Far Lateral Disc Herniation — Extremely Painful

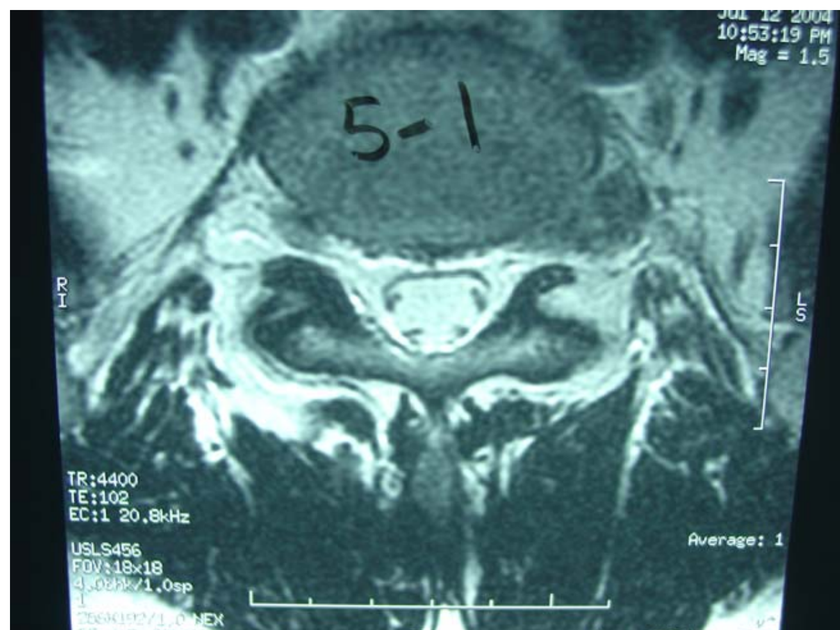
Patient Chooses Surgery for Immediate Relief and Cox® Technic for Post-Surgical Management

This is a case of a 54 y/o man with excruciating left L5 dermatome sciatica. No motor weakness is noted. Deep tendon reflexes at the ankle and patella are bilaterally +2. No bowel or urinary signs are present. The only remarkable problem is extreme pain that makes standing or ambulation impossible.

A housecall is made (remember them?) and he is lying in bed screaming in pain. He cannot be touched to do SLR or any test other than tendon reflex and movement of the foot and ankle and knee joints.

Because of the extreme pain, I called a neurosurgeon I work with who was in surgery at the time. The man was transported to the hospital, seen by the neurosurgeon, and morphine administered for pain. The following MRI was performed within a few hours. It is figure 1 and captioned with findings. Remember it well as these hurt extremely badly for the patient.

Figure 1



In Figure 1 note the huge extraforaminal prolapsed free fragment of disc that stenosis the left osseoligamentous canal (intervertebral foramen for those still using that terminology) to engulf the dorsal root ganglion of the L5 nerve (compare to the normal drg on the right side). An interesting note on this case is that the first radiology report said the MRI was normal, but an over read by a second radiologist picked up the L5-S1 left huge free fragment. A good reason to always read your MRIs regardless where they are taken and interpreted.

Due to the great pain, the patient chose surgery over conservative care. Pain does have a way of directing a patient's decision.

