



LOW BACK PAIN

The Lower Back Patient: Converging on a Diagnosis

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Author's Note: This article continues the theme from my [September article](#), but with focus now on examination more than palpation.

Your brain is good at pattern recognition. The key is to put together the history and exam, come up with a diagnosis, treat and rehab based on that, and confirm via audit that you are on the right track. If you are doing something useful, the patient will walk out feeling better and will have less pain on challenging movements. Obviously, results also depend on how sensitized and flared the patient is.

Step #1: Start Off Simple

There are a few tools you have that are likely to help most patients, even if you are not sure of an exact diagnosis:

1. Manipulation and soft-tissue therapies: If you don't hurt the patient, you will probably help the patient. Get the joints, muscles and fascia moving again. If I have any suspicion of flexion intolerance / disc issues, I will avoid lumbar rotary HVLA adjusting. First do no harm.

2. Reassurance: If you tell the patient you know what is wrong, and you know what to do and what they should do, that message will help them. Is this placebo? Probably, and placebo is extremely effective. *Warning:* Nocebo can have the opposite effect. If your practice focuses on scaring every patient with how bad their X-rays look and how severe their condition is; you run the risk of making them worse. The mind is a powerful part of pain and healing. Are you and your words part of the problem or part of the solution?



3. *Encourage and teach good movement.* To quote Gray Cook, "First move well then move often." Movement is almost universally both healing and pain relieving. Walking and other simple exercises are very likely to help on multiple levels. My advice to my patients is to move and exercise, unless they hurt more after they move.

Rehab exercise is very dependent on the right "dose" and intensity. Teach simple principles of how to move, how to use abdominal bracing, how to get up out of bed and off your table, and how to bend and lift. The time you spend on spine hygiene is invaluable for your patient.

Step #2: A More Accurate Diagnosis

Beyond these simple strategies, you can be more effective if you can hone in on the pain generators. The research indicates there are no consistently effective treatments for nonspecific low back pain.

Analyzing / diagnosing fixation / subluxation patterns is not enough. Yes, knowing where the joints are stuck guides us toward a diagnosis, but this is not complete. One example: Iliac crest alignment will be off in virtually *all* lower back problems - but this does not mean the SI misalignment is causing the pain.

Named orthopedic tests are incomplete; they don't necessarily indicate what structures you are challenging. I prefer to look at orthopedic tests through a different lens. What are you stressing? Diagnosis is an art. It is not simple. It is not always accurate, even with imaging. What movements, what stresses elicit the patient's pain? I prefer to describe these movements by the motion that occurred, by the physics of what I am stressing, rather than the orthopedic test name.

Variations on compression testing: Kemp's test is oblique backward bending. You can fine tune this with your loading strategies, into the lower vs. upper lumbar spine. You are loading primarily the facet joints, although the muscles and ligaments are also being loaded by these maneuvers.

If extension hurts, or extension with side-bending and/or rotation, think facet joints; think Maigne syndrome. In your older patient, think spinal stenosis. Do these movements either remind them of their pain or refer pain into their usual pain area?

Do you use axial compression tests? Have the patient seated and ask them to pull up firmly on the seat pan. Repeat this with the patient sitting slumped in lumbar flexion. Another version of this: have them raise up on their toes and then drop down onto their heels. The neutral test may give you a window into the status of the endplate of the lumbar vertebrae. The test in flexion gives you more information about the discs, which don't like flexion.

Another set of compression and stretch tests is the five sacroiliac provocation tests. If three are positive, it indicates that the patient has true SI pain, a ligament injury. (I wish I had understood and mastered this earlier in my career.) You don't need a formal class; just google *SI provocation tests*, study the videos and start utilizing these familiar tests. And then, the tough part - you may need to change your belief systems about the SI.

The prone instability test is a shearing test, a way to assess what level of the lumbar spine is unstable. Use your reinforced thumb with the patient prone. Press P to A with a moderately deep pressure, with oscillation over the lumbar spinous processes. You are perturbing the segment.

An unstable lumbar segment will not like this. I have found that when the patient is more acute, in more pain, this test will be more accurate. This sign leads you toward the disc. You cannot touch the disc; it is too deep. But you can create localized intersegmental motion, irritating that segment and its disc.

Test the nerves. Nerve tension testing, straight-leg raise and femoral stretch give you a window into the large mixed nerves. History of posterior or anterior thigh or leg pain will guide you. Michael Shacklock has really moved us forward in this area. Read his work and take his courses. (A chiropractor in the course I took from Shacklock said, "This is only going to help you in 10 percent of your cases, but in those 10 percent you are lost if you do not understand this model.") This is both an evaluation tool and a treatment tool, using nerve gliding.

The smaller, primarily sensory nerves do not have a simple, reproducible exam finding. You need to hone your palpation tools and know your nerve anatomy. The cluneal complex and the lateral femoral cutaneous nerves come to mind. Specific places along these nerves will be tender when the nerve is unhappy. The nerve is more sensitive to touch when it is closer to the surface or after undergoing a change in direction.

It is quite useful to have a sense of the "state of the patient." Are they oversensitive; does almost any touch hurt? The opposite is the stoic; you have to ask them to tell you if your pressure or movement hurts even a little.

Lower back pain has always fascinated me. There are so many variations that can guide your care, and improve your effectiveness and results. The key is to uncover which type your patient is experiencing and then treat it accordingly.

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