Dynamic Chiropractic

HEALTH & WELLNESS / LIFESTYLE

Chiropractic and the Medical Referral System

DO WE TAKE WHAT WE CAN GET?

Nancy Martin-Molina, DC, QME, MBA, CCSP

Are today's chiropractic practitioners suitable specialists for the referral of complex medical problems? While many of my colleagues will answer "yes," will these same colleagues take full responsibility for coordinating treatment? The following case report serves as an illustration of this point. The patient was referred for a consultation regarding his low back and was not accepted for chiropractic care. (The patient's referring provider was informed in writing of my consultation findings and was provided some information on the condition, as found below.)

History of Present Illness

The patient is a pleasant 47-year-old man with recent multilevel laminectomies and excisions, and drainage of multilevel epidural abscesses. He had been admitted to his local regional hospital due to significant low back pain and elevated white blood cell count. During admission, it was determined he had an elevated liver function. A GI consultation was obtained and he tested positive for hepatitis C. He obtained a spine orthopedic specialist and underwent the aforementioned surgeries.

He was discharged to his primary physician for Coumadin, PT-INR and liver function tests. His primary doctor reportedly stated no further surgery was necessary at this time. The admitting physician reported this was because he was doing very well. My consultation was sought for a reported recent lumbosacral sprain.

As the examination progressed further, this patient reported postoperatively that due to his poor financial status, he initiated some self-procured work in cement masonry. While attempting to lift an object at work, he immediately experienced a bowel loss described as explosive in nature. The patient failed to grasp any significance of this relating to his low back concerns and was very embarrassed to report the event.

The patient's complaint is bilateral low back pain, right greater than left. The pain level was rated as an 8 on a scale of 1 to 10 (10 being severe pain) and moderate interference in activities of daily living. The quality of the pain is stabbing, like pins and needles. There is some radiation of pain into the right lower extremity and right buttock; this area is described as numb.

The patient was taking the following medications: Lortab (pain analgesic), Diazepam (anti-anxiety), Atenolol (high blood pressure) and Warfarin (blood thinner).

Review of Systems

General: There is a history of probable septicemia, as his stool cultured positive. He was placed on antibiotics but currently denies fever, chills, night sweats or weight loss.

Genitourinary: No history of kidney stones, urinary tract infection, hematuria, pyuria, urinary frequency or hernia. There is no loss of urine with coughing or sneezing. There is a recent history of impotency.

Musculoskeletal: Chronic and frequent knee joint pain, current back pain, history of spondylolysis with vertebral anterior slippage and significant neural foramina narrowing, reported as L5 onto S1.

Neuro/Psychiatric: History of anxiety and depression. Underwent psych evaluation, but no current intervention reported. No history of headaches, seizures or epilepsy. One recent fainting episode, recent gait difficulties, positive for current tingling and numbness, and recent paraesthesias.

Hematologic/Lymphatic: Currently taking blood thinners.

Physical Examination

Vital Signs: B/P 178/88, P 88, RR 18, T afebrile

Height: 6'4"

Weight: 210 lbs.

General Postural Inspection and Gait: Wide base, slight lurch in the right hip flexor

Percussion: Positive spinous testing generalized lumbar spine and paraspinal.

Neurological and Orthopedic: II-XII cranial nerves intact. No nystagmus or vertigo. General cerebral function intact. Coordination disturbance (cerebellum vs. posterior columns) intact. Vibratory senses intact in lower extremities. No pedal edema. No calf tenderness on squeeze. Distal pulses are equal. Seated deep tendon reflexes: +1/4 hypo-reflexia, asymmetrically using the Wexler Grading Scale. Unable to perform heel rise and appears unsteady on tandem gait testing. SLR reported pain increase in right buttock. Patient reports "My spine feels weak, and I feel that something is on fire." Requested to bear down in Valsalva's maneuver; positive pain findings.

Myotone or Motor Tests	Right	Left
Flexed Thigh (L1-3)	3/5	4/5
Extended Leg (L2-L4)	4/5	4/5
Foot (Inversion & Dorsiflexion L4)	3/5	4/5
Foot (Great Toe Dorsiflexion L5)	5/5	5/5
Foot (Eversion and Planter flexion S1)	4/5	4/5
Thoracolumbar Range of Motion	limited at 50%	

Record Review

1. Radiology: Spiral CT lumbar spine due to intractable back pain; L5 onto S1 with spondylolysis of lamina L5.
2. Radiology: MRI with contrast lumbar spine; extradural lesions L3-S1 epidural infection with mass effect upon thecal sac L3-4, L4-5, L5-S1 levels. Leptomeningeal enhancement at conus, dorsal and right to L3-4 facet joint subcutaneous abscess. Anteriolisthesis at L5-S1 results in moderate to severe bilateral neural foramina narrowing.
3. Postoperative MD Orthopedist: Laminectomy at L2-L5, excision of soft tissue and bony tissue for biopsy. Findings indicated pus drainage from epidural space; right lateral lumbar deep muscle tissue, necrotic and purulent; right lateral L3-4 lamina small amount of bone draining pus. Ligamentum flavum extremely necrotic and stuck to dura; dura compressed and extremely friable.

Diagnostic Impression

Lumbar sprain/strain, unexplained recent bowel incontinence on lifting effort and impotency during post-operative state. Possible cauda equina syndrome.

Discussion

This patient presents with a complex condition requiring immediate postoperative follow up. As it relates to the history of spondylolisthesis and the bilateral pars defect (spondylolysis), the etiology generally is related to the classification or types of slippage. Dysphasic generally is a congenital abnormality in neural arch of L5 that allows displacement (slippage) to occur. Isthmic has three subtypes which involve alteration to the pars, such as a stress fracture or an acute fracture. Degenerative is long-standing arthrosis of the facet joints and discovertebral articulation leads to slippage, but without any pars separation. Traumatic is secondary to a fracture of part of the neural arch other than the pars. Pathological is in conjunction with generalized or localized bone disease such as metastasis cancer.

This most likely is an isthmic subtype related to a fatigue facture of pars. This is common in patients under age 50 and plausible, given his livelihood. Given the recent history of epidural abscesses, special imaging findings and pathological classification of this patient, spondylolisthesis is considered.

However, this patient originally presented to an emergency room with severe spondylolisthesis that might have been long-standing with resultant infection requiring multilevel laminectomies and I and D. I would suggest he will require further spinal stabilization. Generally, the neurological complication of spondylolisthesis occur in grade 3 or 4, whereby the nerve roots might be constricted and bound by scar and fibrous adhesions about the pars defect. In advancing cases, cauda equina may be subjected to shearing stress at the level of displacement. This patient is three months postoperative and requires postoperative follow up with his surgeon to rule out cauda equina syndrome.

Due to this patient's significant history, current loss in bowel, impotency and previous special-imaging studies objectifying his region of complaints, I do not feel he is a current candidate for chiropractic physical medicine. His current symptoms warrant further investigation.

Recommendations

Instructed to use a suitable back support to prevent further trauma. However, such an appliance might not prevent further progression of his spinal condition if he continues in manual trade labor. Instructed for immediate follow up for: orthopedic postoperative referral, Ortho, MD, current lumbar MRI with contrast to determine extent of pathology and clinical correlation. Instructed that should symptoms worsen or if there is an increase in pain when sneezing or coughing or another episode of incontinence, call 911 and proceed to the emergency room for evaluation.

JULY 2008