Lasègue Sign and the Straight Leg Raise Test: Revisiting a Classic Clinical Sign

REVIEW ARTICLE

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Abstract

Background: The Straight Leg Raise (SLR) test, commonly referred to as the Lasègue sign, is one of the most frequently performed clinical tests in patients presenting with low-back pain and sciatica. Despite its widespread use, its interpretation remains inconsistent. Restriction of straight leg raising is often incorrectly equated with lumbar disc herniation, whereas the test primarily evaluates mechanical sensitivity of the lumbosacral neural structures rather than the presence or size of a disc prolapse.

Objective: This review revisits the historical development, anatomical basis, biomechanics, clinical interpretation and modifications of the SLR test. Particular emphasis is placed on false-positive and false-negative results, interpretation in the presence of neurological deficits or paralysis, muscular factors restricting SLR, differentiation between muscular stretch and neural pain, and the significance of isolated back pain during the manoeuvre.

Discussion: During SLR, passive hip flexion with the knee extended progressively loads the sciatic nerve, lumbosacral plexus, nerve roots and associated neural interfaces. A clinically meaningful positive test requires reproduction of the patient's characteristic neural or radicular symptoms rather than merely limitation of hip flexion. Hamstring tightness, muscle injury, hip pathology and protective muscular guarding may mimic a positive SLR. Conversely, spinal or foraminal stenosis, upper lumbar radiculopathy, advancing age, chronic nerve-root dysfunction and severe neurological deficit may occur with a negative SLR. The presence of motor paralysis does not mechanically prevent a positive SLR because the test is passive; however, a severely dysfunctional root may occasionally lose its typical mechanosensitivity despite worsening neurological deficit. Structural differentiation using ankle dorsiflexion and other neurodynamic manoeuvres can help distinguish neural pain from muscular stretch.

Conclusion: The SLR should be viewed as a dynamic test of neural mechanosensitivity rather than a binary test for lumbar disc herniation. Its diagnostic value increases substantially when symptom location, quality, angle of onset, structural differentiation and the complete neurological examination are considered together. Isolated back pain during SLR should not be labelled a positive Lasègue sign for radiculopathy.

Keywords: Lasègue sign; straight leg raise; SLR; sciatica; lumbar radiculopathy; nerve-root tension; neurodynamic test; disc herniation; hamstring tightness; neurological deficit.

Introduction

The Straight Leg Raise (SLR) test is among the most familiar clinical examination manoeuvres in spinal practice. It is used by Pain Physicians, Neurologists, Orthopaedic surgeons, Neurosurgeons, physiatrists and physiotherapists in patients presenting with low-back pain, leg pain and suspected lumbar radiculopathy.

Its apparent simplicity, however, can be deceptive. The terms restricted SLR, positive SLR, positive Lasègue sign, sciatic tension sign, and even evidence of disc prolapse are often used interchangeably, although they describe different clinical phenomena.

A patient may have a markedly restricted SLR because of hamstring tightness without any neural pathology. Another patient may have a large lumbar disc herniation with neurological weakness but an almost normal SLR. Yet another may develop sciatic symptoms during SLR because of pathology affecting the sciatic nerve outside the spine.

The SLR therefore should not be considered a direct test for a "slipped disc." Rather, it is better understood as a neurodynamic provocation test evaluating the mechanical behaviour and mechanosensitivity of the lumbosacral neural system.

This distinction is supported by the variable diagnostic accuracy reported in the literature. A landmark systematic review reported pooled sensitivity of 0.91 but specificity of only 0.26 for conventional SLR when surgically demonstrated disc herniation was used as the reference standard. The crossed SLR showed the opposite pattern, with lower sensitivity but considerably higher specificity.[1]

The objective of this review is to examine not merely how the SLR is performed, but what it actually means.

Historical Perspective

The history of the Lasègue sign is unusual because the manoeuvre bearing Charles Lasègue's name was apparently never formally published by Lasègue himself.

