Cervical Radiculopathy with a Disc/ Spur Complex at C5/6 with L Nerve Root Compression

submitted by Keith M. Bartley, D.C.
Jasper, IN

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HISTORY AND CHIEF COMPLAINT:

01/21/11

55 year old male press operator for Jasper Chair

insidious onset of Left neck and arm pain of 3 months' duration

pain is worse with sleeping and also increases as the day progresses

draws into his Left upper extremity, posterior brachium, posterolateral forearm, and into the 1st and 2nd digits with constant numbness in the 1st and 2nd digits.

INITIAL ONSET

- emergency room
  - prescribed medication which was ineffective
- Memorial Hospital and Health Care Center
  - prescribed physical therapy that provided no relief
  - therapist told him he would be a surgical case
- Family doctor
  - prescribed a Medrol dose pack at least 2 times without improvement
- Patient
  - feels his condition is worsening with his left arm weakening.
  - has an impending neurosurgical consultation.
  - says pain level 9/10 on a 10 point scale
  - works two jobs totaling over 60 hours per week assembling chairs and lifting furniture

PAST MEDICAL HISTORY:

- Medrol dose pack
- physical therapy
- NSAIDS
- History of being a smoker

PHYSICAL EXAMINATION

- Patient is well developed, well nourished and does not appear to be in any acute distress.
- Blood pressure is 130/84.
- Pulse: 68
- Ht. 5'9".
- Wt. 175
- Active cervical range of motion was
  - Left rotation 50
  - Right rotation 60
  - Flexion 40
  - Extension 40
  - Left lateral bending 20
  - Right lateral bending 30

- Brachial Plexus Tension Test
  - Reproduces L radicular symptoms.
- The pain also was drawing into his L upper trapezius and upper thoracic region.
- Slump test and the Modified Slump Test (Neuromeningeal Tract Tension) did not reproduce chief complaint.
- Palpable tenderness revealed tightness and myospasm throughout the L upper trap, levator scap, rhomboid area as well as the L anterior and posterior scalenes.
- Motion palpation revealed joint fixations at C5/6 L and T5/6/7 L.

Motor exam of the upper extremities

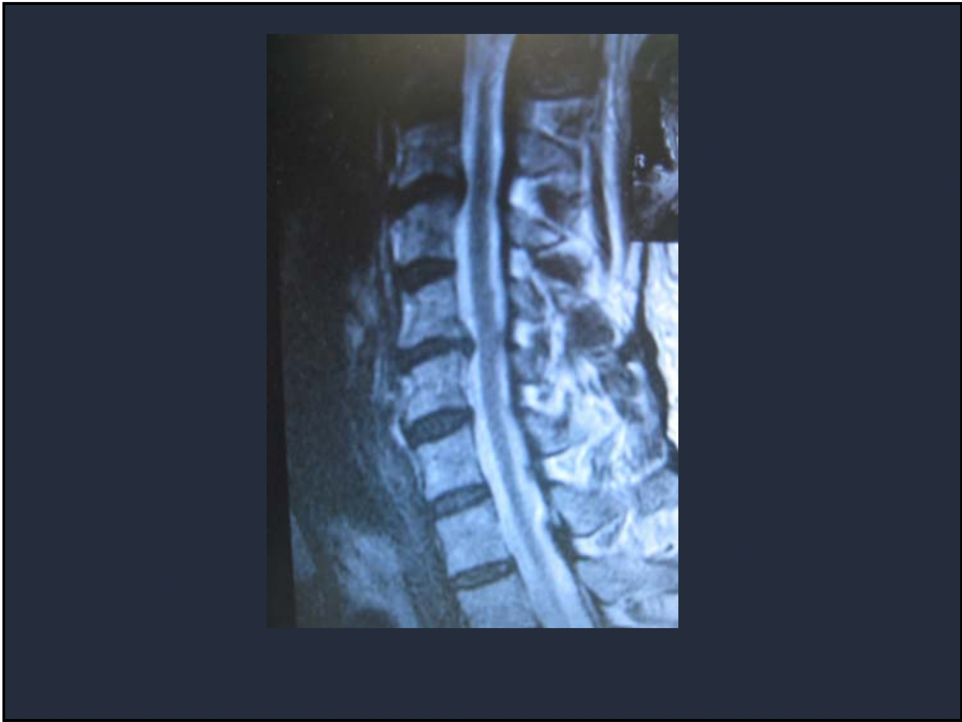
- no weakness with bilateral shoulder shrug, deltoids, biceps, wrist extension, grip, interossei and finger extension.
- Sensory of upper extremity intact.
- Reflexes 1+ upper extremity bilateral.
- Muscle tone normal.

