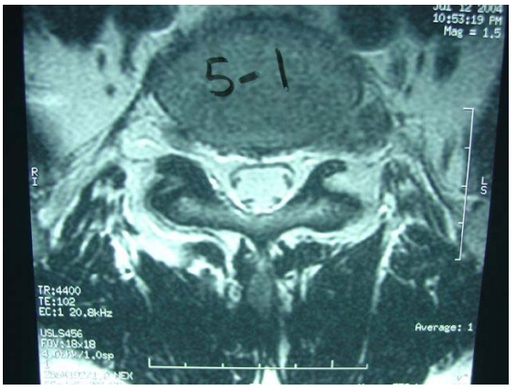
CASE OF FACET REMOVAL FOR SURGICAL REMOVAL OF LARGE EXTRAFORAMINAL FREE FRAGMENT OF L5-S1 DISC



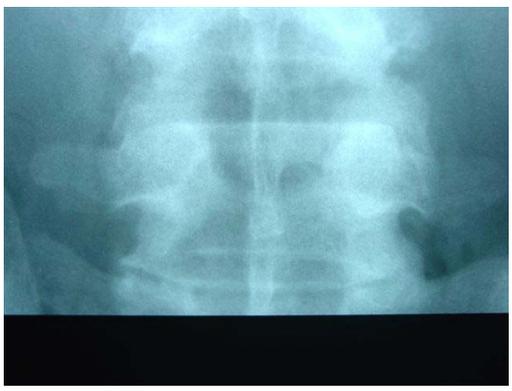


Figure 1 shows the very large left extraforaminal sequestration of L5-S1 disc which infiltrates the left fifth lumbar dorsal root ganglion.

This causes extreme left fifth lumbar nerve root radiculopathy. The 55 year old man is unable to move at all and in the fetal position for relief of pain. Straight leg raise is impossible to any degree of elevation due to both back and leg pain, especially leg pain. No range of motion is possible of the thoracolumbar spine. The man is literally screaming in pain as I made a housecall to see him. Upon seeing him, I called a neurosurgeon I do cases with, and the patient was transported to the hospital via ambulance. Morphine was given, and the MRI seen here was performed. Due to the pain, surgery was performed.

Figure 2 is the anteroposterior view of the spine following surgery and Figure 4 is the oblique view showing the surgical removal of the left L5 inferior facet joint. This was performed in order to remove the fragment.

Figure 3 is the lateral view post surgical showing the marked disc space dessication and anterolateral ankylosing osteophytosis.

Following surgery, the leg and back pain was greatly relieved, but he continued to have persistent anterolateral leg and dorsum foot numbness and pain. With the surgeon's co-management, decompression adjusting of the accompanying degeneration of the L4-L5 and L3-L4 discs was performed. Positive galvanism was placed on the L5-S1 left osseoligamentous canal following decompression manipulation. Exercises were slowly added consisting of walking, knee chest, hamstring stretching and abdominal strengthening. It is absolutely mandatory that stabilization exercises continue by this patient to sustain his relief. Discat Plus which is chondroitin and glucosamine sulfate was given at 2000 mg a day.

The patient was enlightened that rotation and flexion lifting postures should be avoided. He also likes to golf and bowl. He is advised not to bowl, and we will slowly start golf while avoiding rotation at the waist. This may not be possible. Certainly, the patient must know of the instability of the lumbar spine he will contend with for the rest of his life. This patient is now over 90% free of his pain following co-management between surgery and chiropractic decompression adjusting and physiological therapeutics described above. It is quite possible that surgical fusion may be necessary in the future, largely depending upon the patient's determination to follow treatment suggestions.

Admittedly, this is an unusual case of surgical sacrifice of a facet joint for disc fragment removal. We are confronted with cases similar to this and must establish protocols of care. It makes a chiropractic physician consider the altered mechanics in this spine and the potential further pathological changes that may occur.

Respectfully submitted,
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