Ernest-Charles Lasègue (1816–1883), a French physician, published Considerations on Sciatica in 1864. Although this work contained extensive observations on sciatica, the classical straight-leg- raising manoeuvre was not described in that publication.[2]

The manoeuvre was formally described in 1881 by Jean-Joseph Forst, Lasègue's pupil, in his doctoral thesis. Forst acknowledged that his teacher had drawn his attention to the phenomenon. Importantly, the original description consisted of two parts:

1. elevation of the extended lower limb reproduced the patient's sciatic pain; and
2. flexion of the knee while maintaining hip flexion relieved the pain.

The second component is frequently omitted from modern descriptions, although historically it was an important part of the observation.[3]

An even earlier description deserves recognition. Serbian physician Lazar K. Lazarević published his observations in 1880, before Forst's thesis. Based on six patients, Lazarević described several manoeuvres that stretched the sciatic nerve and correctly proposed that neural stretching was responsible for the reproduction of sciatic pain.[4]

Forst and Lasègue initially attributed the phenomenon largely to compression of the sciatic nerve by the hamstring muscles. Lazarević's explanation that the symptoms arose from tension applied to the neural structures was conceptually closer to the modern understanding.

For this reason, some authors have argued that the sign could more accurately be referred to as the Lazarević–Lasègue sign.[5]

What Does the SLR Actually Test?

The conventional SLR consists of passive hip flexion with the knee maintained in extension.

As the limb is elevated, mechanical forces are transmitted progressively through the:

- tibial and common fibular/peroneal components of the sciatic nerve;
- sciatic nerve;
- lumbosacral plexus;
- lumbosacral nerve roots;
- nerve-root sleeves; and
- associated meningeal and neural interfaces.

The test predominantly assesses the lower lumbosacral neural pathway, particularly the L5 and S1 roots, although L4 may also contribute.

It is considerably less useful for L2–L4 radiculopathy. In suspected upper lumbar radiculopathy, the femoral nerve stretch or reverse SLR test is usually more appropriate.

Two concepts are fundamental to understanding the SLR:

Neural excursion

Peripheral nerves and nerve roots normally move relative to surrounding tissues during limb and spinal movement.

Neural mechanosensitivity

Neural tissue that is inflamed, irritated, compressed or otherwise sensitised may become painful when subjected to an otherwise physiologically tolerated mechanical load.

Thus, the SLR is not simply a "nerve stretch test." It evaluates the interaction between neural movement, neural loading and symptom reproduction.

A Positive SLR Is Not the Same as a Restricted SLR

This distinction is central to accurate clinical examination.

A patient's leg may stop at 45° because of:

- sciatica;
- hamstring tightness;
- hamstring injury;
- hip pain;
- gluteal pain;
- fear;
- muscular guarding; or
- severe nonspecific low-back pain.

All these patients have a restricted SLR, but they do not all have a positive Lasègue sign.

A clinically convincing radicular SLR should ideally reproduce the patient's familiar leg symptoms, especially when those symptoms demonstrate neural characteristics and can be modified by changing neural load.

The examiner should therefore document:

- the angle at which symptoms begin;
- the location of symptoms;
- the quality of symptoms;
- whether they correspond to the patient's presenting complaint;
- whether symptoms extend below the knee;
- whether paraesthesia occurs; and
- whether structural differentiation alters the symptoms.

Performing the Test

The patient lies supine and relaxed.

The examiner raises the affected leg slowly, maintaining the knee in full extension while progressively flexing the hip.

The patient should be asked:

- "What do you feel?"
- "Where do you feel it?"
- "Is this the same pain that normally troubles you?"
- "Is it pulling, stretching, burning, electric, tingling or painful?"
- "Does it travel below the knee?"

The examination should stop at the onset of the relevant symptom, rather than simply determining the maximum angle to which the hip can be flexed.

Traditionally, reproduction of radicular leg pain between approximately 30° and 70° of hip flexion has been considered most significant. These angular limits, however, should not be interpreted rigidly.