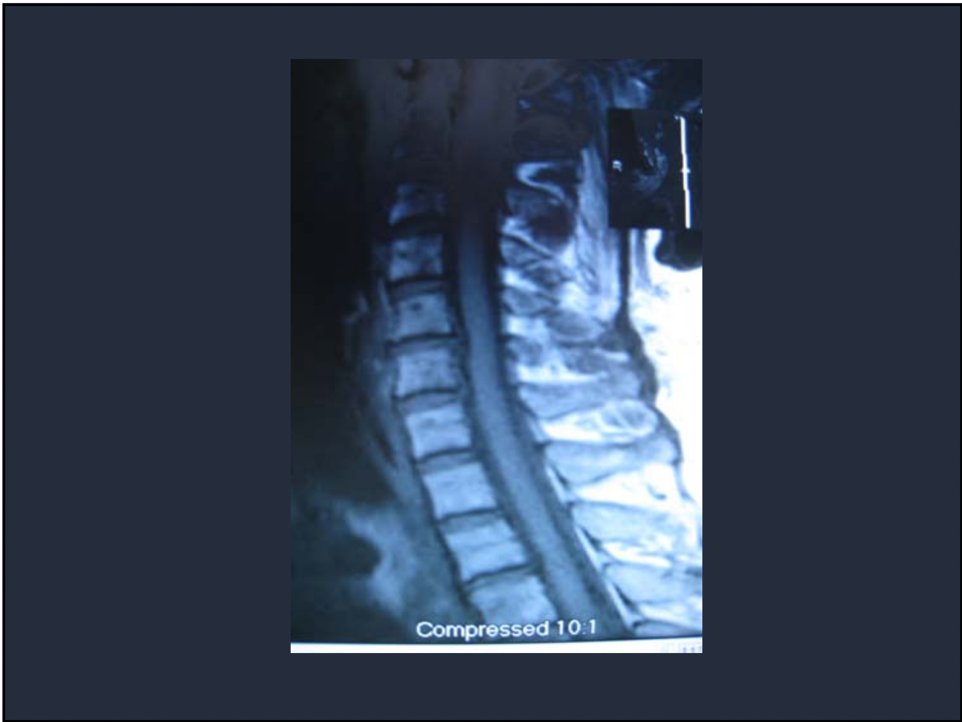
RADIOGRAPHIC EXAMINATION:

01/05/11 Cervical MRI without contrast.

- **C5/6:**
  - revealed prominent disc bulge/spur complex diffusely.
  - This is asymmetrically prominent in the L intraforaminal location.
  - There is effacement of the thecal sac, minimal impression upon the spinal cord.
  - There is mild prominence of the uncinate processes.
  - There is crowding of the neural foramina, greater on the L than the R.
  - Some impingement of the left C6 nerve root is suspected and should be excluded clinically.
- **C6/7:**
  - There is broad based spurring/disc bulging, some effacement of the thecal sac.
  - No impression upon the spinal cord is noted.
  - Some prominence of the uncinate processes is present.
  - There is some crowding of the neural foramina without definite nerve root impingement.
  - Facet joints are unremarkable.

Impression: Disc spur complex at C5/6 interspace effacing the thecal sac with probable impingement of the Left C6 nerve root. Some multilevel degenerative spondylosis as described, more prominent at the C6/7 level.

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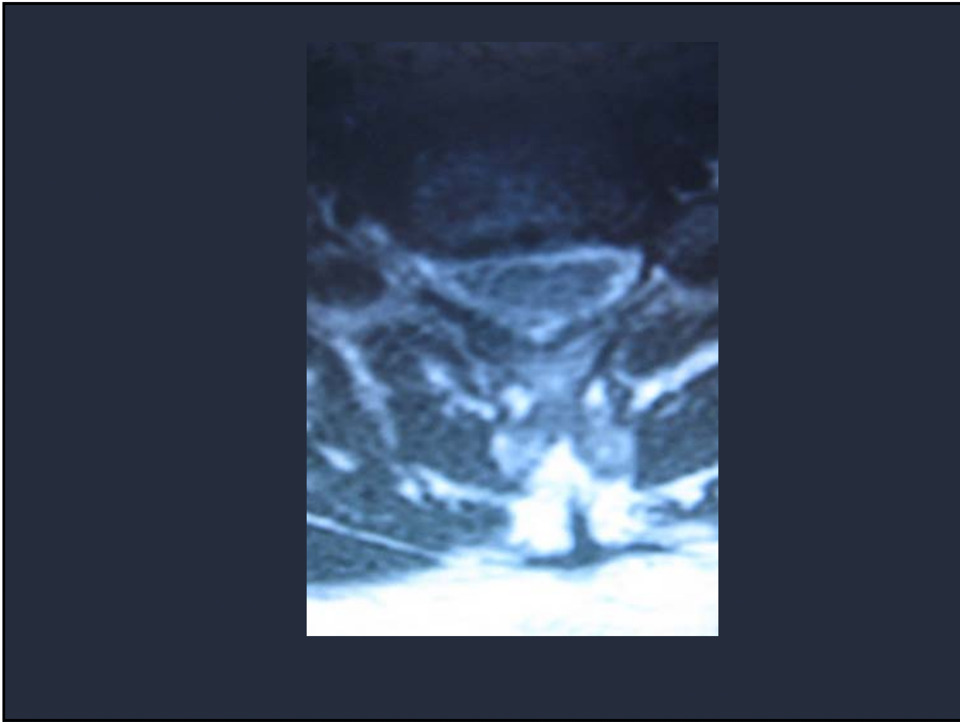

