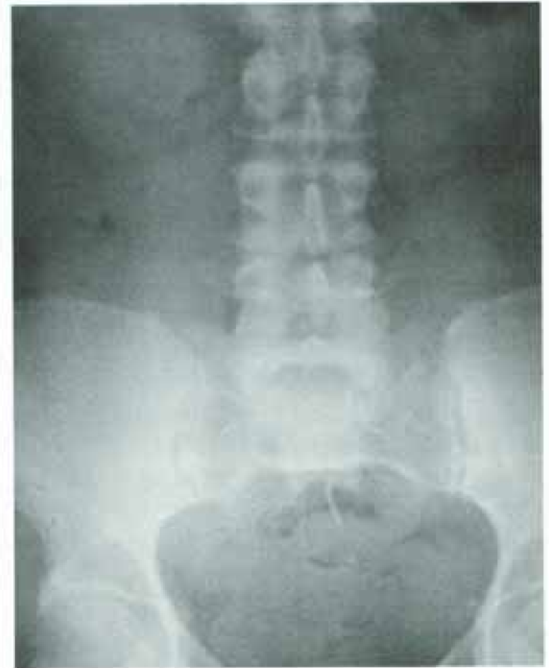
Differential Diagnosis of Lower Back and Hip Pain

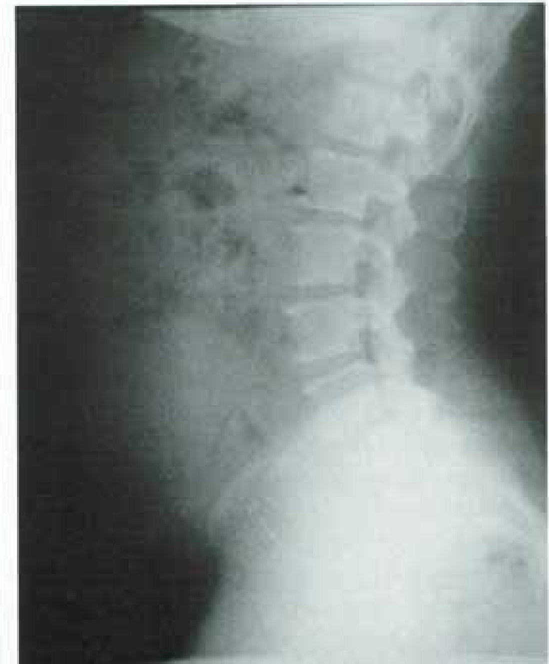
by Marc Gottlieb, DC

A 45-year-old black female, self-employed as a day care owner with left hip and leg pain of three months duration. The onset was insidious and causes numbness and tingling on the outside of the leg in the gluteus medius trigger point pain referral pattern. Her pain was described as moderate in intensity and characterized as dull aches occurring intermittently on a daily basis and significantly aggravated by sitting, particularly in soft chairs or while laying on her left side. Palliative factors included standing, walking, and sleeping on a hard floor. There was no history of previous episodes, prior treatment, or diagnostic tests. Physical examination demonstrated a well developed, well nourished, overweight female with essentially normal lumbar ranges of motion with the exception of flexion limited to 70 degrees due to tight hamstring musculature. Orthopedic tests were negative including Gillet's , Braggard, Fabere, Ely/Nachlas, Yeoman, and Homan sign. Straight leg raise was negative for lower back pain however reproduced leg pain at 60 degrees on the left. Upper and lower extremity reflexes were 2+ brisk and bilaterally symmetrical. Cranial nerves and lower extremity myotomes were normal and left lower extremity dermatomes were hypesthetic. Postural findings noted include a right high shoulder, left scapular winging, left high crest, and left foot pronation. Chiropractic palpation demonstrated intersegmental joint fixations at the levels L3, 4, and 5. The left gluteus medius muscle was tender to palpation and reproduced the pain pattern. Pedal pulses were essentially normal.

What is your working diagnosis? What other tests or information would you like to have at this point? Are you comfortable with treating this patient at this point? Why? Why not?

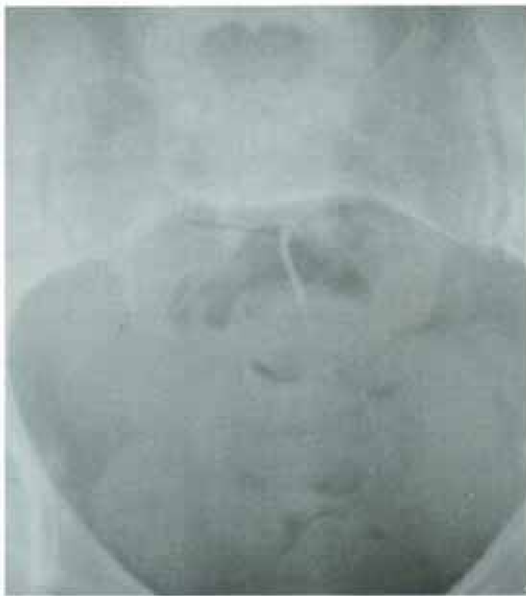
A/P and lateral lumbosacral radiographs were taken. Please review the following films and determine your final judgment on accepting this patient for care and what type of treatment you will recommend. After making this judgment turn page for case conclusion.

