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Treatment for Herniated Discs

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Introduction

Axial decompression of the lumbar spine is not a new type of treatment; the idea has been around for many years. In fact, in the past, traction has been employed for treatment of low back pain and many, mistakenly, think traction and axial decompression are the same. Traction has many limitations, one of which is dependent upon the weight of the patient. The amount of force used in traction is limited to 50 lbs., which is then distributed from the L5 disc to the top of the thoracic spine. In most cases, this does little more than separate the facet joints.

However, with axial decompression, in general, that force is capable of being directed to the specific lumbar disc level that is desired (L1-L5). This is done by utilizing a pelvic and a thoracic harness, thus immobilizing the pelvis, as well as the thoracic spine at T12 and above. In addition, it is possible to control the directional force, by changing the vector force that is being applied to the lumbar spine. With that, 0-5 degrees applies force to the L5-S1 disc, 5-10 degrees to the L3-L4 disc, and so on. Also, the force limitation (50 lbs) for traction is either constant or completely intermittent; whereas, with axial decompression, the force being applied is fifty percent of the patient's body weight as the top parameter and half of that as the bottom parameter, with the force oscillating between those settings. The decompressive force applied to the lumbar spine increases blood flow, and the slow stretch causes a relaxation in the paraspinal musculature. Axial decompression causes a negative pressure (less than 0) to develop inside the disc, causing oxygen, water and nutrients to be pulled into the disc. As we bring the water, oxygen and nutrients across the vertebral end plate, the healing process inside the disc is facilitated by giving the chondroblasts, as well as the fibroblasts, what they need to begin the healing process and, in a sense, allow the disc to heal from the inside out.

In this article, I will discuss the benefits of axial decompression of the lumbar spine for herniated disc. In it, we will talk about a particular patient that had tried several different "conservative" treatments, each with marginal or no success. We will also track this patient through a three-year period following his initial treatment to evaluate his outcome over time. It is important to note this was not conducted as a clinical trial but is, rather, a retrospective case study.

History

This patient was a 40-year-old active non-smoking male, with a fifteen-year history of low back pain. The patient's pain developed as a result of a 25-foot fall into a manhole, and was radicular in nature in the right leg. Immediately following the fall, the patient saw his family doctor, who sent him to a neurologist for evaluation. At that point, a myelogram was performed, which indicated three bulging discs in his lumbar spine.

In the interim, the patient received several side posture chiropractic manipulations to his lumbar spine, which elicited no improvement. He returned to the neurologist and was put on pain and anti-inflammatory medication, which helped moderately. He then experienced an increase in symptoms while sitting, bending, lifting and twisting, but was able to alleviate the symptoms somewhat by bending/stretching his legs.

The patient was then seen in the emergency room two weeks following the injury, and recommended for L4/5 L5/S1 lamenectomy, which he declined in favor of an epidural injection that was repeated every six months for the next 12 years. These epidural injections had a diminishing success over time, so, when I evaluated the patient, he had had one just three weeks prior to his consultation and evaluation.

Physical Evaluation

The patient's weight and vitals were taken, and the proper chiropractic and orthopedic tests performed with the following results: Kemp's sign, + bilaterally at LSJ; left leg flexion and extension, weak 2/4; inversion/eversion and right great toe, all weak 2/4; left L3 & 4 dermatomal deficits, with S1 deficit bilaterally. Lesague's test was positive bilaterally at 45 degrees; palpable tenderness existed at L4/5 right, with muscle spasm present, as well as tightness and tenderness over both sciatic notches. Nauchlas test and Ely's sign were, also, both positive on the right, with Yoeman's sign present bilaterally at the lumbosacral junction as well.

Discussion

This patient was treated with an axial decompression protocol over a course of 8 weeks. The protocol included a series of twenty-five treatments over a six-week period, including twenty-five minute treatment sessions on the axial decompression table, followed by fifteen-minute interferential therapy combined with cold therapy. This was accompanied by nutritional supplementation.

This patient was treated on a daily basis for the first two weeks (five times per week) and reevaluated, whereupon he indicated a thirty-percent improvement, with a reduction in discomfort in Kemps sign, and Nauchlas sign and Ely's sign, all others remaining constant.

The third week, the patient was seen at a frequency of four visits and subjectively scored himself at forty-percent improvement.

The fourth week of treatment, the patient was seen at a frequency of three visits and subjectively scored himself at almost sixty-percent improvement. At that point, he was reevaluated and Kemp's sign, Nauchlas and Ely's Tests were all negative bilaterally. This patient also noted improved foot and leg strength.

The fifth week, the patient was seen two times and scored himself at eighty-percent improvement. At this point, he was, once again, reevaluated and noted mild tenderness in the lumbar spine, with all other ranges of motion being pain free. Muscle strength was equal bilaterally, with minor discomfort during Yoeman's test in the right sacroiliac joint. All other tests were negative.

This patient was then seen on an ongoing basis with occasional exacerbation, due to an increase in activity. After approximately three additional weeks, he was released to a chiropractic maintenance plan, which began at a frequency of about every two weeks during the first six months and, subsequently, at a frequency of three-to-four weeks for the next year. He is now being seen periodically to maintain the proper function of the lumbar spine.

It is important to note, the patient is now stating a 95-100 percent improvement, with no pain at all.

Conclusion

Axial decompression of the lumbar spine is a very beneficial treatment for patients with

lumbar disc problems. Although there are very many treatments for lumbar disc pain, as well as low back pain of any etiology, there is none that is completely foolproof. Axial decompression is not a substitute for chiropractic manipulation of the lumbar spine; however, it can be used effectively in cases which may not be responding to specific manipulation. The incorporation of axial decompression into the chiropractic office has many benefits, expanding the ability to help patients that may have advanced beyond the normal limits of chiropractic care, as well as helping many patients avoid severely invasive or—possibly—failed back surgeries. Axial decompression of the lumbar spine may, indeed, become the answer for many of those patients whose only option becomes surgery.

With that in mind, there are many new axial decompression tables being developed and they continue to get better, both in treatment abilities and in price. So, look around.

Axial decompression tables can be leased and, in some cases, there is up to a ninety-day no-payment option available to the doctor at the time of sale. This is a particularly good option, because it does take time to build a patient base, just as it does in beginning any new practice. In my office, we work exclusively on a cash basis with these patients and have received a wonderful response with that. If you are interested, I have developed a marketing, as well as a cash, program that goes right along with the use of these tables. Give me a call.

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