

**SURGICAL FUSION AND HIP REPLACEMENT PATIENT
TREATED FOR BACK AND LEG PAIN SUCCESSFULLY
WITH Cox® FLEXION-DISTRACTION ADJUSTING
AND LONG Y AXIS DECOMPRESSION UNATTENDED:
*REALISTIC EXPECTATIONS***

This is an interesting case of surgical fusion and hip replacement in an 80 year old man.

He had a right hip replacement in 1998 and a spinal fusion for degenerative spondylolisthesis in November 2006. He returned to our clinic in April 2007 complaining of left leg pain. The x-rays shown were taken at that time. His vital signs are normal at age 74 except he is under hormone treatment for prostate cancer.



Figure 1

You will note the L3 through the L5 pedicular fusion with decompressive laminectomy at the L4 level. You will also note the fusion of the sacroiliac joints bilaterally and the replacement of the right hip joint.



Figure 2:

This shows the surgical fusion with the degenerative spondylolisthesis now fixed at the L4 level. You will also note the DISH at the thoraco-lumbar spine. Note that L5-S1 is not fused.



Figures 3 and 4:

The oblique views showing the sacroiliac joint fusion and the placement of the fusion and anterolateral ossification of the anterior ligament.

You will note that a decompressive laminectomy at the L4 level has been performed with pedicle screw fixation from L3 to L5. See figures 1 to 4. You will also note on the anteroposterio view of the sacroiliac joints that they are fused, probably from osteodegenerative arthritic change since no evidence of enteric or psoriatic changes are noted. You will note the persistent degenerative spondylolisthesis of L4 on L5 and the fact that L5 is not fused to the sacrum. You will also notice the diffuse idiopathic skeletal hyperostosis and fusion of the lower thoracic and thoraco-lumbar spine. The x-rays shown were taken at in April, 2007.

It is probable that the surgical fusion has lead to further degenerative changes above and below the levels of the fusion. Noting that the patient complains of left leg pain, the L5-S1 disc space is targeted for gentle flexion distraction manipulation.

The expectation of treating the L5-S1 disc space with flexion distraction was to attain 25% improvement at the end 3-4 weeks of care. On the 10th visit the low back and leg pain had diminished from 7 of 10 VAS to a 5. At the end of 1 month treatment the pain had diminished from a 7 to a 4 on a VAS scale and the patient noted definite improvement in his low back and left leg pain. He continued to improve through the 2nd month of treatment and the treatment was changed to unattended intermittent long y-axis decompression, which continued to give him relief and as of June 2007 he has attained well over 50% relief of his low back pain and has no leg pain. This is an excellent clinical outcome. We often say we do not cure back, but rather we control it. Certainly in this spine, which is a post surgical spine, both the doctor and the patient can be happy with the improved quality of life and the diminishing of 50% relief of the pain.

It is this author's opinion that sometimes neither the doctor nor the patient appreciate the relief of 50% as being a good clinical outcome. In this 80 year old man, it is certainly a satisfying increase in quality of life. Perhaps clinicians could reflect on this case and treat such patients with realistic expectations that both patient and doctor can attain and appreciate.

Respectfully submitted,

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