

Chronic Lower Back and Left Leg Pain

*by Niko Kalgeropoulos DC, Athens, Greece
submitted on 7/18/24*

CHIEF COMPLAINT:

A 63 year old female pensioner presented to my office with a chief complaint of lower back pain radiating down the left leg, the whole leg, starting from the groin region medially radiating caudally, anterior thigh, sometimes posterior thigh, into tibia and ending into the middle three toes. These pains are chronic coming and going. Five months ago there was an exacerbation and the surgeon warned that she would need surgery to prevent cauda equina syndrome, which led her to seek my advice. The patient walks with a cane and has a guide dog. There is a slight forward flexed antalgia and a slight waddle gait.

HISTORY:

History revealed no major traumas, many minor falls on a few steps and smooth pavement. She reports intestinal problems of bloating and indigestion. She has had hepatitis, gynecological problems, and polyarthritis. She is a smoker. She takes various medications, pain killers, and anti-inflammatories consistently.

EXAMINATION:

Palpation revealed fixations in the sacrum, L5 region, upper thoracic spine, and thoracolumbar region. SLR reproduced some of the pain at 70 degrees. All lumbar ranges of motion were decreased not so much due to pain but inability to do them. For example, forward flexion was only performed if she held onto something like a cane or a wall. Myotomes, hip flexors, quad and hamstrings were +4, patella and Achilles reflexes were +1.

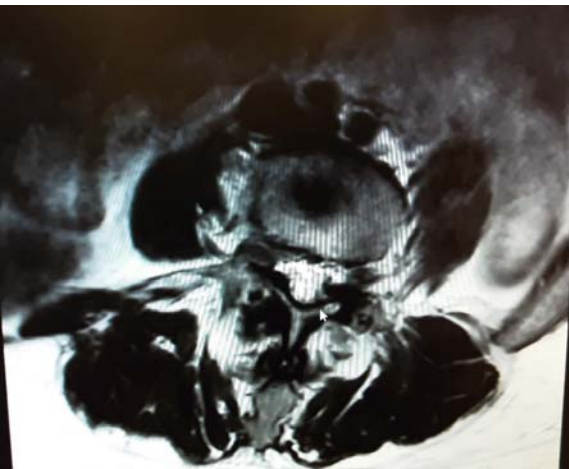
The difficulty of this case was presented to the patient accompanied with an explanation that an outcome of 40% improvement in terms of pain and mobility was the goal. The patient was advised that exercise was her responsibility once I showed her some simple strengthening exercises.

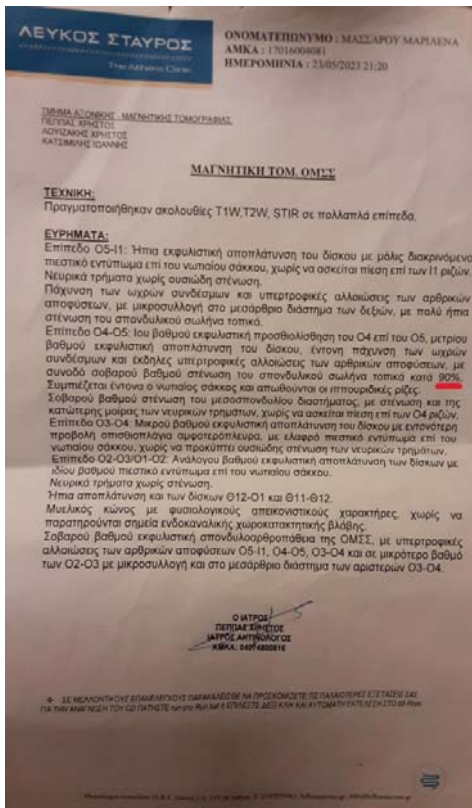
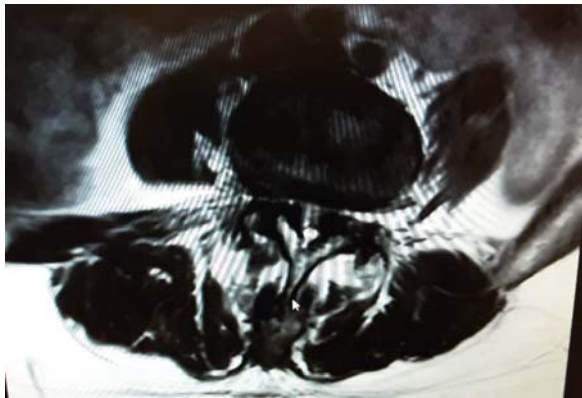
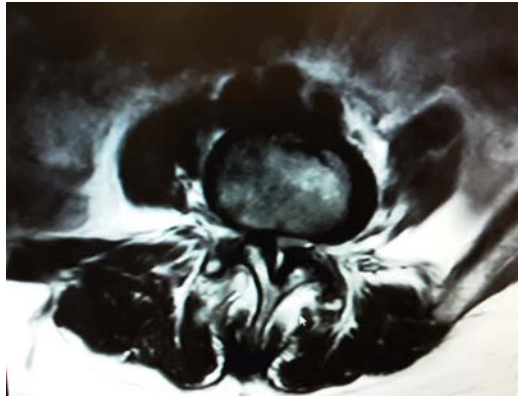
IMAGING:

The first set of images are the ones she brought with her. The second set of images were taken a year later.