The SLR angle by itself has substantially less diagnostic value than the nature and behaviour of the symptom reproduced.

What Constitutes a Clinically Convincing Positive SLR?

A convincing positive SLR usually contains three elements.

1. Reproduction of the patient's familiar symptoms

The provoked pain should resemble the complaint for which the patient is seeking treatment.

2. A distribution compatible with neural involvement

Pain radiating from the buttock or posterior thigh into the calf or foot is more suggestive than simple tightness confined to the posterior thigh.

3. Modification by neural structural differentiation

The symptom should change when neural loading is selectively increased or decreased.

These principles make the test substantially more useful than simply stating:

"SLR positive at 45°."

Modifications and Variations of the SLR

Bragard-Type Manoeuvre

The leg is raised until the patient's symptoms appear. It is then lowered slightly until the symptoms diminish.

The ankle is subsequently dorsiflexed.

If the patient's characteristic distal pain reappears, neural involvement becomes more likely.

Experimental cadaveric work has demonstrated that ankle dorsiflexion during SLR increases excursion and strain within the tibial nerve while having little effect on the distal biceps femoris muscle. This provides a biomechanical basis for using dorsiflexion as a structural differentiation manoeuvre.[6]

Historically, the routine use of the term "Bragard sign" for this manoeuvre has itself been questioned; earlier descriptions of foot dorsiflexion in association with Lasègue testing were attributed to other clinicians.[7]

Crossed Straight Leg Raise

The asymptomatic or less symptomatic leg is elevated.

The test is considered positive when this manoeuvre reproduces radicular pain in the opposite, symptomatic leg.

The crossed SLR is much less sensitive than the conventional SLR but considerably more specific for disc herniation. The systematic review by Devillé et al. reported pooled sensitivity of 0.29 and specificity of 0.88.[1]

Clinically, a positive crossed SLR should raise suspicion of a more significant central or paracentral disc-root interaction, although the sign should not be used to determine disc morphology in isolation.

Slump Test

The slump test increases neural loading through a sequence that may include:

- thoracolumbar flexion;
- cervical flexion;
- knee extension; and
- ankle dorsiflexion.

Because proximal neural loading is added, the slump test can occasionally reproduce symptoms when conventional SLR does not.

In one study of patients with lumbar disc herniation, the slump test demonstrated greater sensitivity than SLR, although SLR was somewhat more specific.[8]

The available studies show variable results, reinforcing that neither test should be interpreted independently of the clinical syndrome.

Bowstring Test

The affected limb is raised until symptoms are reproduced and the knee is then flexed to reduce neural loading.

Following symptom reduction, pressure may be applied over the sciatic/tibial neural structures in the popliteal region.

Reproduction of the characteristic neural pain may support sciatic mechanosensitivity.

Reverse SLR/Femoral Nerve Stretch Test

This is not truly a modification of the sciatic SLR but represents the corresponding neurodynamic examination for the upper lumbar roots.

It is especially useful for suspected:

- L2 radiculopathy;
- L3 radiculopathy;
- L4 radiculopathy;
- upper lumbar disc herniation; or
- femoral nerve pathology.

A negative conventional SLR should therefore not be considered evidence against an upper lumbar radiculopathy.

Differentiating Muscle Stretch Pain from Nerve Pain

One of the commonest sources of diagnostic error is interpreting hamstring stretch as sciatic pain.

During SLR, the hamstrings are progressively lengthened because they cross both the hip and knee joints.

The principal muscles involved are:

- biceps femoris;
- semitendinosus; and
- semimembranosus.

Consequently, posterior thigh discomfort is common even in individuals without neurological disease.

Features Suggesting Muscular Stretch

Muscular restriction is more likely when symptoms are:

- described as pulling, tightness or stretching;
- predominantly localised to the posterior thigh;
- relatively symmetrical bilaterally;
- produced mainly at higher angles of hip flexion;
- not associated with paraesthesia;
- not associated with distal radiation;
- different from the patient's usual pain; and
- relatively unaffected by neural structural differentiation.