Figure 2

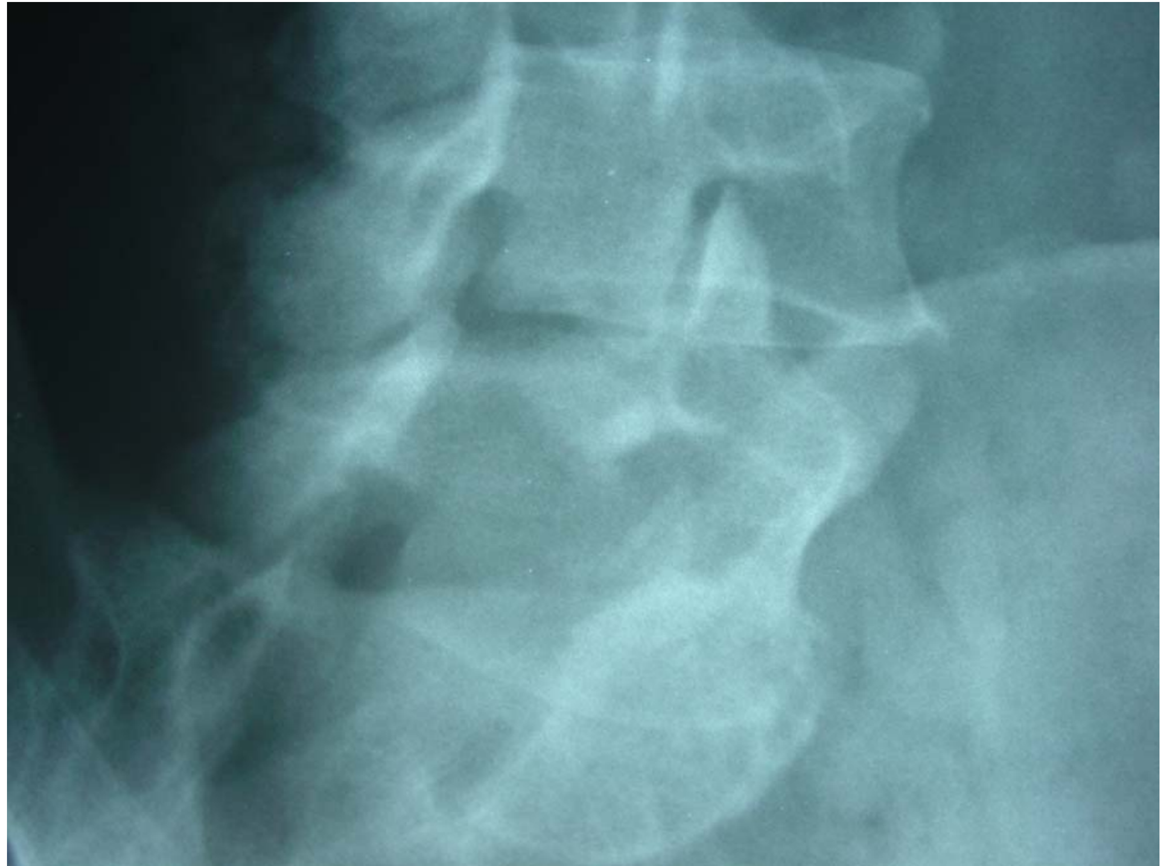


Figure 2 shows that to remove this huge free fragment, the inferior left L5 facet joint was removed (see the oblique view Figure 2). This xray was taken at my clinic three months after the surgery.

Figure 3

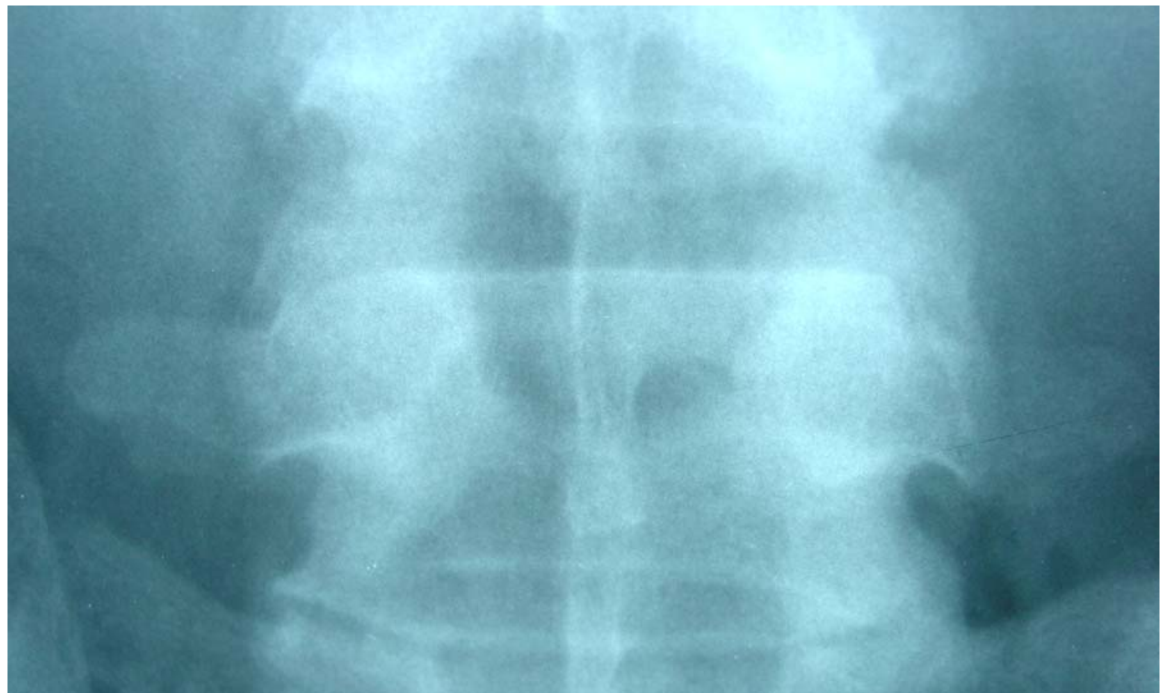


Figure 3: Note the removal of the left L5 inferior facet joint (noted on your reading left side)