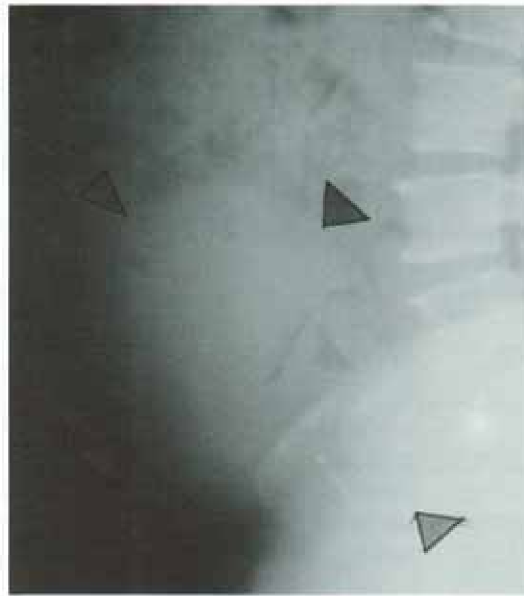




About the author

Dr. Gottlieb currently practices in Raleigh, NC. He is a Logan College graduate.





After not having seen a physician for a period of 12 years the patient decided to have her hip pain addressed and was planning an updated physical. The patient was encouraged to follow up with her gynecologist that afternoon. Her films were also sent out for a second opinion and read by a local chiropractic radiologist. The patient did follow up with her gynecologist who diagnosed uterine fibroid tumor and scheduled surgery within two weeks. The chiropractic radiology report follows.

Lumbar Spine

Frontal and lateral views of the lumbar spine are submitted. Coronal alignment demonstrates slight pelvic unleveling, low left side. Sagittal alignment demonstrates anterior weight bearing of the lumbar spine.

Overall bone mineralization is adequate. Anterior spondylophytic proliferation is present at the discovertebral margins throughout the lumbar spine. All disc spaces appear well maintained. Slight facet hypertrophy is noted bilaterally at L5-S1. All remaining joint spaces appear well maintained.

An intrauterine diaphragm (IUD) artifact is noted overlaying the sacrum on the frontal view. An oval radiopacity is noted within the pelvic cavity. The remaining soft tissues are unremarkable.

Impressions

1. Spondylosis throughout the lumbar spine.
2. Mild facet arthrosis at L5-S1.
3. Postural changes as described above.
4. IUD artifact.
5. Oval radiopacity of undetermined nature in the pelvic cavity. Ultrasound is recommended for further evaluation.

Patient treatment and response :

Diversified spinal manipulation was utilized to treat L3-L5 as well as interferential electrical muscle stimulation for the left hip and gluteal region. Within two treatments the pain that was all the way down the leg had now localized to the low back and left buttock. Treatments were continued until the day before surgery and at that point the patient was reporting long periods of relief without any pain. Due to complications from hysterectomy, the patient was not able to follow up with care for seven weeks. Upon returning to chiropractic care the patient reported low back and flank pain in addition to the hip pain. The pain and examination findings were slightly different in nature than previous findings. The addition of adjustment of the left sacroiliac joint was added to the treatment regimen. The patient repeated the same patterns as the previous session of adjustments had accomplished, in that she received quick relief of her symptoms with only a mild residual discomfort in the left gluteal musculature stemming from trigger points. The patient had a mild exacerbation after missing a period of treatment due to a hurricane, but upon returning to care had resolution of her symptoms.

This is a good example of avoiding tunnel vision in clinical practice. Although the patient had a relatively simple and straight forward neuromuscloskeletal complaint, patients are allowed to have more than one condition at one time which we sometimes lose focus on. The troubling factor in these types of cases is the absence of positive orthopedic findings and difficulty in clearly reproducing the patient's symptoms. Compounding the clinical judgment is the dramatic relief of symptoms from the adjustment which could easily lead to the continuance of the clinical trial without referring for a second opinion to answer that intuitive call, "there's something else going on here."

Did you notice the radiographs the displaced IUD, which has a matchstick appearance and the large abdominal mass outline by four arrows? The pelvic radiopacity measured 18x13 centimeters. ■