THE GEORGIA
CHIROPRACTOR

SPRING 2011

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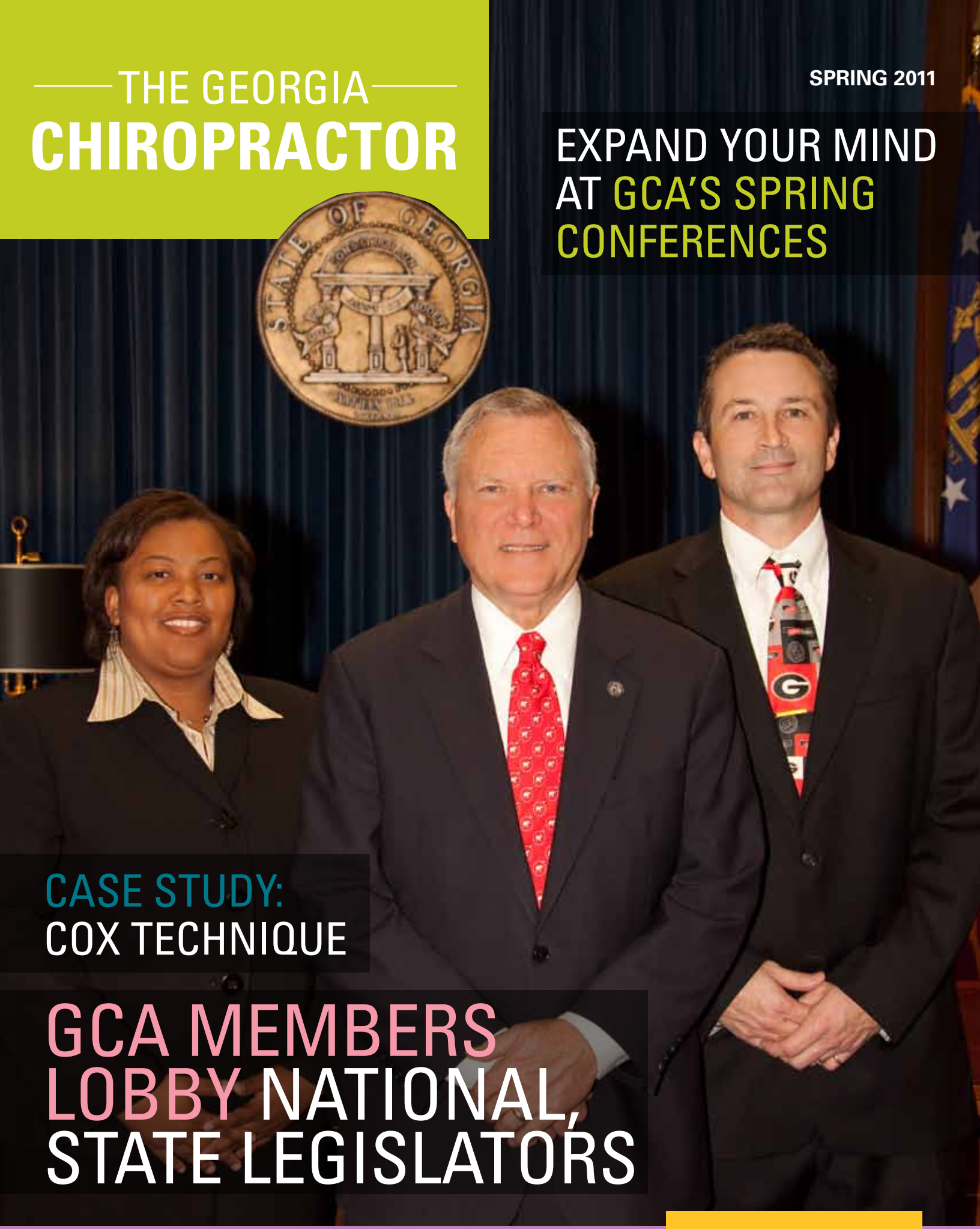

CASE STUDY: COX TECHNIQUE

GCA MEMBERS LOBBY NATIONAL, STATE LEGISLATORS

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CASE STUDY

Spinal Stenosis in an 82-Year-Old Male

By Robert A. Hayden, D.C., Ph.D., F.I.C.C.

