscles, muscle spindles &amp; tendon organs</td>
</tr>
</tbody>
</table>

![Diagram showing neural pathways of the Dorsal Column](image.png)
Axons of the second-order neurons

Called Internal arcuate fibres cross the median plane.

Decussate with the corresponding fibres of the opposite side in the medulla as sensory Decussation.

Fibres ascend as a single compact bundle called medial lemniscus through the brainstem.
## Spinocerebellar Tracts

<table>
<thead>
<tr>
<th>Destination</th>
<th>Cerebellar Cortex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Through Superior &amp; Inferior Cerebellar peduncles</td>
</tr>
<tr>
<td><strong>Pathways</strong></td>
<td></td>
</tr>
<tr>
<td>Anterior Spinocerebellar tracts (Superior)</td>
<td></td>
</tr>
<tr>
<td>Posterior Spinocerebellar tracts (Inferior)</td>
<td></td>
</tr>
<tr>
<td><strong>2nd Order Neuron</strong></td>
<td></td>
</tr>
<tr>
<td>Nucleus Dorsalis/ Clarke’s column C8-L3/4</td>
<td>V-VII</td>
</tr>
<tr>
<td><strong>1st Order Neuron</strong></td>
<td></td>
</tr>
<tr>
<td>Collateral branches of Ascending tracts of Dorsal Column from dorsal root ganglion</td>
<td></td>
</tr>
<tr>
<td><strong>Receptors</strong></td>
<td>muscle spindles &amp; tendon organs, joint receptors</td>
</tr>
</tbody>
</table>
SPINOCEREBELLAR TRACT

KEY
- Axon of first-order neuron
- Second-order neuron
- Third-order neuron

CEREBELLUM

Arbor vitae

MEDULLA OBLONGATA

SPINAL CORD

Anterior spinocerebellar tract

Posterior spinocerebellar tract

Spinocerebellar pathway

Proprioceptive input from Golgi tendon organs, muscle spindles, and joint capsules

(d) Spinocerebellar pathway
## Other Ascending Tracts

<table>
<thead>
<tr>
<th>Tract</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinotectal tract</td>
<td>Spinovisual reflexes&lt;br&gt;Movements of the eyes &amp; head in response to the source of the stimulation</td>
</tr>
<tr>
<td>Spinoreticular tract</td>
<td>Reticular formation, Levels of consciousness, Pain perception</td>
</tr>
<tr>
<td>Spino-olivary tract</td>
<td>Conveys cutaneous and proprioceptive information to cerebellum</td>
</tr>
<tr>
<td>Spino-cervicothalamic pathway</td>
<td>Hair movement, pinch, pressure, thermal stimuli, noxious stimuli</td>
</tr>
</tbody>
</table>
DESCENDING TRACTS
CORTICOSPINAL TRACTS

<table>
<thead>
<tr>
<th>Origin</th>
<th>Primary motor cortex (area 4), secondary motor cortex (area 6), parietal lobe (areas 3, 1, and 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass through</td>
<td>Corona radiata, posterior limb of Internal Capsule middle 3/5 of basis pedunculi of midbrain</td>
</tr>
<tr>
<td>Site of crossover</td>
<td>pyramids of medulla</td>
</tr>
<tr>
<td>Pathway</td>
<td>Corticospinal tracts</td>
</tr>
<tr>
<td>Termination</td>
<td>98% on contralateral alpha and gamma motor neurons in grey matter or interneurons.</td>
</tr>
</tbody>
</table>
(a) The lateral corticospinal pathway

(b) The anterior corticospinal pathway
CORTICOSPINAL TRACTS

▪ also known as pyramidal tracts.

▪ Controls rapid, skilled, non-postural, voluntary movements, especially distal ends of limbs

▪ gives branches to cerebral cortex,
  • basal nuclei,
  • red nucleus,
  • olivary nuclei,
  • reticular formation.

