

It's Time to Take the Sting Out of Lumbar Facet Pain

Marc Heller, DC

Let's focus on lumbar facet-generated pain: an accurate assessment protocol, how to adjust these facets appropriately, and a specific self-mobilization exercise that can be effective.

History and Exam Clues

The patient's history can be helpful or confusing. They are likely to be more comfortable sitting than standing. They may have pain on walking. (Both standing and walking put the spine into extension.) Some may have pain down the leg, which sounds like sciatica, but on further assessment, this pain may be coming from the facets.

They will have lower back pain, usually unilateral. They may have pain or tenderness over the iliac crest area that refers farther down the lateral leg, and can look like trochanteric bursitis or iliotibial band syndrome.

A medical definition of facet pain might start with X-ray findings of degenerative change. Our definition is more functional. Can we stress the facet joints and reproduce their pain? They hurt more on extension or on extension with rotation (oblique extension).

It is useful to watch the quality of their forward bending, and to have them do repetitive forward bending, as you do want to rule out flexion intolerance. Occasionally, you'll see a patient with both a facet problem and a disc / flexion intolerance.

If you watch them, the patient may come up off the table from supine lying with relative ease, depending on their level of conditioning and tone. (This is a flexion motion, and your flexion-intolerant patients cannot do this with ease.) They have a negative straight-leg raise and slump test, with no obvious nerve-root tension signs.

Is there one lesion that is at the center of their problem? For facet pain, the pain generator and the area you are adjusting are one and the same. (This is quite different for both lower back discs, and true SI pain; you are going to treat other areas in these types of cases.)

Palpation Tips

Can we touch their pain? Can we find a tender facet joint via palpation? The palpation can get a little more challenging. When the involved facet is at L4 or L5, it is fairly straightforward. Deep pressure on those facets, either sitting or prone, will usually hurt.

As we move higher in the spine, it gets more challenging to get a good palpatory read. Between L3 and T11, the spine is in the depth of its lordosis. You need to move the spine somewhat out of lordosis, into

the neutral-to-flexion range, to assess these facets.

How do we do this? If the patient is sitting, first you need to place your active contact inferior to the facet. Second, using your other contact hand on the shoulders and upper back, move the lumbar spine into flexion and rotation away. You can ask the patient to help by saying, "Let your low back slump forward."

The idea here: You are trying to open the facet joints between the L3 and T11 level, and feel both for a lack of opening at a specific level and a tender facet joint. (See <https://www.youtube.com/watch?v=q1j51sLlMZg> for a demonstration.)

If you have a flexion-distraction table, you can use it to enhance your palpation of these stuck facets. As you flex the lower section of the table, does a specific segment on one side hang up or not glide open? Focused, joint-specific flexion-distraction is a great way to adjust these patients.

These patients often respond well to traditional side-posture HVLA adjustments. How inflamed is the facet? You may need to modify your techniques for a "hot" low back. If you prefer low force, muscle energy technique (post-isometric relaxation aimed at the spinal joint), taking the patient into flexion and rotation away and using a contract-relax method, works quite well. Muscle energy is likely to be more easily tolerated in your inflamed and older, stiffer patients.

You may need to address the nerves that exit from the upper lumbar spine. I have been hammering on this topic for some time. (Visit <http://sosas.us/professional-resources/articles-2/> and click on the thoracolumbar junction link to access six articles.

Rehab: Self-Mobilization

I always want to show my patient a self-mobilization, an exercise that helps them reinforce the adjustment. I really don't want my patient to have to come to me every time the same segment gets stuck. Adjusting the same place over and over may be a good business model, but it is not "best practice." It is not wellness; it is not finding the cause.

Is there an exercise that will help unlock or self mobilize the facets? I use a slight modification of McKenzie side-bending [see <https://www.youtube.com/watch?v=Zjje2cBT55k>]. This exercise was originally designed to help the patient get out of side-bending antalgia from a disc problem. I have re-purposed it to unlock the facets.

It is useful to visualize the facet jamming as if the two lumbar segments are stuck together. The patient stands perpendicular to a wall. They bring their bent arm up to 90 degrees, and support themselves on this arm. They then slowly sag to the wall, letting their lumbar spine and pelvis sink toward the wall. They will end up with the trunk vertical and parallel to the wall.

Once they reach this position, they will put their opposite hand up against their iliac crest and isometrically or isotonicly push out against their hand, allowing up to 1-2 inches of motion. Repeat three times, at least twice a day.

(My preference is to show them their tender points and the position / motion that provokes their pain. Then, before I adjust, have them do this exercise and then recheck. If it is going to be useful, they will be less tender, and have less pain on motion.)

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