By Robert A. Hayden

This case is illustrative not only of the clinical efficacy of Cox® decompression manipulation as a technique, but also of the benefit of collaborative efforts among health professionals to the benefit of patients whose care must be carefully coordinated through multiple providers.

THE PATIENT

Mr. A is a very active 82-years-young man who has been an instructor in a trucking school for a half century. He is a widower, living alone, but has the loving support of his daughter, a registered nurse. He is 6'2" tall and weighs 158 pounds. He is a well-controlled Type II diabetic, but his health has been good otherwise.

THE PRESENTATION: MARCH 2010

Mr. A's pain began with a gradual onset over two months of worsening lumbar pain, radiating to the left gluteal area, posterior left thigh, and lateral left leg. His gait was stiff and antalgic. His pain was exacerbated by lumbar extension, walking and prolonged sitting. Reflexes were within normal limits and symmetric. Sensory exam revealed decreased pin prick to both lateral and posterior left calf. Toe walk was negative bilaterally, but there was some weakness in dorsiflexion on the left. Lumbar range of motion was decreased with pain in all directions. Kemp's test was positive on the left. Valsalva was negative. Bechterew's test was positive with calf pain of the left. SLR was positive at 30 degrees on the left with calf pain, localizing to L5 dermatome on the left with Braggard's test. There was spasticity of quadratus lumborum on the left with a high ilium on that side. Abdomen was benign with slightly hypoactive bowel sounds, but negative for bruits or abnormal pulsations. Peripheral pulses in lower extremities were normal and symmetric.

Plain film X-ray showed some degeneration of L4 and L5 discs and a prominent sagittal L4/5 facet joint on the right. There was calcification of the abdominal aorta consistent with age. The left ilium was slightly high with a mild right convexity of the lumbar spine. DEXA scan showed significant osteopenia.

DIAGNOSIS

Lumbar pain with sciatic radiation to L5 dermatome. The presence of mild muscle weakness is alarming in an independent senior who lives alone, as the risk of a catastrophic fall must be considered. This was discussed with Mr. A's daughter, and with patient's input, a four-poster cane was obtained to assist with balance for ambulation.

