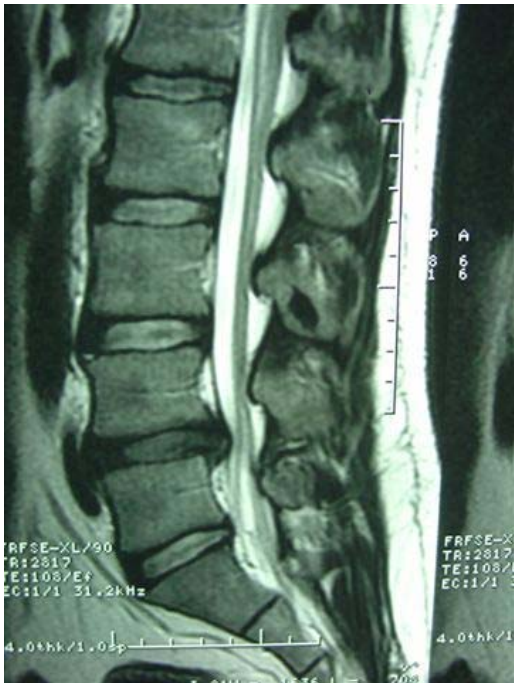
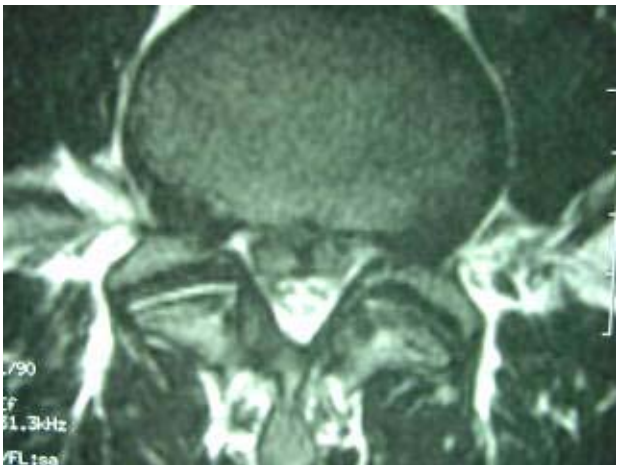
Large Right L4-L5 Disc Extrusion Corrected with Reverse Cox® Flexion Distraction Manipulation – Protocol I





PMH: R.L. was a prior patient of mine presenting with mild strain/sprain of the lumbar spine w/o sciatica. He was a prior patient of a local chiropractor but was concerned that no x-rays were ever taken prior to manipulation. X-rays taken by me on 1-31-05 revealed no evidence of any tumors, fractures, or osseous pathology. There was a small, less than 5-degree left lateral listhesis of the lumbar spine on the AP projection. Reflexes were 2 plus in the lower extremities and the pinwheel was felt equally & bilaterally in the lower extremities. He exhibited approximately ¾ AROM in the lumbar spine in all planes. Kemp's, toe walk and heel walk were positive. SLR was positive on the rt. @ 30 degrees. He was placed on Interferential Electrotherapy for 10-15 minutes followed by Gonstead Axial Manipulation to the Rt. Pelvis and 4th Lumbar. The case went forward without any complications.

Background: R.L. is a 35-year-old white male who presented to my office on 3-21-2005 in severe left antalgia. He stated that 2 days prior he lifted an 80 pound bucket of home building material when he couldn't straighten up. He presented with such extreme pain that he was unable to sit; stand up, lie prone, supine or on his side. He was referred for an emergency MRI that day to the lumbar spine.
Figures 1 and 2

Imaging Findings: The MRI of 3-21-05 is shown in Figures 1 and 2 and the report stated: "At L-4-L5, there is loss of disc height with changes of disc desiccation. There is a large posterior central and right para median disc extrusion extending along the superior endplate of L5, causing mass effect on the ventral thecal sac and descending L5 roots in the lateral recess, more on the right. Additionally, there are congenital short pedicles. The combination of these findings causes mild central canal stenosis. The thecal sac measures 7 mm in A.P. dimension. There is bilateral foraminal narrowing secondary to annular bulge and mild degenerative changes of facet joint."

Discussion of Treatment: Mr. R.L. returned with his MRI's on 3-23-05 in a worsening situation. His symptoms of lower back pain as well as rt. grade 3 (Quebec task force Gr. 4) sciatica were dramatically increased. He found no position (sitting, standing, lying) that was comfortable. He was unable to even sit on the Cox® Flexion/Distraction table. Any attempt at movement was followed by extreme pain. At this point, we called 911 and had the EMT's transport him, with his MRI's, to the E.R. of Charlton Hospital, Fall River, Ma for their intervention. He came back to me the following day in pretty much the same shape as the day before. He stated that the ambulance ride to the E.R. was incredibly painful. He spent 4 hours on the gurney before being seen. In fact, the EMT's made two more trips from my town to the E.R. and saw him lying there without attendance. The E.R. doctor refused to even look at the MRI's, said it was a pain management problem, gave him Vicadan and to f/u with a Neurosurgeon. He saw the neurosurgeon the next day and was told that he would give him a cortisone shot on April 28th , 2005 and sent him home. If comprehensive spinal rehabilitation with therapy with the steroid injections did not relieve the pain, surgical decompression would be performed.

Methods: When seen at my office on 3-23-05, he was able to lie with his left side down and a Protocol I side posture procedure commenced. He was told to return that afternoon with advice to apply an ice pack 10 minutes to the low back every 1 ½ hrs. He was told to wear a back brace. There was no change and again a Protocol I side posture, right side up procedure was performed (Interferential Electrotherapy and ice were given prior to Cox® Protocol I). In fact, the procedure made him **worse** as I started using the Flexion portion of the Protocol I procedure. On March 25th with his condition at status, I decided to reverse the Protocol I side posture procedure by putting his head on the foot rest, right side supine, pelvis resting on the chest piece with his wife at the foot end putting her hands on his shoulders so he would not think he was slipping off the table. I then tilted the table caudally and he stated that he could feel his toes again. I followed this with 3 20-second pumps and did 3 sets of this procedure. I followed up on the afternoon of the 25th of March again and 2 appointments on the 28th of March. He then went to one time per day on the 29th of March. He was last seen on 4-1-05 and will be returning to work as a Glazer on 4-4-2005.

Conclusions: Cox® Decompression Manipulation is an effective treatment with clinical outcome comparable to single level diskectomy. In my few years of being certified as a Cox® Practicioner, I have never encountered a case such as the one described above. My feeling is that the extrusion, by going Inferior, made this a much more difficult case than one encounters in a disc oriented practice. I am going to try to f/u with a Post MRI in the near future. By reversing the Protocol I procedure, we have added one more dimension in our arsenal of effective non-surgical treatment.

Respectfully submitted,
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