

# Spondylolisthesis at L5 in a Truck Driver, Long-Standing Low Back and Leg Pain, Relieved with Cox® Decompression Adjusting

## HISTORY & EXAM



Figure 1

A 54-year-old, white male, working as a truck driver is seen for the chief symptom of low back and right anterior thigh pain. History shows he stepped off a truck on to his right foot, felt left anterior thigh pain, and low back pain. He went to work, went home, and was seen by a company doctor who adjusted his low back. The pain continued and he had a MRI a month later. He received no report of it. The company doctor then sent him to therapy for physical therapy consisting of ultra sound and electrical muscle stimulation and exercises until May of 2004 when he saw a physiatrist who gave him Aleve and Ultram. He had not worked for approximately 2 months at that time. He was given a maximum medical improvement report and returned to work in June, 2004. With failure of recovery under medical care, he consulted with us. Our examination reveals a negative Minor sign but a positive sitting straight leg raise causing low back pain. The deep tendon reflexes of the lower extremities were plus two bilaterally. No spinal tilt, no Kemp's, Neri Bow, or Lewin tests were normal. No motor weakness was found of the lower extremities. Pain on palpation was noted on L4 through S1. The ranges of motion were 60 degrees flexion and 20 degrees extension and 10 degrees right and left lateral bending, all producing pain. The sensory examination of the lower extremity was negative. Adduction was painful in the right thigh and the adductor muscles were quite short and painful. Straight leg raise defined tight hamstring muscles bilaterally and again the Patrick's test showed bilateral short adductor muscles. No motor weakness of the lower extremities were found.

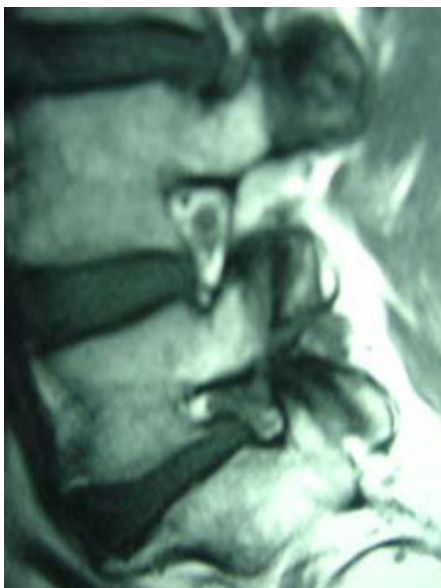


Figure 2

## IMAGING

Figure 1 is a T2 sagittal image of the lumbar spine defining L5-S1 loss of signal intensity and a 15% spondylolisthesis of L5 on sacrum. The T11-T12 and T12-L1 discs reveal loss of signal intensity and moderately advanced degenerative disc disease. The remaining discs are well hydrated.

Figure 2 is a sagittal view of the L5-S1 disc space showing the spondylolisthesis of L5 on sacrum and the bulging of the disc to be contacting the L5 nerve exiting the osseoligamentous canal at L5-S1.



Figure 3

Figure 3 is a coronal view of the thoraco-lumbar spine showing T11-T12 and T12-L1 degenerative disc disease with large disc protrusions at both levels, most marked at T11-T12.

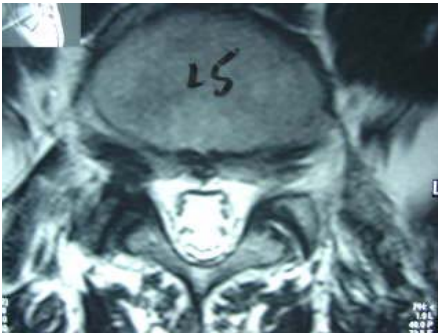


Figure 4

Figure 4 is an axial image at L5-S1, which shows pseudodisc herniation at L5-S1, which is typical of spondylolisthesis.

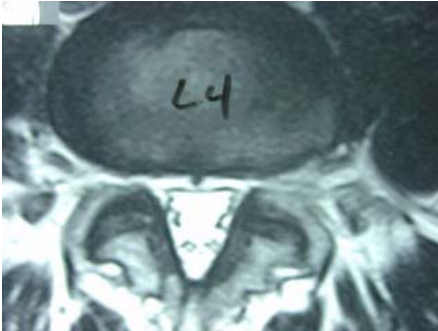


Figure 5

Figure 5 shows bilateral stenosis at the L4-L5 disc level due to facet hypertrophy and facet syndrome of the L4-L5 level.

## DIAGNOSIS

1. L5 15 % true spondylolisthesis with pseudodisc herniation producing nerve root compression as seen in figure 2.
2. L4-L5 facet hypertrophy and facet syndrome
3. A small L3-L4 central disc herniation was also found in this case.

## TREATMENT

1. Protocol 1, Cox® Decompression Distraction Adjusting was given at T11-T12, T12-L1, and L3-L4, and L4-L5 levels. Always contact the spinous process superior to the spondylolisthesis segment.
2. Electrical stimulation consisting of positive galvanism and tetanizing currents was placed through the osseoligamentous canals and intervertebral disc at the L4-5-S1 disc space.
3. Home exercise program consisting of hamstring and adductor muscle stretching, utilizing PNF procedures were given.
4. He was placed on Discat Plus (Chondroitin Sulfate and Glucosamine Sulfate) 2000mg per day for 3 months and then reducing to 1000mg per day. (from [www.chiromanis.com](http://www.chiromanis.com))
5. At home he was instructed to apply ice to the low back and follow it with massage with liniment. This was done at bedtime.
6. He attending low back wellness school to learn ergonomics of lifting as well as to review his home exercise program.
7. Five treatments resulted in relief of the thigh pain with the pain isolating to the low back and right hip. At this time massage therapy consisting of deep tissue massage of the low back, right hip, and adductor and quadratus lumborum muscles was started.
8. Ten treatments were given over the first month of care resulted in over 50% relief of the low back and leg pain. Patient was able to stand straight and ambulate without pain.
9. At six weeks of treatment, 15 treatments, the low back pain was 85% relieved, the right buttock pain was 60% relieved and there was no anterior thigh pain. At this time he did complain of some cervical spine pain for which decompression manipulation was started.

On February 1, 2005, following completion of 20 office visits consisting of the therapy outlined above, constantly increasing home active and decreasing in clinic passive care to weekly visits. The patient complained of no low back or hip pain, and only had neck pain of a VAS of 1. He is back to his normal job as a truck driver and when last seen on February 22, 2005, he complained of no low back or leg pain, only some neck pain. He has been doing cervical spine exercises consisting of the Cox® Isotonic headband for the last four weeks. (from Dee Cee Labs—1-800-251-8182)

This is an excellent case of true spondylolisthesis with degenerative disc disease at several levels of the lumbar and thoracic spine which failed to yield to classic medical care but which had an excellent clinical outcome with decompression distraction manipulation.

Respectfully submitted, James M Cox DC DACBR

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