The images that follow are from May 2023 clearly showing the advanced degenerative disc disease, anterior osteophytic change, degenerative joint disease, antero-spondylolisthesis bordering grade 1 with grade 2, arthritic change, protrusions, herniations, hypertrophy of the ligament flavum, the scoliosis, muscle atrophy.

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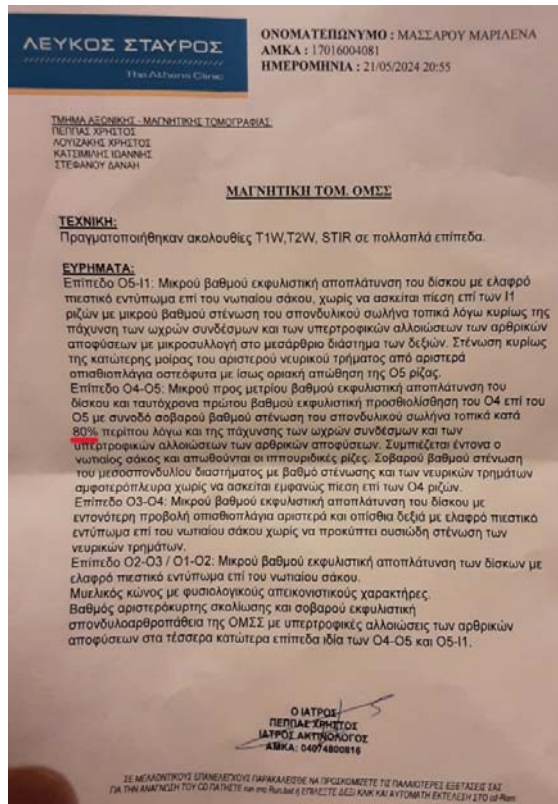




This is the report from the diagnostic center. The thing that I want to highlight here is that the L4-L5 level there is local severe canal stenosis of 90% (underlined in red) and applying pressure on the spinal cord.

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The interesting thing about this case is the same diagnostic center verified a *decrease* in canal stenosis, from 90% closure to 80 % closure. This was achieved with 33 treatment sessions over a one-year period.

TREATMENT PLAN:

Treatment was initiated. All treatments consisted of Cox® Technic Flexion Distraction Decompression. First, Protocol 1 – *3 sets of 5 four-second pumps from the taut point* – was delivered after careful tolerance testing revealed no aggravation, then Protocol 2 – *full range of motion under distraction: flexion, lateral flexion, circumduction* – but mainly long Y-axis distraction starting from L3 and then moving cephalad. Trigger point therapy was utilized over the gluteal muscles bilaterally and piriformis on the left. On a couple of occasions, I adjusted the left Alar using the drop piece and the upper thoracic spine.

Advice was given to prevent certain movements like bending, lifting and twisting, but it was not followed because of her daily routine of feeding cats and dogs and generally looking out for and after stray animals.

Strengthening exercises were attempted to stabilize the lumbar spine as well as correct walking posture.

Supplements were suggested in the form of Chondroitin Sulphate and Glucosamine Sulphate as Dr. Cox suggests, but lack of funds prevented her from following this advice.

OUTCOME:

The patient is still in pain though not as severe and still takes medication. She has not changed her lifestyle, but her mindset is away from the surgery the doctors had recommended for her. She was warned of possible cauda equina syndrome.

Dr. J. Cox has repeatedly proven that spinal canal stenosis can be reduced, thereby increasing the canal, and I think that this case, although slowly, supports Dr. Cox's tenets.

Dr. Cox Comments:

Good mentally stimulating case. This case brings these facts in focus:

- 1. There is advanced L4-5 degenerative spondylolisthesis with ligamentum flaval hypertrophy and facet degenerative arthritis.**
- 2. Lowering nerve compression to 20 mm can render relief for radicular pain.**
- 3. Decrease of inflammatory type I cytokines such as tumor necrosis factor alpha, IL6 and IL1B have been shown to decrease with spine manipulation and mobilization.**
- 4. How is the patient's decision to accept the relief or go to surgery. Also continue to work with core stabilization, multifidus muscle strengthening and lowering fat infiltration. Nutrition with perna canaliculus is needed. Tumeric for inflammation reduction is needed. It also appears that ADLs need discussion as her animal work probably aggravates her pain. Strange as it may sound, wearing a lumbosacral support may give more relief.**

I like this case as it appears to render sufficient relief to make her life better.

James M. Cox DC, DACBR