ACUTE DISABLING SCIATICA: Assessment and Treatment *without* The Benefit Of Imaging

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HISTORY

A 36 year old male presented with 4 days of severe disabling right sided sciatica (10% low back 90% leg [glute to foot]). He was an undocumented worker from a Central American nation and worked manual labor supporting his family who lived in a distant suburb. He was evasive about the onset, but I suspected work related, and the employer likely did not have mandated insurance coverage. He was referred by a family member I had treated; his wife drove him nearly 40 minutes one way. He had no private health insurance. He was unable to sit, stand, walk, sleep or move without the pain intensifying. He was unable to work. He rated his pain as a constant 8/10, reported no cauda equina symptoms, and described the pain as sharp and numb. He reported that pain reduced to some degree by lying flat "in a certain position."

EXAMINATION

- Visual: Purple distended blood vessels at or around L4 under the skin.
- Posture: Forward antalgia and varying degrees of left to right antalgia.
- Motor, Sensory, Reflex Examination: Right Achilles absent. Bilateral heel toe walk difficult due to pain. Lower extremity muscle testing inconclusive due to break away pain. Sensation roughly within normal limits however pain overrode perception.
- Ortho: Valsalva inconclusive. SLR right: leg pain intensified at 3-40 degrees. Left SLR reduced right leg pain and at 45 degrees severely provoked LBP.
- Dual Incline ROM: Barely moved any direction.
- Oswestry: Not applicable due to language barrier affecting validity.

DIAGNOSIS

- Right sided Sciatica, likely L4-5 central to right central disc pathology. Sciatica more inflammatory versus compressive.

TREATMENT PLAN

- Home: Relative rest with 20 minute rule (no more than 20 continuous minutes sitting, standing, walking, lying down during awake times). Icing gluteal muscle and low back 15 minutes, 3-8 times a day.
- Nutrition: Disc & Joint Pain Relief Complex, a compound of curcumin and turmeric root.
- Clinical: Acupuncture & Spinal Adjusting with Cox® Technic flexion distraction.

- Short Term Goal: Improve sitting/standing from 1-2 minutes to an hour. Centralization of radicular symptoms.
- Progress Exam: 30 days.

OUTCOME

- Intervention: Pre-treat with acupuncture, prone, 15 minutes. GV3; bilateral BL23, BL25, BL25. Ion bypass cord attached to right BL24 and right BL60. Adjust using Cox®7 Table: L2, L3, Sacrum using directional preference.
- Note: Due to high pain, even with no finances, he chose to go to Urgent Care after seeing me on first visit. No MRI and only pain meds.
- Treatment Day 2: Pre-treatment: gluteal pain 8/10, right calf 9/10. Post treatment: gluteal pain 0/10, right calf 1/10.
- Progress Exam (visit 8, 30 days): Pain in right calf, multiple days a week typically no higher than 3-4/10. Able to sit, stand walk for couple of hours. Too much bending or twisting provokes back and leg pain. He just returned to work a few days prior and was self-monitoring activity. Note: friends and family at work were helping him a lot so he could get jobs completed.
- Progress Exam (visit 10, 60 days): Had a grand total of 10 visits. He knew what his limits were, would stop if he felt leg sensation or back pain. He rested often to avoid provoking activity, was dropping weight, and doing home exercises of his choice. Discharged.

Comment from James M. Cox DC DACBR:

This case illustrates "Choosing Wisely," the new clinical guideline for diagnostic imaging and treatment. Cox Technic protocol instruction has taught that in the absence of progressive neurological deficit treatment for low back and radicular pain can proceed for 4 to 6 weeks. If 30% to 50% relief has been gained in this period of care, no diagnostic imaging is performed unless red flags are present. This is a good example of that premise. This gentleman progressed well with Cox® Technic treatment, and no diagnostic imaging was performed. I would note that this is the future guideline in medicine for treating spine and radicular pain. Also note that this has been our didactic teaching for the past 40 years.

Respectfully submitted,

James M. Cox DC DACBR