

POST SURGICAL RETURN OF RIGHT LEG PAIN. TREATED SUCCESSFULLY WITH COX® FLEXION DISTRACTION DECOMPRESSION ADJUSTING

A 47 year old white married female was seen for the chief complaint of low back and right leg pain. This pain is a 7 on a VAS scale in both the low back and the leg. History shows the low back pain started with pregnancy 20 years previously and started in the hip joint. She had back surgery for disc herniation at the L5-S1 level in 2005 for low back and right leg pain and return of the leg was noted within 2 months after the surgery. She did have epidural steroid injections prior to the surgery. She is referred to us by her treating chiropractor who has treated her for the past 20 years successfully until this post surgical recurrent low back and leg pain is encountered.

Her vital signs are normal. Spine examination does show the surgical incision for removal of L5-S1 disc. Her deep tendon reflexes are +2 at the patella and ankle in the lower extremities and her great toe down going. There is low back and leg pain on sitting straight leg raise sign. Both Kemp signs are positive. There is weakness on dorsi and plantar flexion of the great toe and foot at the ankle as well as the gluteus maximus and biceps femoris muscles on the right side. Pulses are good in the lower extremities. The straight leg raise is positive at 40 degrees on the right side with a positive Braggard sign. Marked tenderness is noted over the L5-S1 level and ranges of motion are reduced to 60 degrees flexion and 15 degrees extension.

IMAGING STUDIES



Figure 1: On the lateral lumbar spine study, note the post-surgical L5-S1 disc space which shows advanced degenerative change and possible posterior endplate hypertrophy.



Figure 2: Note the right rotatory curve of the thoracolumbar spine on the anteroposterior view.



Figure 3: Note the advanced discogenic spondylosis at the L5-S1 disc level with the high intensity zone within the posterior disc space. This is a T1 weighted image. This is a post-surgical microdiscectomy which failed to relieve this patient's back and right leg pain.



Figure 4: On this T2 weighted sagittal image again note the L5-S1 disc degeneration with the posterior high intensity zone. Note the patency of the vertebral canal and good space and hydration of the discs superior to the L5-S1 level.



Figure 5: Note the far lateral disc bulging into the osseoligamentous canal at the L5-S1 disc level. Also appreciate the degenerative loss of disc space height at the L5-S1 level compared to the superior levels. The dorsal root ganglion is seen to lie within the upper third of the osseoligamentous canal.

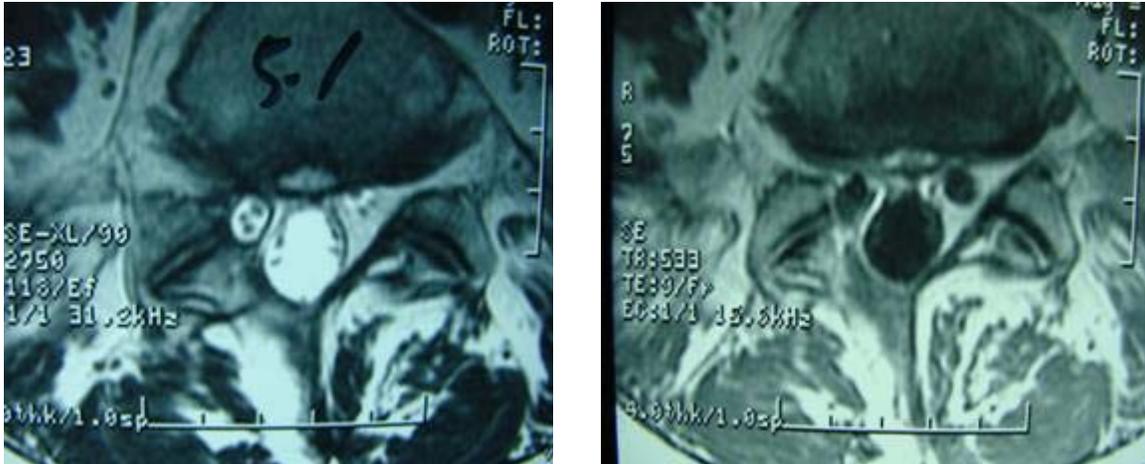


Figure 6: Axial MRI showing the high intensity zone in the central posterior L5-S1 disc space. This indicates active inflammatory change within the disc. Note the S1 nerve roots appear with no compressive change. Chemical inflammation is noted within the posterior medial disc which is written as a cause of back leg pain.

The plain radiographs of the lumbar spine are shown as well as the MRIs. See Figure 1 to 6. The diagnosis from these MRIs is that there is a surgical removal at the L5-S1 level with marked degenerative change as seen on the plain film, and the MRI scans show the same degenerative disc disease at the L5-S1 level and a disc bulge of the L5-S1 disc within the mid-line with a high intensity zone within it. You will note that the first sacral nerve roots are not compressed. The L4-L5 disc reveals no evidence of disc herniation and the L5 nerve roots are not compressed. An incidental finding is a hemangioma of the L2 vertebral body. The conus medullaris is normal.

The diagnosis of this case is L5-S1 internal derangement with a high intensity zone and a small bulge, which is creating a probable chemical back pain and radicular component.

TREATMENT PLAN:

Flexion distraction manipulation at the L5-S1 level was administered manually with protocol 1 and is followed by galvanic current into the L5-S1 disc space with ice application and this is followed with bilateral tetanizing currents to the L5-S1 area and the right posterior hip muscle group in the retrotrochanteric location. She is given home instructions to apply 10 minutes of heat, followed by 10 minutes of ice, followed by 10 minutes of heat and is told to perform exercises 1 through 5 on the red sheet. She is given Discat+, 4 at breakfast and 4 at bedtime. Orthotics are placed in both shoes to correct pes planus. She is also given an herbal pain killer on an as needed basis for pain control.

Following her first visit she felt sore but she noted relief of calf pain on the right side. No ankle cuffs were used with flexion distraction. She was treated on the second visit without using ankle cuffs, but rather holding the ankle when applying Protocol I flexion distraction decompression.

This treatment was applied for a period of 3 months and a total of 31 visits. It is to be noted that as the lower extremity pain centralized, the manual flexion distraction was replaced with automated axial distraction. The exercises did result in return of motor power of the gluteus maximus muscles within 8 weeks. The patient's ability to walk continued to increase until she had 100% relief of both back and leg pain at the completion of the above described care.

We are called upon to treat the post surgical backs. This is a good representation of treating the post surgical spine with flexion distraction adjusting and automated long y-axis decompression. Patient acceptance and happiness with such relief is high.

Respectfully submitted,

James M. Cox, D.C., D.A.C.B.R.

www.coxtechnic.com/casereports.asp

