LESSON:
DO NOT MISS THE BIG PROBLEM BECAUSE MRI FINDINGS MISLEAD YOUR ATTENTION

An 81-year-old female is examined for the chief complaint of lumbar spine pain and left thigh pain, both anteriorly and posteriorly, to the knee.

History shows she has had epidural steroid injections in the left hip in February 2003, transforaminal injections in 2003 and 2004 that gave some relief. She has also had facet joint injections in the lumbar spine in December 2004, May 2005, and August 2005. She continues to worsen with pain, reduced range of motion, complains of a left limp, and now uses a cane to ambulate.

The history of this case is further omitted from this case, but following the MRI findings and above extensive care, the osteodegenerative hip disease is seen on our examination, heretofore omitted (or missed) from diagnosis or consideration.

X-ray examination of the lumbar spine reveals advanced left femoral and acetabulum degenerative change. See Figures 1 and 2.

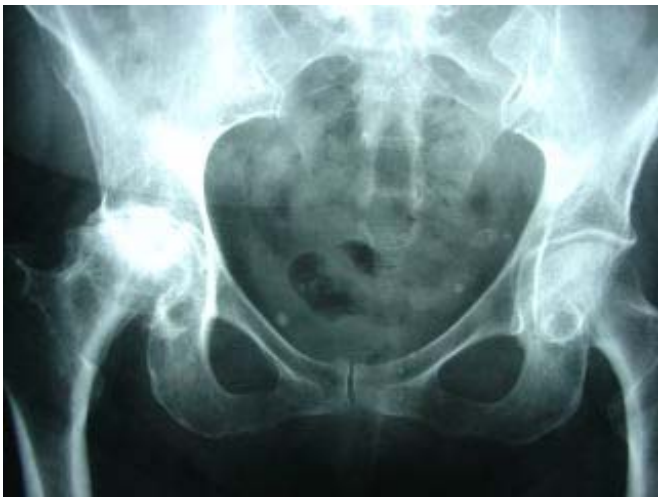

Figure 1
Left hip osteodegenerative arthritis, advanced is seen

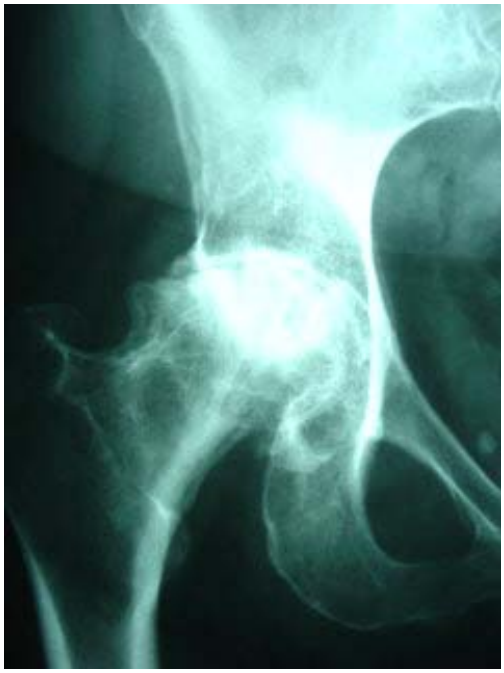

Figure 2
Left hip study showing advanced cystic degeneration of the left femoral head and acetabulum

An MRI report shows severe stenosis at the L4-L5 level due to hypertrophic facet disease, spondylolisthesis, and scoliosis. See Figure 3. Figure 4, an axial image at the L4-5 level shows moderate to severe bilateral facet hypertrophy. These findings suggest moderate central canal stenosis. At the L2-L3 and L3-L4 level, there is retrolisthesis subluxation noted.

