



Case Report: To Treat or Not to Treat

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INTRODUCTION

42 year old male reports chronic left gluteal pain of 7 months' duration. The patient went to see a chiropractor with no clear diagnosis conveyed to him. The patient received what is understood as a Thompson drop manipulation to the lumbar spine. About 3 days later, he was cleaning his deck and progressively began to "seize up". He was rendered immobile and could only lie in a hook-lying position. He visited a local ER and was prescribed Naproxen. Symptoms progressively worsened, and he presented to another ER where he received a CT scan. Details noted below along with current care and treatment outcome.

CHIEF COMPLAINT

At the time of presentation, he reported intermittent resolving low back pain (about 2 weeks after his second trip to the ER). It was resolving to the point he had considered cancelling his appointment. Symptoms are sudden and progressive but then ease. Quick movement, exercising, standing and straight lying are all provocative. Sitting and rest are palliative. Pain is sharp. Gluteal pain was noted for months. After the Thompson adjustment, symptoms travelled to the L foot. At the time of presentation there were only minimal symptoms to the the gluteal area. Peripheral symptoms were reportedly improving overall. Pain is rated 4/10, stiffness was noted in the morning but pain symptoms increase over the day. He reports less skating and exercising as ADL limitations. As noted, symptoms were gradually improving, he consulted with me on the recommendation of a colleague.

PAST MEDICAL HISTORY

The patient is a 42 year old computer programmer. He is 5'11" and reports a weight of 190 lbs. He is married with 2 daughters aged 12 and 8. He admits Naproxen and Lyrica usage. He admits a history of a right club foot (corrected at birth) and a right ankle fracture in 1986. No other medical issues are reported. He doesn't smoke, admits 2 alcoholic beverages per week, and 5-8 glasses of water a day. He states a maternal history of metastatic disease and a paternal history of hypertension.

EXAMINATION

Valsalva manoeuvres were positive historically, not at present, and no bowel or bladder issues were reported. Range of motion (ROM) findings were somewhat limited in all planes, and he reported stiffness. Lateral flexion and extension were both greater than 50% with extension producing pain at end range. Kemp's, Seated SLR/Slump, SLR and Braggard's were all negative. He was a little weak on the right at L4 and L5 with myotome testing; he attributes this to his clubfoot as he has always had a little weakness there. Reflexes were +1

at L4 and S1 on the left and +2 on the right. No sensory changes were noted. Heel and toe walking were negative. Palpation revealed significant hypertonicity throughout the lumbar spine with slight mechanical restriction, but nothing of significance mechanically other than challenging into extension.

IMAGING FINDINGS

CT scan performed at the second ER visit yielded the following findings: "L4-5 Disc height loss with a large right parasagittal disc herniation which measures 2.1 cm at the base and 1.4 cm in AP dimension with marked narrowing of the central spinal canal which is nearly completely attenuated. This is new relative to previous findings (which were not disclosed). There is associated marked narrowing of the right neural foramen and mild narrowing at the left neural foramen. At L5-S1 there is a mild diffuse disc bulge with no significant narrowing of the central canal. Neurosurgical consultation is advised."

DIAGNOSIS

In light of the lack of orthopaedic findings, the primary pain generator in this case did not strike me as being discogenic, rather, mechanical in nature. This is likely secondary to the disc lesion however.

TREATMENT/DISCUSSION

Through the course of the history, exam, report of findings, and discussion, the patient demonstrated some hesitation to go through with any care. Usually, I would work them through their fears and discuss the gentle nature of Cox® treatment. However, in this case, the patient's symptoms were resolving, and I suspected some articular irritation that was improving. I also felt that there was a little damage control that could be exercised in light of his experience with chiropractors historically.

As we all know discs can have a mind of their own, and I felt that this was a case that a "wait and see" approach was more prudent. No treatment was provided. The patient was encouraged to follow up if anything changed or his symptoms worsened again. He was also advised that should he develop any progressive neurological deficiencies or any changes in bowel or bladder function he was to report to the nearest ER for cauda equina evaluation.

I thought this was an interesting case to present to Cox® doctors because we have all seen the amazing outcomes that can be achieved with this technique. Some of you may have taken on this case and yielded fantastic results. We are all confident that (Cox®) flexion distraction is one of if not the best technique for complex challenging cases. However, we still need to exercise caution and restraint if we get that "uh-oh" feeling. Could I have started treatment? Yes. Was there potential for a fantastic outcome? Yes. However with near full stenosis of the canal secondary to soft tissue, I felt that the risk outweighed the benefit and thus decided to not start any treatment, especially in light of the fact that the patient reported that he was feeling significantly better. Pay attention to those gut feelings; they come from a very intelligent place, especially in those of us who are Cox® practitioners.

Respectfully Submitted,
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