Hamstring tightness has specifically been identified as an important potential source of false-positive SLR interpretation.[9]

Features Suggesting Neural Pain

Neural involvement is more likely when the SLR causes:

- reproduction of familiar sciatica;
- pain radiating below the knee;
- burning or electric pain;
- shooting or lancinating pain;
- tingling or paraesthesia;
- marked side-to-side asymmetry;
- symptom change with neural sensitising manoeuvres; and/or
- accompanying dermatomal sensory, motor or reflex abnormalities.

No single characteristic is absolute. The diagnosis emerges from the pattern.

Structural Differentiation: A Practical Method

When the patient develops posterior thigh pain during SLR, the examiner can lower the leg slightly until the symptoms diminish.

The ankle is then dorsiflexed.

If familiar distal neural symptoms are reproduced, neural mechanosensitivity becomes more likely.

Experimental evidence supports the mechanical rationale: dorsiflexion during SLR preferentially increases tibial nerve excursion and strain relative to the distal biceps femoris.[6]

However, this manoeuvre must itself be interpreted anatomically. Ankle dorsiflexion also stretches the gastrocnemius and posterior calf structures. Therefore, reproduction of calf tightness alone is not sufficient evidence of nerve-root pathology.

The strongest response is reproduction of the patient's recognisable neural pain.

Which Muscle Contractions Can Restrict SLR?

Muscular restriction of SLR may arise either from true muscle shortening or from protective muscular activity induced during the test.

Hamstrings

The hamstrings are the most important muscular limitation because simultaneous hip flexion and knee extension produces progressive elongation of:

- biceps femoris;
- semitendinosus; and
- semimembranosus.

True hamstring shortening may therefore produce an apparently low SLR angle without neurological pathology.

Protective Hamstring Contraction

An irritated neural system may itself provoke protective muscle activation.

Thus, hamstring contraction during SLR does not always mean that the primary disorder is muscular. The muscle may contract defensively because further limb elevation increases neural loading.

This creates an important clinical distinction:

> **Primary muscular tightness can restrict SLR, but neural mechanosensitivity can also secondarily generate protective muscular guarding and thereby restrict SLR.**

Gluteal Musculature

Gluteus maximus and deeper posterior hip muscles may become stretched with increasing hip flexion.

Pain or guarding in this region may restrict further elevation, particularly at higher angles.

Lumbar Paraspinal Muscles

Patients with acute back pain frequently activate the lumbar paraspinal muscles defensively during leg elevation.

This can:

- restrict pelvic movement;
- increase discomfort;
- produce apparent stiffness; and
- cause the patient to stop the manoeuvre before significant neural loading occurs.

Gastrocnemius

The gastrocnemius becomes particularly relevant when ankle dorsiflexion is added.

Calf tightness generated by dorsiflexion must therefore be distinguished from reproduction of characteristic neural symptoms.

General Protective Muscle Activity

Neurodynamic loading itself can induce muscle activation. Electromyographic studies in healthy participants have shown that adding ankle dorsiflexion to SLR results in earlier distal muscular activity and broader proximal muscular responses.[10]

Therefore, muscle contraction during SLR may be a response to neural loading, not merely a confounding factor.

False-Positive SLR

The term false positive requires clarification.

If SLR is considered a test specifically for lumbar disc herniation, many conditions can produce symptoms during the manoeuvre despite the absence of disc herniation.

If, however, SLR is regarded as a test of neural mechanosensitivity, some of these conditions may represent genuine positive neurodynamic tests.

This distinction is essential.

Hamstring Tightness

This is one of the commonest reasons for falsely labelling SLR as positive.

The patient typically experiences:

- posterior thigh pulling;
- no distal radiation;
- no paraesthesia;
- symptoms at higher angles; and
- similar limitation on the opposite side.

The problem is therefore not the SLR itself, but the interpretation of any painful restriction as radiculopathy.

Hamstring Injury or Proximal Hamstring Tendinopathy

Elongation of an injured hamstring can cause marked posterior thigh or ischial pain.

