Back Pain due to Disc Degeneration with Facet Degeneration Helped with Cox® Technic

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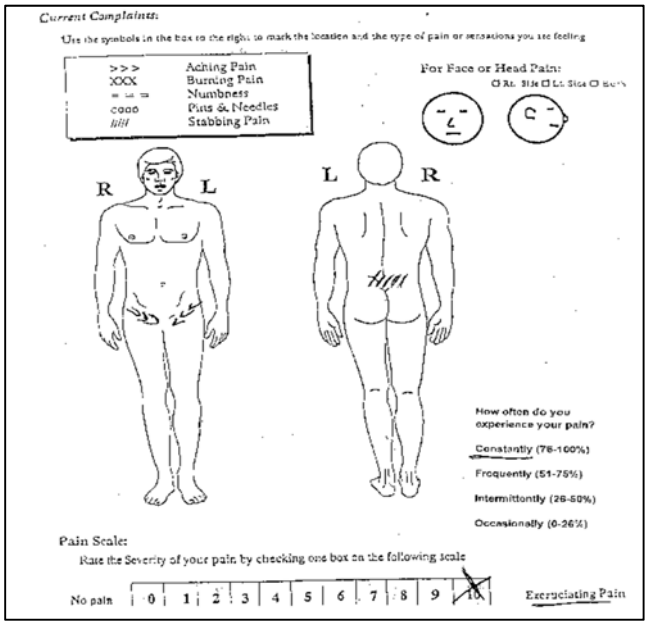
at the Philadelphia Honors Course, Fall 2018, Case #5

HISTORY

Having been a patient approximately twenty years ago, a 49-year-old male standing 6' 0" and weighing 190 pounds, using a walker and wearing two lumbosacral supports presented to the office with a desire to be "cracked" for relief of his back pain and walk home. His back pain episode now includes more complications. Two weeks prior to the initial appointment, he had developed severe, constant, excruciating low back pain that migrates into his groins bilaterally. He has a history of IV drug abuse and had been released from prison 2 months prior. He is taking medications for addiction. He presented to local emergency room and was admitted for 4 days for an infection in his spine for which treatment included IV antibiotics.

CHIEF COMPLAINT

His complaint of left low back pain radiating to left anterior thigh described as sharp, shooting, throbbing, dull and achy was rated at a 10 of 10 (10 being the worst possible pain). He described it as excruciating which migrated into his groins bilaterally. He has difficulty walking, standing, sitting, reclining and sleeping. Nothing improves condition.

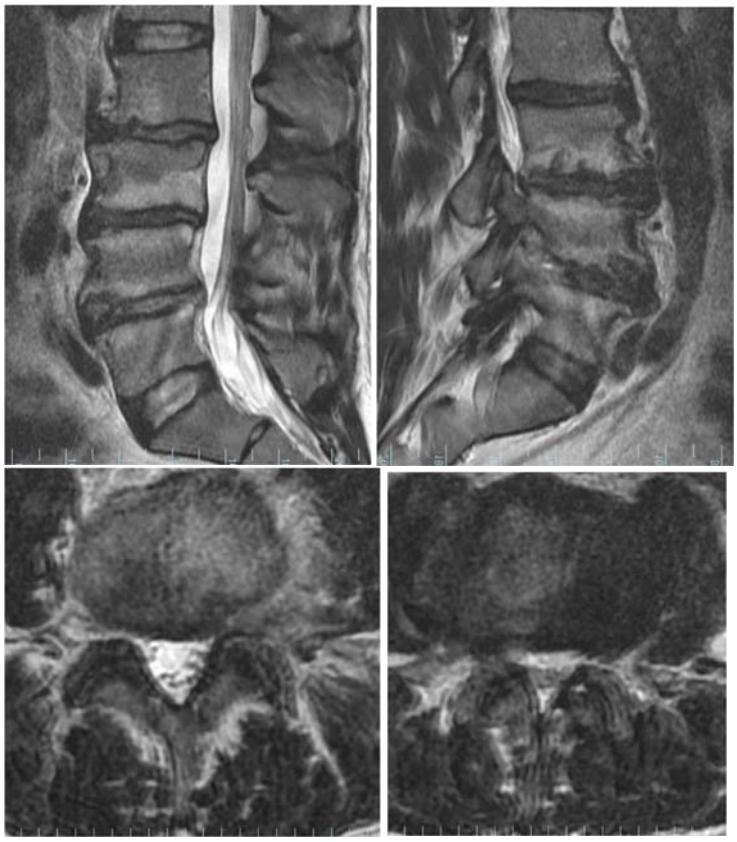


PHYSICAL EXAMINATION

The examination revealed reduced lumbar ranges of motion, a positive orthopedic exam, deep tendon reflexes of 2/5, no loss of muscle strength in lower extremities. The exam was limited. He was in severe pain using a walker and lumbosacral supports.

IMAGING

A lumbar spine MRI taken on September 3, 2018, ordered by his medical doctor, revealed
L1-L2 – No disc herniation or bulge. No central canal or foraminal stenosis
L2-L3 – Annular bulging, facet degeneration LF hypertrophy, moderate canal stenosis.
L3-L4 – Mild disc bulge, facet degeneration, LF hypertrophy, no significant canal stenosis.
L4-L5- moderate disc bulging & mild facet degeneration, no canal stenosis. Infection within psoas muscle, not discitis/osteomyelitis.
L5-S1 – No disc bulge or herniation, no central canal or foraminal stenosis.



TREATMENT PLAN

The treatment schedule was set for three visits per week for a 4-week period using Cox® Flexion Distraction Decompression Manipulation to achieve 50% subjective and objective clinical improvement. The 50% Rule seeks 50% relief of pain within the first 30 days of treatment. If that is not attained, further imaging or surgical consult would be arranged. Also, once 50% relief of pain (subjectively and objectively measured) is attained, treatment frequency and style are modified: treatment frequency is reduced by 50% and treatment style would transition from Protocol I (segment specific flexion distraction to open the canal area by 28%, increase the width by 17%, and reduce the intradiscal pressures to as low as -192mmHg) to Protocol II (range of motion adjusting to specific segments with long-y axis decompression opening the spinal canal first). Because the patient was in too much pain to lie prone and until he could lie prone comfortably, the patient was treated side-lying (special positioning for patients who have too much pain to lie prone that allows with the help of The Cox®8 Table to have flexion performed using the lateral flexion motion of the table) with electrical muscle stimulation being applied that way as well. Lumbosacral support use continued. Infrared light therapy was administrated after each treatment. A home stretching and strengthening program was recommended as was applying ice. This case was co-managed.

TREATMENT OUTCOME

Patient had a positive gradual response to his treatment plan and after 5 treatments he rated his pain at a 5 to 6 of 10 (10 being the worst pain) which he had frequently. 50% was attained for which many patients are quite grateful as it allows them an improved quality of life. He was now walking with a cane. Since this case was being co-managed, he was now under the care of the infectious disease physician.