

Disc Lesion Verses Spinal Stenosis

Mark A. King, DC

Because doctors of chiropractic evaluate many patients with low back and leg pain, this article will discuss a few of the points involved in a disc lesion verses spinal stenosis. This article is not designed to be an exhaustive study of these two conditions, but to give the practicing clinician food for thought. There are several common distinguishing features between these two conditions, including the age of onset. With a disc lesion, onset will most often be in the 30-50 year range; with spinal stenosis it is typically over the age of 60 years. Again, I would state that these are general guidelines and there obviously are variations to this. For example, I have a 24-year-old female patient with congenital spinal stenosis along with a disc lesion.

The pain pattern with the disc lesion will often be acute and sitting typically increases the pain. Flexion usually increases the pain of a disc lesion, although extension may also. With spinal stenosis the onset is insidious and walking will increase the pain. The increase in pain with walking is relieved with rest, but not as quickly as with a vascular claudication. Lumbosacral extension will typically increase the pain with spinal stenosis.

The x-rays taken with a lumbar disc lesion will most commonly be normal, but may reveal degenerative changes. With spinal stenosis you will see a narrow canal upon measurement. In the lumbar spine measurement is made from the posterior body to the center line, midway between the superior and inferior articulating facets. Ten millimeters or less equals absolute stenosis; less than 15 millimeters equals relative stenosis. The x-ray numbers used would be for 40" tube distance. A Pope instrument can be used, but a ruler would also work. On CT scan or MRI disc lesions are represented by herniations of varying severity, but spinal stenosis is represented by a narrowing of the bony canal.

Another important point is that disc lesions will tend to respond better to conservative treatment than spinal stenosis. In our office as long as there is no cauda equina syndrome, unbearable pain, or an increase of pain with stressing of the area, we will adjust the area of subluxation/fixation noted upon our motion palpation examination. David Cassidy, DC, has done tremendous work regarding disc lesions and chiropractic side posture adjustments. One of the things that we have found very helpful for patients with spinal stenosis in addition to osseous adjusting is flexion/distraction. As stated above, lumbosacral extension increases pain with spinal stenosis and lumbosacral flexion tends to decrease the pain and decompress the lumbar spine. Flexion distraction is well known for help with disc lesions.

This information is taught in more detail in the Spine 1 (S1) courses of the Motion Palpation Institute. It is important to evaluate the whole person with these conditions as other factors need to be investigated, including ergonomics, muscle imbalances, altered foot mechanics, emotional stresses, etc. Good luck with these cases. We are best equipped to help these patients.

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