Clues include:

- focal tenderness;
- pain on resisted knee flexion;
- a history of sporting injury or overload;
- proximal ischial pain; and
- lack of typical distal neural symptoms.

Gluteal and Posterior Hip Pathology

Gluteal tendinopathy, muscular pain or other posterior hip disorders can produce pain as the hip moves into flexion.

The pain may be perceived in the buttock and mistakenly interpreted as proximal sciatica.

Hip Joint Pathology

Hip pathology may cause:

- groin pain;
- buttock pain;
- thigh pain; or
- restricted hip flexion.

A severely painful hip can therefore significantly limit SLR without any nerve-root pathology.

The hip examination must form part of the evaluation whenever the pain distribution is atypical.

Deep Gluteal Syndrome and Extraspinal Sciatic Neuropathy

Pathology affecting the sciatic nerve in the deep gluteal region may produce neural symptoms during SLR.

Such a result is not really a false-positive neurodynamic test; the sciatic nerve is genuinely mechanically sensitive.

It becomes a false positive only when the examiner concludes:

“Positive SLR equals lumbar disc herniation.”

The site of neural pathology may be extraspinal.

Peripheral Sciatic Nerve Injury

Previous:

- hip surgery;
- pelvic surgery;
- trauma;
- injection injury;
- tumour;
- fibrosis; or
- peripheral nerve entrapment

can increase sciatic nerve mechanosensitivity.

Again, SLR may correctly detect abnormal neural behaviour while failing to identify its anatomical origin.

False-Negative SLR

The opposite error is equally important:

> **A negative SLR does not exclude significant radiculopathy or nerve-root compression.**

Several clinical situations may produce a false-negative result.

Upper Lumbar Radiculopathy

Conventional SLR preferentially loads the sciatic pathway and lower lumbar/sacral roots.

L2, L3 and many L4 root disorders may therefore occur with a completely normal SLR.

The reverse SLR or femoral stretch test is more relevant in this situation.

Lumbar Spinal Stenosis

Patients with lumbar canal stenosis often develop symptoms through:

- standing;
- walking;
- lumbar extension; and
- prolonged axial loading.

The disorder is therefore frequently dynamic and load dependent rather than predominantly tension dependent.

Such patients may have:

- neurogenic claudication;
- numbness;
- leg weakness;
- heaviness; and
- severe walking limitation,

despite a negative SLR when examined supine.

Foraminal Stenosis

Foraminal compromise commonly becomes more significant with lumbar extension and loading.

Straight-leg raising in the supine position does not reproduce this mechanism effectively.

A patient can therefore have significant foraminal root compression with little or no SLR abnormality.

Advancing Age

The diagnostic behaviour of the test changes with age.

Studies demonstrate a progressive reduction in SLR positivity among older patients with confirmed lumbar disc herniation.

A study involving patients over 60 years with symptomatic MRI-confirmed disc herniation found SLR sensitivity of only approximately 33%.[11]

Another study similarly demonstrated declining SLR positivity with increasing age.[12]

Thus:

> **A negative SLR is considerably less reassuring in an elderly patient than in a young patient with acute sciatica.**

Chronic Nerve-Root Compression

Longstanding nerve-root compromise may produce:

- numbness;
- weakness;
- reflex loss;
- muscle wasting; or
- electrophysiological dysfunction

without marked mechanical pain.

SLR primarily reflects irritability and mechanosensitivity, not the physiological integrity of motor axons.

A chronically dysfunctional nerve root may therefore produce a surprisingly normal SLR.

SLR in Neurological Deficit and Paralysis

The relationship between SLR and motor weakness is one of the most clinically important areas of interpretation.

Does Paralysis Automatically Make SLR Negative?

No.

The SLR is a passive manoeuvre.

The examiner raises the patient's limb; the patient does not need to activate the paralysed muscles.

Therefore, even a patient with marked foot drop or motor weakness can have a strongly positive SLR if the affected root remains mechanically sensitive and nociceptive pathways remain active.