▪ These branches keep the subcortical regions aware about the cortical motor activity.
## Rubrospinal Tracts

<table>
<thead>
<tr>
<th>Origin</th>
<th>Red nucleus of midbrain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site of crossover</td>
<td>Immediately in midbrain</td>
</tr>
<tr>
<td>Pathway</td>
<td>Rubrospinal tract</td>
</tr>
<tr>
<td>Destination</td>
<td>Motor neurons in grey matter</td>
</tr>
<tr>
<td>Function</td>
<td>Facilitates activity of flexor muscles and inhibits activity of extensor muscles in the upper limb</td>
</tr>
</tbody>
</table>
RUBROSPINAL TRACT

- Red nucleus receive afferent impulses through connections with the:
  - 1. cerebral cortex
  - 2. cerebellum.
  - 3. Globus Pallidus
- Extends as far as corticospinal tract
- Cortico-rubral connections from ipsilateral red nucleus
- Indirect pathway by which the cerebral cortex and the cerebellum can influence the activity of motor neurons of the spinal cord.
## Extrapyramidal Tracts

<table>
<thead>
<tr>
<th>Tract</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reticulospinal tract</td>
<td>Inhibit or facilitate voluntary movement, reflex activity, assist hypothalamus controls sympathetic, parasympathetic outflows.</td>
</tr>
<tr>
<td>Tectospinal tract</td>
<td>Reflex postural movements of head concerning visual stimuli</td>
</tr>
<tr>
<td>Vestibulospinal tract</td>
<td>Unconscious maintenance of posture and balance; acts on extensors, mediates head &amp; neck movements in response to vestibular sensory input</td>
</tr>
<tr>
<td>Descending autonomic fibers</td>
<td>Control sympathetic and parasympathetic systems</td>
</tr>
</tbody>
</table>
LESION OF SPINAL CORD
Injury to the ascending tracts within the spinal cord

Right Lateral Spinothalamic Tract Lesion

Click to animate

Lateral spinothalamic tract lesion
Contralateral loss of pain and temperature sense

Common causes include MS, penetrating injuries, and compression from tumors.
- **Anterior Spinothalamic Tract**
  
  - contralateral loss of light touch sensations below the level of the lesion
  
  - contralateral loss of pressure sensations below the level of the lesion

  The patient will

  not feel the light touch of a piece of cotton placed against the skin

  and can't feel pressure from a blunt object placed against the skin.
Common causes include MS, penetrating injuries, and compression from tumors.

**Ipsilateral** loss of light touch, vibration, and position sense in the right arm and upper trunk.
Tabes Dorsalis

- is caused by syphilis.

- a selective destruction of nerve fibres at the point of entrance of the posterior root into the spinal cord,

  > specially in the lower thoracic and lumbosacral regions.

  > Results in loss of some sensation & hypersensitivity of others.
Injury to the descending tracts

Upper Motor Neuron (UMN) Lesions:

- Lesions of corticospinal tracts (Pyramidal Tracts)
- Lesions of Extrapyramidal Tracts
Lesions of corticospinal tracts (Pyramidal Tracts)

- Babinski sign is present.
- Superficial abdominal reflexes are absent.
- Cremasteric reflex is absent.

There is loss of performance of fine-skilled, voluntary movements, especially at the distal end, of the limbs.
Lesions of Extrapyramidal Tracts lesions:

- Spastic paralysis, (lower limb extended, and the upper limb flexed),
- Exaggerated deep muscle reflexes in some flexors,
- Clasp-knife reaction -the muscles, after resistance on stretching, suddenly give way.
Lower motor neuron (LMN) lesions

- By any lesion (ex. Poliomyelitis) destroying neurons in the anterior grey column or its axon in the anterior root or spinal nerve.

