MRI Misses Clinical Findings — Left L4-5 Free Fragment with Only Low Back and Retrochanteric Pain

Gemelli-Obturator Internus Complex Present and Treated

Figures 1 and 2 are sagittal and axial images of a 50 year old male who is seen today for low back pain and pain radiating into the left retrotrochanteric region and the left groin areas. HE HAS NO SCIATIC LEG PAIN.

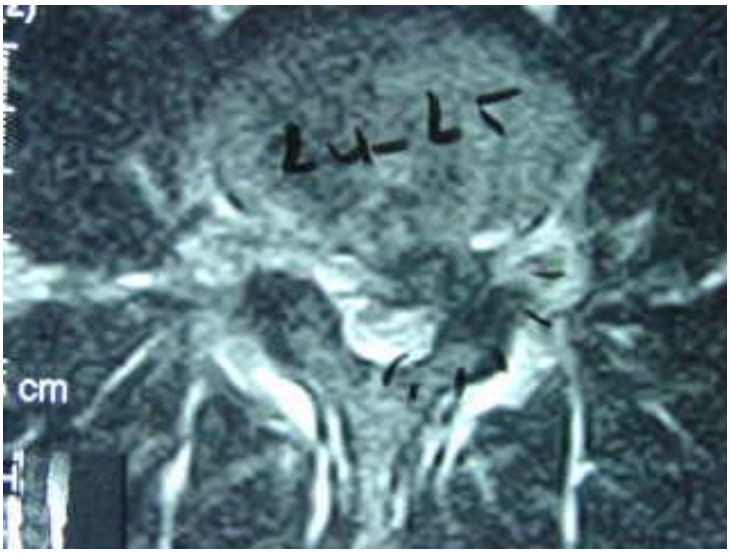

Figure 2

Figure 1 (left). Note the L3-4 advanced degenerative disc disease with endplate sclerosis and osteochondrosis. A slight disc bulge is also noted. The L4-5 disc level reveals a large disc prolapse which in the axial image, Figure 2, shows a large left free fragment that displaces the thecal sac and occludes the left lateral recess. This fragment would contact the L5 nerve root. Note on sagittal section how stenotic the vertebral canal is in the presence of this disc prolapse. Yet no sciatica is present as well as no motor, reflex, or sensory changes.

History is that two weeks ago he developed low back pain but he had pain previously in the left retrotrochanteric region which is described as a “toothache in the butt” since September, 2005. The low back pain is so severe that went to his medical doctor two weeks ago and the above MRI was performed as shown and explained in figures 1 and 2. An epidural steroid injection was given which gave two days of partial relief and then the pain returned.

The interest of this case is the absence of sciatic radiculopathy in the presence of this large free left fragment of disc at L4-5 level. Examination shows sitting straight leg raise positive for low back pain which radiates into the left buttock retrotrochanteric region. Supine SLR is negative right and positive for low back and buttock pain at 70 degrees. No motor weakness is seen of the lower extremities. Deep tendon reflexes at the ankle and knee are plus two bilaterally. The patient can heel and toe walk normal. No sciatic scoliosis is noted. Sensory examination is normal.

No sciatica is present in the presence of this large L4-5 free fragment that contacts the thecal sac

and occludes the left lateral recess at the sight of the L5 nerve root. Note that the retrotrochanteric pain was present for many weeks before the low back pain started. I have seen this clinical presentation before – namely retrotrochanteric pain prior to back pain or sciatica. It may be the first sign of disc herniation eminence. Perhaps the retrotrochanteric pain is scleratogenous pain from disc degeneration internal disc disruption.

This patient came to me wanting to be quickly fixed so he could go on vacation in a week. I told him that was not possible and that our first goal is to keep the pain from radiating into the left leg as sciatica. He was cautioned that there was great chance that he would develop left leg pain and not to be surprised if he does. This prevents him from even thinking my care might be responsible for the leg pain. He is scheduled to see two surgeons for their opinions. I work with both of them and told the patient that they would not operate on him with his present findings and that I think both of them are satisfied with my treating the case with the constant monitoring of neurological signs that might indicate a surgical need. This patient is anxious for quick resolution of the problem and needs to learn that he will not be cured, but rather controlled of his pain. He will need the principles of low back wellness school to cement this concept in his mind – namely that we will control his back pain and not cure it. His degeneration is too far advanced to be normal again and clinical expectations must realistic.

I will treat this case with protocol I decompression flexion distraction adjusting at the L4-5 level. Treatment will be daily. Positive galvanism into the disc fragment and electrical stimulation of the paravertebral muscles at the L4-5 level and the left gemelli – obturator internus complex will be administered. Home care will be ice therapy for 30 minutes every 4-6 hours followed by massage by his wife of the low back and left buttock. A lumbar brace will be worn between treatments. Four Discat Plus (chondroitin and glucosamine sulfate) capsules will be taken at breakfast and dinner. The clinical expectation is 50% relief of objective and subjective symptoms and signs within 6 weeks of care or surgical consultation will be held.

For an in-depth discussion of the gemelli – obturator internus complex I refer you to Cox JM, Bakkum BW: Possible Generators of Retrotrochanteric Gluteal and Thigh Pain: The Gemelli-Obturator Internus Complex. *Journal of Manipulative and Physiological Therapeutics* Volume 28 Number 7, September, 2005. I feel this bursal origin of pain and sciatica is part of the clinical scenario of the severe buttock pain accompanying disc herniation, especially prior to herniation of the disc.

This is an excellent case to illustrate the principle that MRI does not show clinical findings. Contrast this case with last month's clinical case in which I shared an L3-4 disc herniation with marked motor weakness and the disc herniation was not nearly as large as the one presented here. Without agreement between the doctor and the patient concerning clinical outcome and course of treatment in a case like this, dissatisfaction can result. The patient must understand his options of treatment and agree to the course of care outlined, having full knowledge of possible problems and resolution.

Respectfully submitted,
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