

## Irritable Bowel and the Spine

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Traditional nondrug treatments for irritable bowel syndrome (IBS) include proper food selection and supplementation. These approaches can be useful to some degree or may even completely solve the problem. Medications may be necessary in extreme cases, especially if significant inflammation or infection is involved. However, the usefulness of medications always must be evaluated in relation to the unwanted effects.

Another potential factor that can cause or effect IBS is spinal integrity. This is a subject that is poorly represented in practice and in literature, and appears to be a topic that is avoided. However, the subject of manipulation and IBS or pseudo IBS has been presented in a practical manner by Dr. Robert Maigne, a French physician and manipulative practitioner. In his text on spinal manipulation, *Diagnosis and Treatment of Pain of Vertebral Origin*, he makes specific references to the thoracolumbar syndrome (aka Maigne's syndrome). The syndrome involves the mechanical dysfunction of the thoracolumbar junction, typically the T12/L1 and L1/L2 spinal levels. This may broaden to include T11/12 and L2/3 levels in some individuals.

Dysfunction and/or irritability to nerve roots of those levels (mainly T12 and L1 roots) can cause low back, hip, groin, thigh and pelvic complaints. One of the pelvic complaints reported by Dr. Maigne as a result of his research and practical observations is an irritable bowel disorder, which he referred to as a pseudo disorder secondary to nerve root disturbances. Often, genitourinary complaints were observed. Most often, the pelvic complaints ended up being examined and treated as primary complaints, unsuccessfully.

When a cause of such complaints was spinal, there was rarely any complaint or mention of back pain, soreness or other back complaints in the thoracolumbar region. Treatment by manipulation to the thoracolumbar region when dysfunction was recognized often resulted in improvement or alleviation of the complaints.

I have noticed a high percentage of gastrointestinal complaints when examining patients with low back pain related to thoracolumbar dysfunction. My method for identifying a T/L dysfunction is motion palpation in the prone position. A manipulable dysfunction would be a hypomobile dysfunction (fixation). Most such dysfunctions have restrictions in extension (or P-to-A glide), rotation and lateral bending. Flexion restriction also may be a component. Non-manipulable hypermobility may be a factor at times, and disc pathology and arthritis may be factors.

The use of X-ray or MRI analysis may show pathologies such as DJD, Schmorl's nodes and disc disorders. One such example was a case featuring chronic intestinal and digestive disorders of more than 20 years in duration. Also associated with these complaints were shortness of breath, such as in climbing stairs; and an episode of shingles in the T12 dermatomal pattern. An MRI showed the existence of a T12 disc herniation with mild flattening of the cord.

In this case, adjusting the extension and rotation restrictions of T12/L1 proved very useful in combination with eating restrictions/guidelines, nutritional supplementation and exercise. (Treatment of the shingles involved the addition of a short course of an anti-herpes viral medication.) Most cases can be managed with a combination approach, but in my opinion should include spinal evaluation for subluxation, dysfunction and pathological disorders, which may cause neurological irritations.

As Dr. Maigne pointed out in his text, however, radiological analysis often proved to show no pathology at the thoracolumbar junction. Local thoracolumbar symptoms, such as T/L back pain, also were not present. What was present was segmental dysfunction at T12/L1 and L1/L2. The thoracolumbar junction syndrome may also be associated with abdominal pain, bursitis-type pain at the hip, pubic pain, and iliac crest nodular disorders. A dermatomal skin-rolling examination also tests positive.

Traumatic compression injuries may occur at T11, T12 and L1, with subsequent pathology developing. It is interesting to note, however, that seldom are degenerative complaints seen (in contrast to the lumbosacral region) in the absence of trauma. Patients presenting with lesions characterized by Scheurman's disease, Schmorl's nodes or other degenerative processes at the thoracolumbar region appear to be more vulnerable, according to Dr. Maigne.

The low back pain associated with thoracolumbar syndrome usually is more predominant on one side, but may be on both sides. It can easily be confused with lower lumbar and sacroiliac pain, and may manifest as iliac crest pain, buttock, hip or lateral thigh pain. In most cases it is described as deep, rather than superficial.

My point is that taking the above into consideration, the treatment of IBS should include spinal evaluation and manipulation if called for. Manipulation can be done manually or using instrumentation. I use both approaches in my treatment of spinal disorders.

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