Clinical signs:

1. Flaccid paralysis
2. Muscular Atrophy
3. Loss of muscular reflexes
4. Muscular fasciculation
5. Muscular contracture and degeneration.
SPINAL SHOCK SYNDROME

Following a spinal cord injury there will be:

- a short term loss of all neurological activity below the level of injury.
- loss of motor, sensory reflex & autonomic function.

due to temporary physiologic disorganisation of spinal cord function, may last 30-60 minutes or up to 6 weeks.
COMPLETE CORD TRANSECTION

It can be caused by fracture dislocation of the vertebral column,

Clinical features:

1. Bilateral LMN paralysis
2. Bilateral spastic paralysis below the level of the lesion
3. Bilateral loss of all sensations below the level of the lesion.
4. Bladder and bowel functions are no longer under voluntary control
1. Bilateral LMN paralysis in the segment of lesion,
2. Bilateral spastic paralysis below level of the lesion,
3. Bilateral loss of pain, temperature & light touch below the level of the lesion,
4. Two point discrimination & vibratory and proprioception sensations are preserved.
1. Bilateral LMN paralysis in the segment of lesion,
2. Bilateral spastic paralysis below the level of the lesion with characteristic sacral sparing,
3. Bilateral loss of pain, temperature & light touch and pressure sensations below the level of the lesion with characteristic sacral sparing.

CENTRAL CORD SYNDROME
Hemicord Lesion (Brown-Sequard Syndrome)

- **Dorsal column lesion**: Ipsilateral loss of light touch, vibration, and position sense.
- **Lateral corticospinal tract lesion**: Ipsilateral upper motor neurons signs.
- **Lateral spinothalamic tract lesion**: Contralateral loss of pain and temperature sense.

Click to animate
A 36 year old male is observed to have difficulty in walking during a clinic visit. Testing indicates that his joint position sense is intact. However, his reflexes in his lower limbs are diminished. Based on the findings in this patient, which of the following pathways most likely have been damaged?

A. Lateral spinothalamic

B. Ventral spinothalamic

C. Dorsal spinocerebellar

D. Cuneocerebellar
A 19 year old gang member presented in the ER with a stab wound of the neck. Neurological examination revealed left hemiparesis with complete loss of vibratory and joint position sense below C6 on the same side as the weakness. Loss of pain and temperature sensation was elicited on the left at C6 only and on the right below C6. An MRI of the cervical spinal cord will reveal which of these findings?

A. Hemisection of the left spinal cord

B. Complete transection of the spinal cord

C. Lesion of the left anterolateral white mater only of the spinal cord

D. Damage to the cervical dorsal roots at C6 on the left side only
A patient has an injury that results in damage to the lower motor neurons. Which of the following would you expect to see in the patient?

A. Spastic paralysis
B. Hyperreflexia
C. Increased muscle tone
D. Flaccid paralysis
A pain researcher wants to make a lesion to the Spinothalamic tract so that his subjects feel no pain and temperature sensation from the right leg, but leaves pain and temperature sensation rostral to the arm. Where would you advise this researcher to make his lesion?

A. Lesion the most lateral aspect of the left spinothalamic tract

B. Lesion the most medial aspect of the left spinothalamic tract

C. Lesion the most lateral aspect of the right spinothalamic tract

D. Lesion the most medial aspect of the right spinothalamic tract
During a play-off game, a college hockey player is struck hard on the back of his neck with a hockey stick. A CT scan reveals a bone fragment lodged into the medial aspect of his dorsal columns in the cervical spinal cord. Which of the following functions will most likely be affected given this patient's presentation?

A. Touch, pressure, vibratory sense from ipsilateral leg

B. Pain and temperature sense from contralateral leg

C. Pain from ipsilateral face

D. Pain and temperature sense from contralateral arm
5 year painter was rushed to the ER after he fell from a high building and fractured his cervical vertebra and damaged his spinal cord. During examination of his reflexes immediately after the accident, which of the following are most likely to be seen?

A. Increased reflexes
B. Decreased reflexes
C. Rigidity
D. Fasiculations