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Resolution of low back and radicular pain in a 40-year-old male United States Navy Petty Officer after collaborative medical and chiropractic care[☆]

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Abstract

Objective: The aim of this study is to describe the interdisciplinary care, including chiropractic services, in a military health care facility of an active duty member of the United States Navy with low back pain, leg pain, and foot numbness.

Clinical Features: A 40-year-old patient developed low back pain, leg pain, and foot numbness after moving furniture. The patient described his symptoms as pain in the right low back, pain shooting into the right lateral thigh and lower leg, and numbness into the right lateral foot. Magnetic resonance imaging confirmed disk extrusion at L4/L5 occupying the lateral recess and abutting the exiting right L5 nerve root.

Intervention and Outcome: Providers, including primary care, chiropractic, and orthopedics, in an established multidisciplinary health care system contributed to the case management. The patient received 11 chiropractic treatments (spinal manipulation, flexion-distraction, abdominal rehab exercises) over 72 days. Subjective complaints resolved, and the patient was released back to full duty.

Conclusion: Integrative care, using medical and chiropractic services, was successful in the conservative management of a patient with low back pain and radicular symptoms secondary to disk extrusion.

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Introduction

Low back pain (LBP) is a major concern to the military.¹ Active duty service members may be predisposed to both acute and chronic episodes of LBP, related to their high levels of physical activity. Essential to operational readiness, military physical

training programs are used to maintain physical fitness.² Active duty service members are required to complete a physical readiness test every 6 months. Performance is graded,³ with a less than satisfactory performance leading to a probationary status. Disability discharges related to back conditions are issued when a service member cannot perform his or her job and/or complete the required physical readiness test satisfactorily. A study of 15 268 active duty military personnel hospitalized for musculoskeletal conditions concluded that back conditions had the greatest 5-year cumulative risk of disability, with 40% being related to intervertebral disk displacement and degeneration.⁴

The clinical management of service members with disk degeneration or injury may be a challenge in the military setting. Each member has a primary care manager (PCM), who manages and coordinates the care of each patient. Deployments, temporary duty assignments, and patient compliance all affect the smooth transition of care between specialists and, ultimately, the outcome of each case. Considering the direct and indirect costs of back surgery⁵ and the impact surgery may have on a service member's career, it becomes imperative that, when appropriate, nonoperative therapy is included in the management of these cases. Since the addition of their services to the military health care system in 1995, chiropractic physicians have become part of the health care delivery team at 49 military treatment facilities in the United States. An additional 11 sites are scheduled to be opened, including 3 overseas, by the end of 2009.⁶

This case review demonstrates how one patient, with a confirmed disk extrusion at L4/L5, achieved a successful outcome after interdisciplinary management in a military treatment facility that included chiropractic services.

Case report

A 40-year-old male active duty United States Naval Petty Officer first class presented to his PCM with complaints of LBP, pain shooting into the right lateral

thigh and lower leg, and numbness into the right lateral foot. The patient's job consisted of a variety of responsibilities, including desk work, heavy lifting, and a considerable amount of travel, which involved sitting several hours in the back of a C-130 transport plane traveling to and from work sites.

Having experienced mild, intermittent bouts of LBP since driving a truck long distance 4 years prior, this was his first ordeal with pain or numbness into either lower extremity. This episode began after lifting furniture while moving to a new house. The PCM's working diagnosis was LBP with radiculopathy into the right lower extremity to the foot. This patient was part of an elite Navy squadron, with which he was required to travel a considerable amount of the time, both stateside and overseas.

The first clinical contact the patient had for this condition was with his PCM, a naval flight surgeon. It took place 4 days after the onset of pain. Besides the right leg pain, he had experienced transient right testicular pain that lasted for 2 days. No bowel or bladder changes, or lower extremity weaknesses were noted. The PCM prescribed 800 mg ibuprofen and 975 mg acetaminophen twice daily. Lumbar radiographs and a magnetic resonance imaging (MRI) were ordered, and consults were placed to both chiropractic and orthopedic services. The patient was instructed to schedule a follow-up appointment with the PCM after seeing the orthopedic specialist or if symptoms worsened. Over the course of the next 2 weeks, he continued to work with limitations on lifting and exercise, and took his medications as prescribed.

Initial presentation to the chiropractic clinic was 14 days after the appointment with his PCM. The patient indicated that his chief complaint was constant dull aching pain in the low back, radiating into the right "hip" (sacroiliac joint), buttock, and leg and numbness in the lateral right foot. An examination was performed (Fig 1), and copies of a noncontrast MRI were reviewed. This revealed a prominent disk extrusion at L4/L5, occupying the lateral recess and abutting the

Initial Examination	Exit Examination
<ul style="list-style-type: none"> Moderate to severely limited lumbar active range of motion in extension, left rotation, right rotation, right lateral flexion 	<ul style="list-style-type: none"> Mildly limited lumbar active range of motion in right rotation; all other planes of motion were normal
<ul style="list-style-type: none"> Pain in the right low back, buttock, leg, and foot increased in all planes of movement 	<ul style="list-style-type: none"> Pain-free in all planes of motion
<ul style="list-style-type: none"> Straight leg raise test radiating pain on right at <35° Sicard's test radiating pain on right Crossed straight leg raise test radiating pain on left 	<ul style="list-style-type: none"> Straight leg raise, Sicard's and Crossed straight leg raise tests negative
<ul style="list-style-type: none"> Low back and right leg pain 3/10 Taking medications as prescribed by PCM 	<ul style="list-style-type: none"> Patient reported being pain-free (0/10) for 3 weeks Not taking any pain medications

Fig 1. Examination findings.

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