Motor paralysis itself does not mechanically abolish the test.

Can Severe Neurological Deficit Be Associated with a Negative SLR?

Yes.

This creates an apparently paradoxical but clinically important situation.

A severely compressed or chronically injured nerve root may demonstrate major electrophysiological and motor dysfunction while exhibiting relatively little mechanical pain.

Matsui et al. studied compressed lumbar nerve roots and found that patients with severe motor disturbance tended to demonstrate SLR angles closer to those of controls. Negative SLR, advanced age and prolonged severe weakness were associated with poorer motor recovery in that cohort.[13]

The exact biological explanation cannot be reduced to a single mechanism. Possible contributors include:

- severe sensory axonal dysfunction;
- altered nociceptive transmission;
- chronic adaptation;
- reduced neural mechanosensitivity; and
- differences in the anatomy and chronicity of compression.

The practical implication is more important than the proposed mechanism:

> **A negative SLR must never provide reassurance when objective neurological function is deteriorating.**

The Painful Root and the Failing Root Are Not the Same Thing

Clinically, it is useful to distinguish between root irritability and root dysfunction.

Predominantly irritated root

The patient may have:

- severe shooting leg pain;
- marked mechanical sensitivity;
- very restricted SLR;
- paraesthesia;
- but relatively preserved motor power.

Increasingly dysfunctional root

The patient may develop:

- motor weakness;
- sensory loss;
- reduced reflexes;
- reduced endurance; and
- muscle dysfunction.

The SLR may be positive, mildly positive or negative.

A Previously Positive SLR Becoming Negative: Improvement or Warning?

Normally, resolution of SLR-associated pain accompanied by clinical recovery is favourable.

However, the examiner must ask:

> **What happened to neurological function at the same time?**

If SLR improves while:

- leg pain decreases;
- sensation improves;
- power improves; and
- function improves,

the change is reassuring.

If SLR becomes negative while:

- motor power deteriorates;
- foot drop develops;
- sensory loss increases;
- saddle sensation changes; or
- bladder/bowel dysfunction appears,

the disappearance of pain should not be interpreted as improvement.

Neurological function takes priority over the pain response.

SLR and Cauda Equina or Major Neurological Deficit

The SLR should never be used to exclude serious neurological compression.

A patient with:

- progressive motor deficit;
- bilateral weakness;
- saddle anaesthesia;
- urinary retention;
- altered bladder sensation;
- bowel dysfunction; or
- other features suggestive of cauda equina compromise

requires urgent neurological assessment irrespective of whether the SLR is positive or negative.

In such situations, the test becomes secondary to the objective neurological findings and clinical urgency.

What If SLR Produces Only Back Pain and No Leg Pain?

This is another frequent source of incorrect terminology.

If SLR produces only axial low-back pain, without reproduction of leg or radicular symptoms, it should generally not be called a positive Lasègue sign for radiculopathy.

The test has provoked pain, but it has not demonstrated the characteristic neural response for which the Lasègue sign is intended.

Possible explanations include the following.

Discogenic or Mechanical Back Pain

Straight-leg elevation changes:

- pelvic orientation;
- lumbosacral mechanics;
- tension in posterior structures; and
- loading of the lumbar motion segments.

An irritable lumbar disc or other mechanical spinal structure may therefore produce back pain during SLR without radicular involvement.

Hamstring-Pelvic Interaction

Short hamstrings can alter pelvic motion during hip flexion.

As hip flexion progresses, restriction of normal pelvic movement may increase stresses across the lumbopelvic region and provoke axial pain.

Paraspinal Guarding

Acute lumbar pain may provoke involuntary paraspinal contraction during leg elevation.

The patient may therefore stop the test because of local lumbar pain rather than neural symptoms.

Sacroiliac or Posterior Pelvic Pain

Changes in pelvic loading may reproduce pain around the sacroiliac or posterior pelvic region.

Again, this does not establish nerve-root irritation.

