Dynamic Chiropractic

SOFT TISSUE / TRIGGER POINTS

Some Good News on Lumbar Stenosis

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It is a commonly held opinion that the natural course of spinal stenosis is poor and that the patients should be operated on without too much delay.[1] In a recent study by Johnsson, et al.,[1] after analyzing 32 unoperated patients with spinal stenosis from 1981 to 1989, "the majority of non-operated cases with spinal stenosis remained unchanged after four years and no proof of severe deterioration was found." They recommended surgery only if the pain was intolerable or there were progressive neurologic findings.

This type of information provides some more confirmation for the doctor and the patient regarding a trial of conservative chiropractic treatment. An old patient of mine who has lumbar stenosis told her neurosurgeon that she wanted to try chiropractic first. The surgeon agreed to a trial of conservative care with the admonition that the patient should not be manipulated. With all due respect to the referring surgeon, I believe that the final answer as to whether a patient should or should not be manipulated should be based on the chiropractor's experience with similar conditions. The MRI showed mild to moderate stenosis at L2-L3, with flattening and deformity of the sac related to hypertrophic joints. At L3-4 a diffuse disc bulge and hypertrophic ligament and facets resulting in moderate stenosis. At L4-L5 more marked stenosis and a probable disc herniation into the right lateral foramen. Flexion distraction, reduction of a unilateral piriformis syndrome and specific lumbar and sacroiliac adjustments have provided this patient with a significant reduction in lumbar pain and has significantly reduced her level of neurogenic intermittent claudication.

Cassidy and Mior[2] treated 70 patients with lateral canal stenosis who showed about 50 percent positive results over a five-year period.

Kirkaldy-Willis[3] mentions the treatment of lateral canal stenosis of the dynamic type, (i.e., entrapment occurring with position changes versus the continuous pain representing the end stage of the degenerative process) by adjusting the spine into flexion and axial rotation in the pain-free direction to open up the lateral canal and foramen. He states that manipulation may also be used for central stenosis since flexion of the lumbar spine increases the diameter of the spinal canal and impingement of posterior articular processes on the cauda equina may sometimes be reduced by flexion and rotation.

Cox[4] presents successful case histories of stenosis treated by manipulation.

Postachini[5] states that untreated spinal stenosis may respond due to progressive dehydration in a degenerated nucleus pulposus leading to a reduction of nerve root compression.

While this article does not pretend to discuss all aspects of spinal stenosis, one of the principle symptoms that may lead a practitioner to think of this problem is what is known as neurogenic

intermittent claudication versus vascular claudication. While leg pain on walking in one or both extremities is the prominent symptom in both conditions, the neurogenic stenotic type is more likely to be effected by postural changes. Lumbar flexion usually relieves and lumbar extension usually exacerbates the neurogenic type. In the neurogenic type, walking uphill might be easier than walking downhill, and riding a bicycle (flexed lumbar spine) could be done longer than walking. In the neurogenic type, standing at rest may exacerbate compared to the vascular type. Of course, the arterial pulses of the lower extremities should be investigated along with patches of hair loss due to poor circulation. A Doppler examination might be significant (ankle pressure should be greater than arm pressure in the supine position). The pain of vascular claudication is usually a severe cramp while there is more tingling and numbness in the neurogenic type.

References

1. Johnsson K, Rosen I, Uden A: The natural course of lumbar spinal stenosis. Clin Orth & Related Res., 279:82-86, 1992.

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3. Kirkaldy-Willis WH: Managing Low Back Pain. New York, Churchill Livingstone, 180:1983.

4. Cox JM: Low Back Pain: Mechanism, Diagnosis and Treatment, ed 5. Baltimore, Williams & Wilkins: 290-305.

5. Postacchini F: Lumbar Spinal Stenosis. Wien, New York, Springer Verlag, 173-218, 1988.

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Editor's Note:

Dr. Hammer will conduct his next soft tissue seminar on October 24-25 in Scottsdale, Arizona. You may call 1-800-359-2289 to register.

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