CASE STUDY: Pain Management (Low back pain)

Indications/Patient Presentation

52 years old woman without significant past medical history or medications use, presented with few months history of moderately severe lower back pain. The pain is worse with standing and walking and improved when lying down. Pain radiates mainly anterior to the right groin and somewhat to the right thigh region but not below the knee. She completed 12 sessions of lumbar spine physical therapy without meaningful pain relief. Also several courses of pain killers and muscle relaxants including NSAIDs are tried with some relief but resulting in an unpleasant side effects.

Objective Findings

When patient was asked to point to her maximum pain area she points to the back of her right hip. Straight leg test is negative. Point of tenderness is located about 2 inches medial and caudal of the right PSI. Muscles strength is normal in all limbs. Deep tendon reflexes are normal including ankle jerks.

Lumbosacral MRI is remarkable only for multiple very small disk bulges. Plain hips and pelvis X-R is consistent with right sacroiliitis appears as sclerosis in the joint and erosion of the bone around the right SI joint, Also the X-R is noted for absent fractures or misalignment.

A) My impression was that this patient has right SI arthritic dysfunction.

Treatment

Right SI injection. With C-Arm fluoroscopy guidance a total of 2.0 cc of Depro Steroid and Marcain 1% was injected. Patient was asked to follow up in the out-patient clinic in 2 weeks.