



BACK PAIN

Missed Causes of LBP: It's the Syndrome, Not the Subluxation

Marc Heller, DC

When I read the chart notes of other chiropractors, I am usually disappointed. They list what vertebrae are fixated or misaligned. They may describe the involved fascia and muscles. In Diagnosis, I see terms such as lumbar or pelvic dysfunction, lumbar or pelvic strain or sprain, etc.

What is missing? A great deal. I have no idea what is wrong with this patient! These notes may be perfectly legible and compliant. Oh, sometimes the history will tell me a bit more, especially if it describes a mechanism of injury or exactly where the pain is located.

What's wrong? The diagnosis is incomplete. Far too many patients end up in the vague category of nonspecific lower back pain. It is no wonder research results are equivocal. Some of us tend to think in terms of correcting the subluxation. Some of us think primarily in terms of rehab. Some of us are focused on releasing the tight fascia and muscles with soft-tissue techniques.

A Different Model

I would like to propose a different model. I want to attempt to identify the pain generators and create a map of the pattern or syndrome that is causing that person's pain. This needs to be broad, and must include the fixation, rehab strategies, and the involved soft tissue. Yes, each patient is unique, and every part of your strategy will need fine tuning for the individual patient. (This model is inspired by Don Murphy, DC.¹)



In any recurrent or longer-lasting pain, it is essential to get the whole picture. Our job is to help the patient manage and hopefully correct the problem, not just adjust the subluxation or release the muscles. P.S.: The subluxation correction will not hold and the tight muscles will recur if you do not address the underlying patterns.

Three Commonly Missed Syndromes

Here is my take on the most common (and most missed) syndromes. You may notice that none of these is really properly identified in ICD-10. It is too bad that functional conditions are ignored in our diagnostic systems. I add a statement to my assessment part of SOAP notes to give my overall impression.

1. *The flexion-intolerant lower back, aka axial discogenic pain.* This is so common, and yet commonly missed. Think of the patients who hurt themselves bending or lifting, or even hurt when sitting. The classic disc signs are usually equivocal or absent in axial discogenic pain. Trying to adjust the inflamed disc is generally useless or harmful. Extension and decompression are the most valuable pain-relief tools. There really is not a typical subluxation. (If this concept is unfamiliar to you, may I suggest Stu McGill's work, or Phillip Snell's *Fix Your Own Back*.)

To correct the problem, the patient has to be involved, learning new motor habits, performing pain-relief exercises, and rebuilding the inhibited core musculature. The patient must stop doing the common flexion exercises. They sometimes provide temporary relief, but end up reinjuring the already-stressed disc.

Discogenic sciatica is a subset within this same category. This is somewhat easier to identify, as the patient will have a positive straight-leg raise, and may have positive neurological signs. Yes, we can treat this; but please don't forcefully adjust the herniated disc.

2. *Maigne's syndrome, or irritated peripheral sensory nerves with thoracolumbar dysfunction.* This

is another very common and poorly understood syndrome. It can cause pain in the lumbar spine, in the flank, or in the buttock or lateral thigh.

Lyftogh has expanded our understanding of which nerves can be affected here. The peripheral sensory nerves, the cluneal complex, including superior cluneal, T10-11 nerves, ilio-hypogastric, ilio-inguinal, and/or lateral femoral cutaneous nerves can all be involved. There is almost always facet joint dysfunction at T10 through L3.

Typically, but not always, the patient will have pain on extension, or oblique extension. This is often misdiagnosed as SI pain, as the pain is usually unilateral and the tender points are just lateral to (but not at) the SI joints.

The patient often says, "I have sciatica." The pain rarely goes below the knee, and it usually will be somewhat more lateral than typical sciatica, going into the posterior lateral thigh. Straight-leg raise and neurological exams are normal. I find that many patients with buttock and posterolateral thigh pain have a combination of Maigne's syndrome and dysfunctional hips.² P.S.: You have to treat the spine and the nerves. Treat the nerves themselves by lifting and wiggling the skin, via the [YAP model](#).³

3. Hips that lack mobility and are stuck forward. Rehab systems talk about increasing hip mobility, but this is a substantially different take. I like to call this [functional hip impingement](#), but the term is not well-known.

Hip motion is so basic and important. Opening the hips (exercises into external hip rotation) is contraindicated in these patients. Basically, as Shirley Sahrmann outlined long ago, the femur gets stuck forward. Findings include a lack of hip internal rotation, often accompanied by restricted hip flexion and/or external rotation. The anterior femoral head will be tender and feel stiff, and manual muscle testing will often find an inhibited hip flexor, especially when tested at 30 degrees of flexion.

When the patient complains of groin or lateral hip pain, this may be the primary problem. More often, the hip is minimally symptomatic, but keeps the whole lower spine and legs from working properly, creating compensatory excessive mobility at the SI or lumbar disc areas and throwing off knee mechanics.⁴

The Overdiagnosed Sacroiliac

This is a fourth syndrome, but the SI is really not so much missed as it is commonly overdiagnosed. Manual practitioners, including DCs, DOs and PTs, seem to think that sacroiliac (SI) misalignment implies sacroiliac pain. That is just not the case, according to Laslett.⁵ If the patient has true sacroiliac pain, they will have three of five positive SI provocation tests.

For true SI pain, think of patients, female more than male, who start with somewhat hypermobile ligaments or have had significant trauma. At a minimum, on palpation they will have very tender SI or sacrotuberous ligaments. My belief is that the SI becomes overly mobile to compensate for the three syndromes outlined above. Correct these and the pelvis often realigns itself.

Too many patients have their SI joints mobilized or adjusted over and over. If you are mobilizing the same joint repeatedly, that joint is, at minimum, functionally hypermobile. I'm not telling you not to mobilize stuck sacroiliacs; just recognize that doing so may not be the entire solution.

For the uncommon patient who has true SI pain, the key is not SI manipulation, as true SI pain

almost always involves SI hypermobility. What you need to do is focused rehab, and possibly techniques such as Graston or prolotherapy injections, aimed at stimulating the body to repair the ligaments.

Don't Forget...

This list of syndromes is not meant to be complete. Consider the lower lumbar facets. In older patients, consider spinal stenosis. A sedentary lifestyle with deconditioning reinforces any low back pain. *Don't forget to rule out red flags.* Up to 3 percent of your lower back patients have a significant medical pathology.

Are you the best diagnostician for lower back patients? You should be. Our training, and our opportunity to treat and reassess, make us the best qualified ... but only if we pay attention and look at the big picture.

References

1. Murphy D. *Clinical Reasoning in Spine Pain. Volume I: Primary Management of Low Back Disorders Using the CRISP Protocols.* Self-published, 2013.
2. Heller M. Link to articles in *Dynamic Chiropractic* (look at the Thoraco-Lumbar tab): <http://sosas.us/professional-resources/articles-2/>. Read this one first: www.dynamicchiropractic.com/mpacms/dc/article.php?id=57683.
3. Dermal Traction Method, formerly known as Yank Away Pain. An approach focusing on irritated peripheral nerves.
4. Heller M. "Functional Hip Impingement (Part 1): Evaluation, Hip Sparing and Mobilization." *Dynamic Chiropractic*, April 15, 2015.
5. Laslett M. Evidence-based diagnosis and treatment of the painful sacroiliac joint. *J Man Manip Therapy*, 2008;16(3):142-152. (*NOTE: I found this article very upsetting at first, as he discounts SI manipulation as useless. Read with an open mind and get the big picture.*)

JULY 2018