Hip Pathology

Hip pathology can occasionally produce pain perceived in the buttock or lower-back region during elevation.

A complete hip examination is therefore necessary when findings are atypical.

How Should Isolated Back Pain During SLR Be Documented?

Instead of:

SLR positive at 45°.

a more precise documentation would be:

> **Right SLR limited to approximately 45° by axial low-back pain; no reproduction of buttock or radicular leg pain.**

This prevents a mechanically provocative finding from being incorrectly interpreted as evidence of radiculopathy.

Does Radicular Pain Have to Extend Below the Knee?

Pain extending below the knee increases confidence that the symptom is neural and radicular rather than simply muscular.

Nevertheless, the knee should not be treated as an absolute diagnostic boundary.

Some patients with genuine root irritation may initially describe pain predominantly in:

- the buttock;
- proximal posterior thigh; or
- lateral thigh.

The examiner should integrate:

- symptom quality;
- familiarity;
- neurological distribution;
- structural differentiation;
- asymmetry; and
- the rest of the neurological examination.

Posterior thigh tightness alone, however, is insufficient evidence of radiculopathy.

Does the SLR Angle Indicate the Severity of Disc Herniation?

Not reliably.

A very restricted SLR frequently indicates a highly irritable neural system and may correlate with greater clinical pain.

In patients undergoing MisEpp Spine Endoscopy for lumbar disc herniation, marked SLR restriction has correlated with indices such as pain at rest, night pain, cough-related pain and impaired walking capacity.[14]

However:

> **SLR angle should be interpreted primarily as an indicator of neural irritability, not as a measurement of the size of a disc herniation or the severity of neurological deficit.**

A patient with SLR at 20° may have severe inflammatory root irritation with preserved power.

Another patient with SLR at 80° may have profound weakness from chronic foraminal compression.

Recommended Clinical Documentation

A binary statement such as:

“SLR positive”

provides limited information.

A better description would be:

> **Right SLR reproduces the patient’s familiar posterolateral leg pain extending to the dorsum of the foot at approximately 40°. Symptoms decrease on lowering the limb and are reproduced by ankle dorsiflexion. Left SLR is painless to approximately 75°.**

For muscular restriction:

> **SLR restricted to approximately 60° bilaterally because of symmetrical posterior thigh stretch; no reproduction of familiar radicular pain or paraesthesia.**

For isolated back pain:

> **Right SLR limited to approximately 50° by axial low-back pain without buttock or leg radiation; no true radicular Lasègue response.**

For significant neurological deficit:

> **SLR negative to 75° despite objective L5 motor deficit with ankle dorsiflexion weakness; neurological deficit considered clinically more significant than the negative neurodynamic test.**

This style of documentation conveys much more information than simply recording an angle.

Conclusion

The Straight Leg Raise or Lasègue test remains one of the most valuable clinical examination tools for patients with sciatica and suspected lumbar radiculopathy, provided that it is interpreted correctly.

The test should primarily be regarded as an assessment of lumbosacral neural mechanosensitivity and neurodynamic behaviour, rather than a direct test for lumbar disc herniation.

A restricted SLR is not synonymous with a positive Lasègue sign. Hamstring shortening, muscular injury, hip pathology and protective guarding may all restrict the manoeuvre without nerve-root disease. Conversely, a patient with clinically important root compression may demonstrate a negative SLR, particularly in upper lumbar radiculopathy, spinal or foraminal stenosis, advancing age, chronic nerve-root dysfunction and some cases of severe neurological deficit.

Motor weakness and neural pain must also be understood as different manifestations of nerve-root pathology. A severely painful, mechanically sensitive root may retain normal motor function, while a severely dysfunctional root may occasionally become less painful. Therefore, reduction in pain or disappearance of a previously positive SLR cannot be assumed to represent neurological recovery.

Structural differentiation is central to interpretation. Reproduction of familiar neural symptoms with changes in neural loading provides much stronger evidence than an isolated measurement of hip- flexion angle.

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