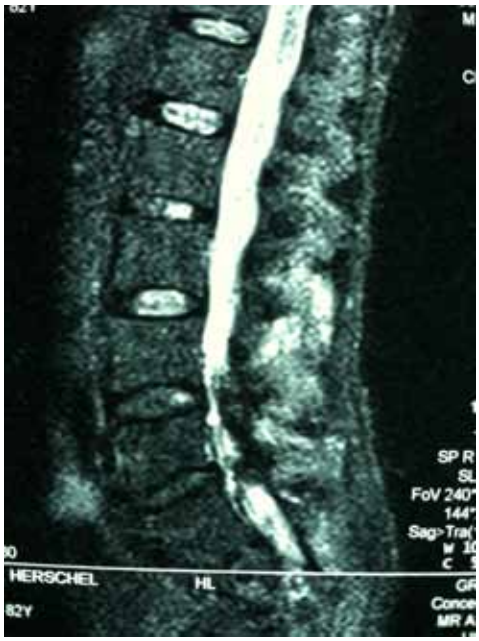
INITIAL TREATMENT

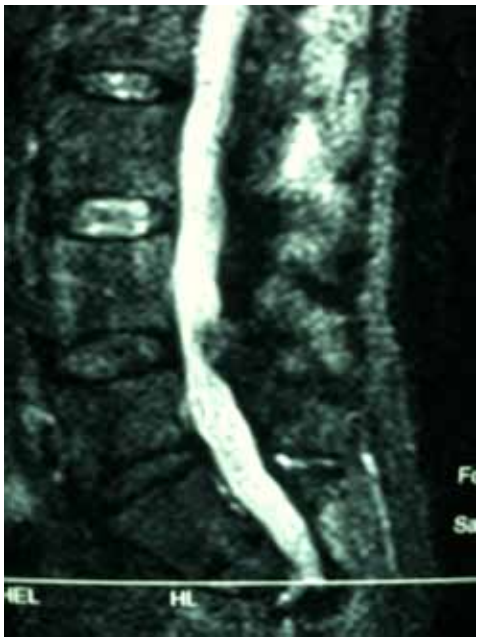
Decompression manipulation was begun per Cox protocol I. This protocol involves stabilization of the L4 spinous process with distraction applied to the L4 and L5 intervertebral discs without any degree of lateral flexion or circumduction. Occasionally, comfort with flexion was improved by pre-treatment with deep ultrasound for 8 to 10 minutes. Pain control was augmented with a Z-tech electrotherapy unit applied with simultaneous active range of motion.

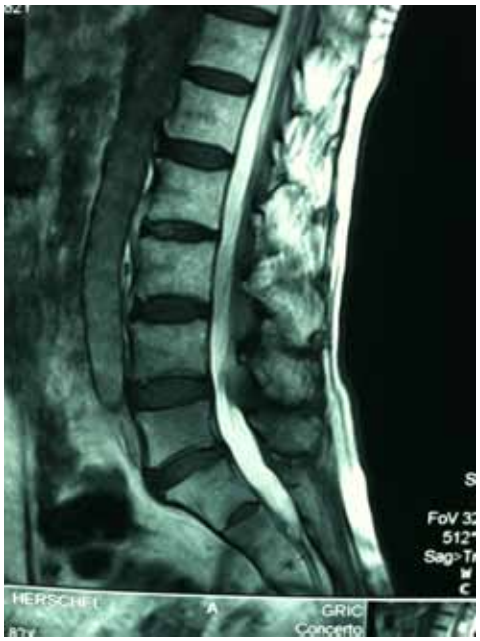
This technique was chosen for its proven efficacy in cases involving sciatic pain. It is also a safe choice where there is known osteopenia or osteoporosis, as no compressive or high velocity force is exerted into bone.

CLINICAL COURSE

By early May 2010, the muscle weakness had receded, but there was significant lumbar and sciatic pain remaining. Because 50% improvement of the subjective complaint had not been eradicated, however, a lumbar MRI was obtained to assess







appropriateness of care. The MRI revealed a tight L4 stenosis of both the neural foramen on the left and the central canal, exacerbated by ligamentum flavum hypertrophy and facet hypertrophy at L4/5 bilaterally, worse on the right.

Mr. A. wanted no part of surgery, and he was a poor surgical risk due to his age. In consultation with his daughter, it was elected to pursue conservative care.

CONSULTATION

A consultation was obtained the next week with an anesthesiologist so that pain could be controlled not only for humanitarian reasons, but to augment distraction. Mr. A. was given an epidural injection with careful observation of his serum glucose. He responded well to the epidural, and distraction was augmented by the reduction of swelling, control of inflammation and pain relief.

OUTCOME

Mr. A. had one additional epidural injection. His muscle strength improved gradually as his pain receded. The paresthesia in the left leg resolved. He began walking with comfort and confidence the within an additional two weeks. By July 2010, he was pain free, walking without his cane, driving again.

FOLLOW-UP

Given the anatomical issues evident in the MRI, the age of this patient, it was deemed desirable to distract this patient to keep him asymptomatic and independent for as long as possible. Monthly distractions have kept him symptom-free with negative neurological and orthopedic exam.

DISCUSSION

We have referred several patients with painful conditions to a pain clinic for co-management. The anesthesiologist there believes, as I do, that one should not do with a drug what can be done without a drug. His philosophy of patient care is supportive of conservative treatment first and foremost, and his clinic procedures ensure that drugs are not abused. This alliance has been useful in a number of difficult cases where the patient's pain became a limiting factor in tolerance of treatment.

Note also the examination of the abdomen in the initial workup. This is always a concern in the elderly, as 9 percent of people over 65 years of age will have abdominal aneurysms that often present with lumbar pain. While not the case here, we always screen patients over the age of 50 on the initial exam.

EPILOGUE

Mr. A. is making arrangements to begin another trucking school.