

The Way It Should Be -- A Case Study

Michael Horney

Ms. V. presented to my office on 5-23-90. She stated experiencing pain in the lower back radiating into the left buttock, thigh, calf, and foot. The pain was predominantly in the lower extremity, not the lower back.

The left leg felt weaker, she stated. Numbness was present on the outside of her foot. There were no urinary or bowel symptoms. The duration had been a few months. The onset might be associated with working-out on Nautilus exercise equipment.

Prior to consulting my office, the patient was seen by another chiropractor who initially gave her some relief. However, the patient then began to feel worse and stopped going. The chiropractor used side posture adjustments. The orthopedist prescribed Naprosyn and told her to return for re-evaluation in a few weeks. He then wanted to admit her to the hospital for traction for ten days, but the patient declined.

The patient's symptoms were aggravated by changing positions; coughing, sneezing, and straining to go to the bathroom (dejerinestriad); and most activities of daily living, driving, walking, etc. Sitting still and rest provided some relief.

Physical Examination:

Lumbar flexion limited and painful.

Toe Walk: difficulty on the left.

Kemp's test: + right, + left for left buttock pain. SLR: Right 30 degrees left buttock pain. Left 90 degrees left buttock pain. Braggard's: Left +20 degrees. Knee reflex: +2 bilaterally. Ankle reflex: Right +2, Left 0.

There was no muscle atrophy.

X-rays/MRI -- Large HNP (L) L5-S1, degenerative disc disease.

Diagnosis:

Lumbar IVD syndrome L5-S1, left.

HNP -- L5-S1 (per MRI).

Treatment:

Initially -- Cox distraction at L5-S1 including:

Range of motion right and left lateral flexion and extension; ultrasound left paraspinal L5-S1 and left sciatic notch EMS for pain control, with ice pack; and placement left lower back and buttock, popliteal fossa, and lateral ankle.

The patient was seen three to five times per week for six months.

Although significant reduction in pain was achieved, the patient still was unable to perform many of the activities of daily living such as extended walking, driving, etc.

She continued to work as a real estate salesperson despite the pain.

On May 31, 1990 an MRI from L3-S1 was ordered.

The results showed a large HNP on the left at L5-S1.

The patient was then referred to a neurologist for consultation and evaluation. EMG and NCV studies revealed nerve conduction problems at L5-S1 root level on the left.

The neurologist felt the patient would be a good candidate for laminectomy and discectomy, and I agreed.

The patient continued to treat with me while she made an appointment with a neurosurgeon.

We attempted lumbar intermittent traction at 100 lbs. to see if that might help.

After about two weeks of treatment, the patient felt the traction actually made her worse.

We resumed Cox flexion distraction in addition to the previously described modalities.

Additionally, the patient took Naprosyn as needed and Proteolytic enzymes.

The neurosurgeon, after consultation, felt the patient would be a good candidate for surgery. Five and one-half months after initial treatment with me the patient had a laminectomy and discectomy at L5-S1 on the left.

Three days after surgery the patient was home from the hospital and ambulatory.

Two weeks after surgery the patient presented to my office. The neurosurgeon referred her back to me for EMS, hot packs, ultrasound, and therapeutic exercise to facilitate healing.

The patient's thigh and calf pain were dramatically improved immediately after surgery.

The patient fully understands the need for conditioning exercise, spinal care periodically in the future, and good biomechanics.

This case study illustrates how a cooperative attitude between medical and chiropractic care benefits the patient and provides the best results.

This is the way it should be.

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