Figure 4

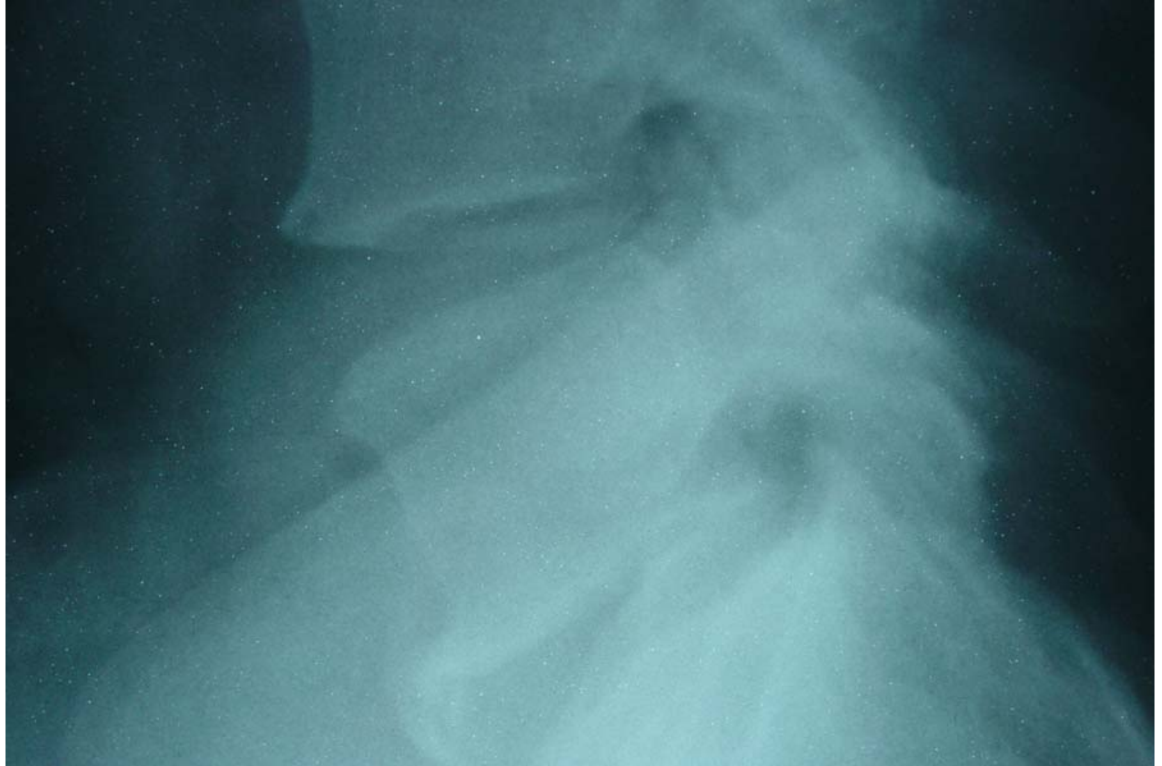


Figure 4: Note the lateral lumbosacral view shows the degenerative L5-S1 disc disease. This xray is taken 3 months after surgery.

Certainly questions arise over how the patient is responding to care. I presented this case at the October 2006 interdisciplinary clinic held at Lutheran Hospital in Fort Wayne for Part III certified doctors of chiropractic. The surgeon who operated on this patient was a presenting lecturer also.

This patient now works his normal job. He retains some numbness of the left L5 dermatome below the knee which becomes worse with long periods of work or standing. Where he used to hit 300 yard drives in golf he now settles for 230 yards while sparing rotation motion at the waist. He feels good enough to not want to do his exercises, but does appreciate that without them his pain exacerbates. He comes to me every three weeks for distraction adjusting of his low back and full spine. He is a very appreciative patient for the relief he has and certainly realizes the restrictive parameters that this surgery places on his activities of daily living. Again a case of a condition we do not cure, but CONTROL.

Point: Far lateral disc prolapses are extremely painful. They do not contact the cauda equina so do not cause cauda equina signs. They just hurt greatly. Thank you for sharing this case.

James M. Cox, D.C., D.A.C.B.R.