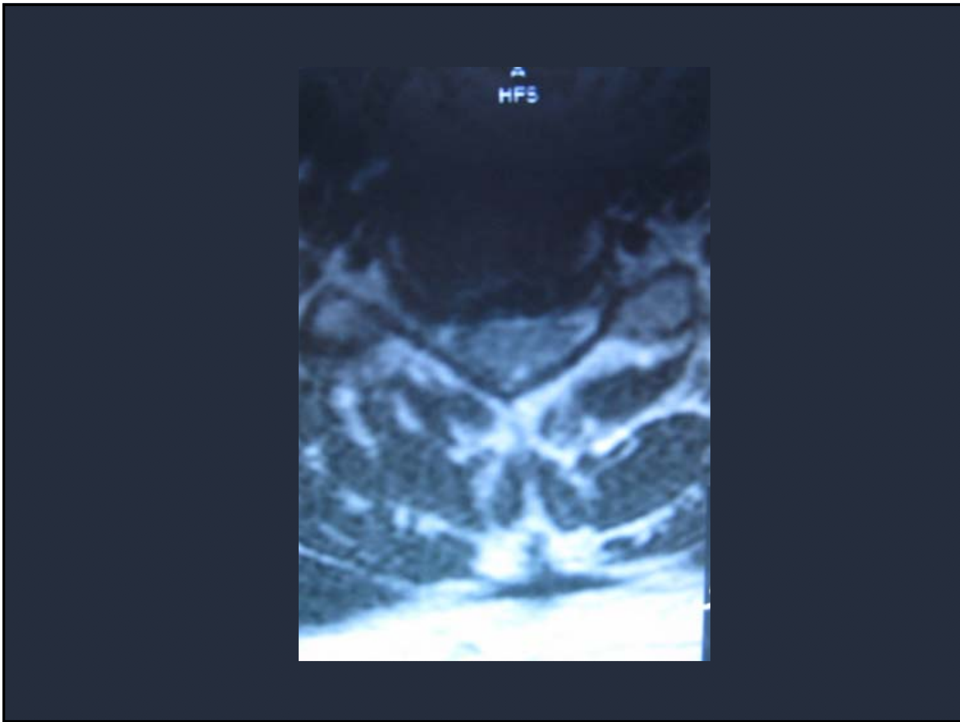
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DIAGNOSIS:

Disc /spur complex at C5/6 interspace effacing the thecal sac with L C6 nerve root impingement associated with radiculopathy, complicated by myofascitis.

TREATMENT PLAN:

- The patient has an impending neurosurgical consultation scheduled through his family doctor.
- In the interim, we will utilize Cox® decompression/manipulation to the Cervical Spine.
- Focal exercises including radial nerve glides, cervical retraction, cervical oblique stretching, scalene stretching.
- Utilization of Active Release Technique (ART) to decrease myofascial adhesions, increase flexibility and elasticity, and release any pertinent nerve entrapments from the scalenes.
- Also the radial nerve entrapments, Upper Trap., Levator Scap. and joint capsules will be addressed.
- 2 treatments/week for 4-6 Weeks

SPECIFIC TREATMENT GOALS:

Long Term Goals:

- Establish a home exercise program.
- Centralize radicular symptoms.
- Decrease VAS 25% and increase hours of sleep.

Short Term Goals:

- Independent home exercise program.
- Abate radicular symptoms.
- Reduce VAS scale and pain 75 to 100%.

CLINICAL OUTCOME:

- After 4 visits and 10 days,
  - the patient no longer needed to take medication
  - only experienced numbness and tingling in the fingertips of his first and second digits
- After 6 weeks and 7 visits, the patient had improved 80-90% from his initial chief complaint.
  - His VAS was down to a 2.
  - He has continued cervical stabilization exercises and is working as many as 50-60 hours a week doing chair assembly and moving furniture.
- He is now seen on a monthly basis to maintain spinal health.
- Also utilizes the Cox® Isotonic neck exerciser from Dee Cee Labs for cervical strengthening.

CONCLUSION:

The combination of Cox® Technic and ART has been profoundly instrumental in relieving and abating the patient's symptoms. With the patient's anatomical issues, including prominent disc bulge/spur complex and degenerative changes, the age of the patient and his type of occupation, it was deemed necessary to continue treating the patient to afford his relief and management of his pain. Monthly Cox® manipulation treatments, removing adhesions utilizing ART, along with his focal exercise program, he has been kept asymptomatic.

DISCUSSION:

Even though the patient did not experience a soft herniation, he was experiencing a true radiculopathy that was greatly affecting his job and ability to function on a daily basis. Utilizing Cox® Technic has insured him a positive clinical outcome, as no longer needs to utilize narcotics and he can continue full employment to support his family. The utilization of Active Release Technique as an adjunct to Cox® Technic was extremely successful in releasing any myofascial pain and expediting his radicular component. We utilize Active Release Technique daily in our practice, especially on acute radiculopathy patients since at times decompression is too painful.