CASE STUDY: Pain Management (Low back pain)

Indications/Patient Presentation

37 years old gentleman without significant past medical history or medications use, presented to my clinic 2 weeks ago with few weeks history of severe left S1 radicular pain associated with low back pain. Pain gets worse when going upstairs and with sitting position and physical activity. He tried several courses of NSAIDs / COX2 and Cyclobenziprine 10 mg TID without good relief.

Objective Findings

Exam is noted for absence of spine deformities on observation and palpation. He is standing in the clinic holding his lower back with his left hand. Straight leg test examined with patient lying down is clearly positive at 130 degrees. Muscles strength is normal in all limbs. Absent left ankle jerk is noted. Reduced left sole light touch sensation.

Lumbosacral MRI is remarkable for a single L5-S1 5.5mm central disk herniation with compression of the left S1 root. Plain lumbosacral X-R is noted for absent fractures or misalignment.

A) The impression was our patient has functionally disabling intractable Left S1 radiculopathy due to a single L5-S1 central disk herniation.

Treatment

Transforeminal steroid injection at L5-S1 level and L4-5 level. With C-Arm fluoroscopy guidance a total of 2.5 cc of Depro Steroid was injected at each level. Patient was asked to follow up in the out-patient clinic in 2 weeks.