

L5 Subluxation: A Cause of Interstitial Cystitis

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A painful bladder syndrome called interstitial cystitis is a typical medical diagnosis where, if no obvious pathology can be found, the patient is treated symptomatically and often with antibiotic therapy and even hysterectomy. Failure to respond to treatment is often labeled a "psychosocial disorder" and referred out for psychotherapy.¹

Thanks to the current information revolution we are living in, several months ago a 28 year old male entered my office with shoulder anterior pelvic pain, perineal pain, frequency of urination, mild low back and buttock pain. His urologist had not been able to detect any infection related to his urogenital system and his condition persisted despite all types of medical treatment. He stated that although his back pain was not as significant as his urological symptoms, he felt there might be a relationship. He decided to do a literature search and found an article in the British Journal of Urology² which described the possible causation of his problem.

This article² states "An identifiable lumbar nerve root compression appears to cause urological dysfunction consistent with interstitial cystitis." Ten patients, nine female and one male, were evaluated for chronic pelvic pain, and cystoscopic and histological appearances were consistent with a diagnosis of interstitial cystitis. All 10 patients stated that their urological symptoms were so severe that they never would have sought neurosurgical consultation, although their back and leg symptoms became worse with standing, sitting or exercise. MRI of the lower spine consistently found in all 10 patients a lateral compression of the L5 dorsal nerve root. Surgical decompression of the lateral foramina of L5 resulted in immediate relief of urological pain in nine patients who had been followed up for six months without a recurrence.

The females in this study complained of clitoral pain and hypersensitivity, pain upon distention of the bladder based on urodynamic evaluation with synchronous cystometrography, EMG and uroflowmetry, dyspareunia in the women and perineal and meatal pain in the man. The patients were cystoscoped under anaesthesia and found to have diagnostic petechial hemorrhages usually seen with interstitial cystitis. The authors of this article point to the autonomic contribution of the L5, S1 and S2 nerves as they leave the vertebral foramina anteriorly to join the hypogastric nerve of the inferior mesenteric plexus. "Together these fibers make up the pelvic plexus which then spreads along the lateral aspect of the rectum to innervate various pelvic organs. The highest density of adrenergic nerves is found in the trigone, bladder neck and proximal urethra, where they serve a sensory function and are involved with vascular innervation."²

My patient's MRI showed a lateral bulge at the L5 level. Orthopedic and neurological evaluation was essentially negative. There was tenderness on palpation at the L5 level. There was a definite fixation at the L5 level. His complaint of back pain was intermittent and not restrictive of activity. He was a weightlifter who was originally referred by the Leahy clinic based on an article in a recent weightlifter's journal on the benefits of Active Release. On his initial visit, his chief complaint was his shoulder. He stated that if I fixed his shoulder, we could then discuss his spinal and pelvic problem with me. I did fix his shoulder, and weeks later after his shoulder improved he

presented me with the reference article and his MRI. Two adjustments of L5 eliminated his pelvic and urological symptoms.

References

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2. Gillespie L, Bray R, Levin N, Delamarter R. Lumbar nerve root compression and interstitial cystitis-response to decompressive surgery. British Journal of Urology, 68:361-364,1991.

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