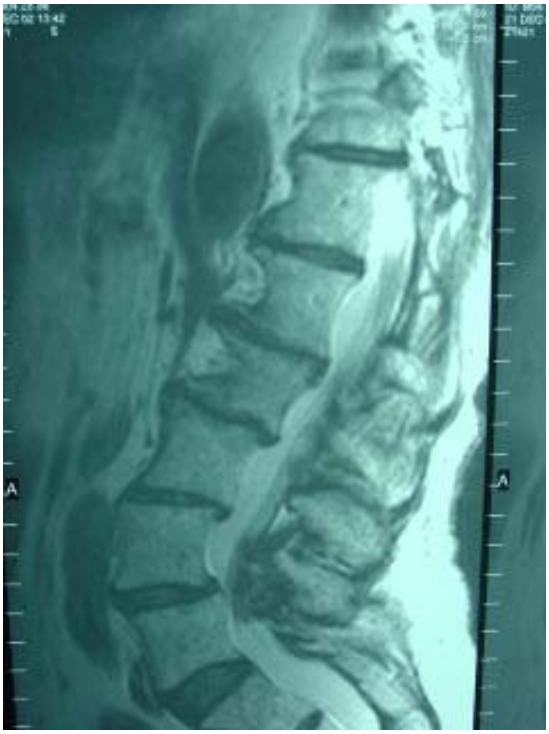

Figure 3

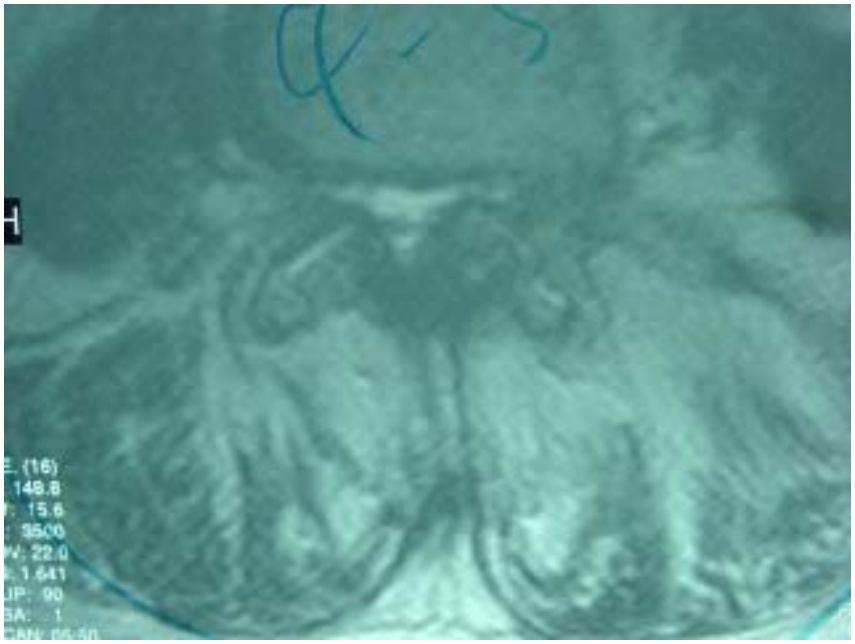

Figure 4

The diagnosis of this case from MRI is:

- Levoscoliosis of the thoraco-lumbar spine, apex at L2, with severe degenerative disc disease at the T12-1, L1-2, and L2-3 levels.
- L4-L5 spinal stenosis, advanced, due to degenerative spondylolisthesis of L4 and facet degenerative changes with ligamentum flavum hypertrophy.

RECOMMENDED TREATMENT:

The interest in this case is the failure to identify the hip disease and act on it. Instead, care was directed to steroid injections of the left hip, transforaminal steroid injections of the lumbar spine and facet injection with steroids. It is my opinion that the altered painful gait causes spine pain in this degenerative spine, and hip joint generated pain is a principle cause of this lady's pain. It is sometimes confusing to follow the treatment patterns given to patients such as this.
Following our examination which showed that this lady has a sign of 4 that is zero in abduction and radiates pain into the left hip, groin, adductor muscles, and anterior thigh, coupled with the fact that the lady has a severe limp and shortness of the left lower extremity, our decision was to have a hip replacement. I have recommended a surgical consultation for a left hip replacement. This could allow a more normal gait, which could help reduce her pain and certainly make manipulative treatment more beneficial.

I recommend long y-axis flexion distraction decompression manipulation of the stenotic levels of this lumbar spine, strengthening exercises of the left gluteal muscles, stabilization exercises of the lumbar spine as best performed to the patient's tolerance and the ultimate outcome being 40-50% relief of pain to be a good clinical outcome. We will also use physiological therapeutics to the lumbar spine and left sciatic and femoral nerves for rehabilitation. Surgical hip replacement followed by the manipulation outlined will hopefully render an improved quality of life for this nice lady.

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