Dynamic Chiropractic

SOFT TISSUE / TRIGGER POINTS

Sciatica or Pseudosciatica? A Case for Fascia

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Not all cases are as they appear. Yes, there is pain radiating down the buttock; yes, it is persistent and precipitated by falling onto the buttocks. With obvious thinning of the L4 and L5 discs, even lacking cough and sneeze responses, a reasonably shoo-in diagnosis of sciatica?

So why after six weeks of continual adjustments and modality use, did the patient seek consultation because of grudgingly admitted but slight improvement? And why virtually miraculous improvement following the very first visit to the consulting chiropractor?

The patient, a 52-year-old caucasian female of stock build, overweight but not obese at 5'6" and 198 pounds, had been very active in various sports in earlier years, suffering various injuries as a result. Despite a heavy schedule in private counseling, college teaching and chores around the house, she was not one to take forced inactivity lightly.

Several factors alerted this consultant to possibilities other than conventional sciatica.

1. There was insufficient progress for the appropriate treatment tendered for classic sciatica of L4-5 origin, so far as could be ascertained.

2. This highly educated woman accustomed to dealing with the nuances of words, chose "tightness" of the buttock area rather than "pain."

3. After coursing down the buttock, the tightness tended toward the medial thigh rather than lateral, suggesting that the condition, if neurogenic at all, stemmed from areas below L4-5.

4. The patient herself brought up the word "fasica" (an "aha" for me, as will be explained later), claiming it came from her DC who later told her he never said it. And why would he, as to my knowledge, I am alone among DCs in separating the term from customary chiropractic use of "myofascial."

5. Tightness of the area was present on arising in the morning. Rest from sleep, unless on a poor excuse for a mattress, would be expected to afford a measure of relief ordinarily.

6. The patient mentioned use of a proprietary phenolphthalein preparation to stimulate fecal elimination. Since the primary complaint involved the right side, the question arose as to a possible referred "pain" (forgive me) from a colon condition, esoteric as that may be.

The points presented bring up an aside of distinct importance: careful history-taking, unhurriedly done so patients unfold rather than feel pressured or coerced into answers they think the doctor is

seeking, or self-editing so as not to waste the doctor's time. Well over a half century of practice only reinforced the feeling that thorough history taking provides at least half the diagnosis, confirmable by examination and, if indicated, laboratory testing.

It is fully realized, especially under managed care, that kind of examination is virtually impossible. Forms do not portray the hesitations, inflections, word choices, expressions or body language so often offering valuable clues.

Were I not in the enviable sufficiently independent position to devote the necessary time to this patient, any information proffered here that some may find of value would have had no cause to be written. Substantial portions of this patient's history were obtained just from conversation while examining her. It is deplorable that today's crying need to minimize time with a patient prevents such procedures. Still, skillful questioning sharpened by experience can yet elicit substantial information to augment the history questionnaire form. If we are forced into losing that verbal art form by economic pursuit, it is not only patient satisfaction that will suffer, but ours as well. And that portends burnout.

Salient features of the examination led to fingering the suspected culprit (maybe divined by the patient herself): the fascia. Admittedly my own bent was only too willing to go in that direction, even in the face of a distinctly tender rights S1 joint with lesser S1 and S2 area tenderness. Fascia is my area of special interest for over 40 years, a result of contact with an orthopedic surgeon, the late Harvey Billig Jr., MD, not long after WWII.

Ranges of motion were even more limited than expected for her stocky architecture, an indication of fascial tightness. End ranges were more akin to the tautness of a polyethylene rope at full stretch rather than a door swung to its maximum hinge capacity. This is characteristic of fascial restriction. Muscle is much more elastic. A feel is gradually developed for the difference. The affected side was more limited. Special testing originally devised by Dr. Billig, and since augmented and modified, confirmed the fascial tightness. Appropriate fascial stretch procedures were then applied.

The patient arose from the table, stood beside it an instant, both incredulous and amazed. Instant relief after all those weeks of continual discomfort. Now I'm no more of a miracle man than you or anybody. Such a reaction is frequent if they diagnosis is correct. We have all known it following certain adjustments. But no adjustments were done here; just the special stretches, some similar to moves we all know but applied differently.

The patient was cautioned that the next 24-48 hours would tell whether we were on the right track. Feeling good the next day, she took on some activities. Still okay after 48 hours, we had satisfactory confirmation.

My approach tends to be holistic as possible. In addition to the bowel stimulant use, she reported irritable bowel syndrome, a low thyroid under medication and frequent use of analgesics for lasting headaches. And due to the advantage of a lengthy entranceway, I was able to observe natural gait, which can change when they do it as part of an examination, believe me. Obvious bilateral hyperpronation was worse on the affected side. So the self-trained change from an early out-toe gait had not alleviated the excess pronation, unless it once was even worse.

Since I believe in the best possible care for my patients and factors involving medicine are at play here, I referred her to an internist understanding of and open to my viewpoint to coordinate and evaluate facets not of our expertise. And because the foot problems strongly influence the low back and hips particularly, I also made referral to a cooperative podiatrist who undoubtedly will have

appropriate orthotic devices fabricated. I know that a specialist up on all the rapid changes occurring now is going to do a critically important job for an overweight, physically self-demanding patient better than I may. I believe in interdisciplinary care. No one field has or can have all the answers. I never was that hungry that I had to try to embrace it all. Maybe today's economics would make me change my tune, but I doubt it.

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