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WHAT IS IT DOC? SLIPPED DISC? PINCHED NERVE?

by Dr. Brian S. Seaman, DC, FCCSS(C), FICC

Last time I wrote about the prevalence of back pain in Canada – astonishing isn't it?!

When back pain persists for more than a couple of days, is quite severe, or getting worse, you should schedule an appointment with your health care professional.

A common question I often hear from patients is "What is it Doc? A pinched nerve? A slipped disc?"

The first thing your health care professional will do is review with you a number of issues or characteristics of your particular problem. These questions would include such things as:

Where is the pain?

What does the pain feel like?

Does it radiate or spread anywhere (down your arm or leg)?

Is the pain worse at night?

Does sneezing or coughing increase the pain?

There are many questions that can be asked, depending upon your response to these initial questions. These will assist your health care professional in identifying the potential sources of the pain and what would be the best approach to further investigations. The examination will help to confirm the suspicions of your health care professional and provide additional information from a clinical perspective.

For instance, a 'slipped disc' --- which does not really 'slip'--- can cause considerable pain. A 'slipped disc' may or may not cause lower back pain but can cause pain in the gluteals or buttocks and extend down the leg to the ankle or foot. Your health care professional will likely ask what part of the leg the pain travels down and into what part of the foot (or toes). This is very important information as this can determine what nerve may be involved and in turn, help to determine clinically, which disc is the most likely culprit. The most common level of disc herniation is the last one in your lower back (referred to as L5-S1). The next most common is the disc right above it (referred to as L4-L5).

Do x-rays show a slipped disc? This is a common misconception. I quite commonly will have patients who will say that "my x-rays showed a slipped disc". In actual fact, regular x-rays (what is referred to as 'plain film') do not show a 'slipped disc'. Regular x-rays will demonstrate disc narrowing or bone spurs (osteophytes) which is referred to as degenerative disc disease (or DDD). However a disc is soft tissue and does not show on regular x-ray which only shows the bones and some soft tissue shadows.

To confirm a diagnosis of a 'slipped disc', your health care professional may recommend a CT scan or an MRI. He/she will review the radiology report (or x-ray report) to determine if the CT or MRI results correlate clinically, to your examination findings and pain pattern. Many people can actually have a disc bulge, or herniation demonstrated on a CT or an MRI, but will have no actual symptoms.

Disc injuries can involve only the outer fibres of the disc (referred to as a bulge of the annular fibres), herniation of the gel in the center of the disc (this is the nuclear pulposus and is often referred to as the 'slipped disc'), or can have part of the disc break off (referred to as a disc fragment) and lodge against the nerve. Your examination findings, as well as the effect on your daily activity level, will have a bearing as to whether surgery would be a consideration.

Obviously, you should pursue all conservative approaches to treating a 'slipped disc' first. This could include chiropractic care, physiotherapy, acupuncture, medication, ice therapy and modification of your activity levels.

"What if it isn't a 'slipped disc'?"

Leg pain is not always a sign of a 'slipped disc'. It can be a referred pain from a joint (or facet) in the lower back or myofascial pain from a muscle in your lower back or gluteals (buttocks). These types of problems usually respond well to such conservative approaches as chiropractic which would utilize specific spinal manipulation techniques or adjustments, and

soft tissue therapy like trigger point therapy, myofascial release and active release.

Another source of pain, resulting in a significant decrease in motion, is an entrapment of what is sometimes referred to as a meniscoid. Meniscoids are essentially a flap or fold of the capsule which at times can get trapped between the surfaces of the joint. These meniscoids are actually quite common, especially in the lumbar (lower back) and cervical (neck) areas. These patients will typically have an acute locking of the neck or lower back, sometimes from a very simple movement which does not cause any actual strain on the area. These cases are often seen in chiropractic offices and usually respond well to spinal adjustment techniques.

What is the most common cause of lower back pain?

The literature tells us that up to 95% of lower back pain cases are related to what is referred to as mechanical type back pain. This is related to restrictions in how the joints are moving in your back (or any other of your spine). The AHCPR guidelines, which were published in the United States in the 90's concluded that acute lower back pain was best dealt with by conservative measures, in particular manipulation which is the primary focus of treatment which is utilized by chiropractors.

In addition to spinal manipulation/spinal adjustments, chiropractors will consider other aspects of your lower back difficulties including potential causes (and how to prevent a recurrence and chronicity), ergonomics (how your job may affect your lower back and how to prevent further strain), and design an appropriate exercise program to correct the imbalances and weaknesses of muscles that may have been contributing factors.

How common are back injuries in the workplace?

Actually, as you will have noticed from a previous article, these are very common! Over the past ten years in Nova Scotia, the percentage of compensable WCB injuries involving the back has been approximately 32% +/- 1%. This is a common percentage. There was a study in Australia in the 1990's on WCB injuries, which revealed their percentage of compensable lower back injuries to be 30%.

Sprain/strain type injuries (Source: WCB Annual Reports) account for approximately 60% of the injuries at the WCB. This could result from a number of different factors including overexertion, reaching too far, or over fatiguing the muscles of your back.

What should I do if I injure my back?

The first step is to stop the activity that caused the problem. This may seem obvious, but is surprising how many people actually try to finish that job that they started or "I tried to work through it"!

The second step is to begin applying ice to the injured area. This will help to reduce the pain as well as the inflammation and irritation associated with the injury.

If the pain is severe or limiting your activity level, be sure to consult with your health care professional as to what would be the appropriate treatment, if any other investigations are needed and to see how you can prevent a recurrence.

Back Facts

Did you know that if you have two episodes of acute lower back pain that you are ten times more likely to have a third? All the more reason to be sure that you take the appropriate steps to find out what caused the problem and how to prevent future recurrences.

The recurrence of back problems is a significant problem not only in Canada but in most societies. Approximately 64% of Canadians experienced an episode of back pain in the past year and 15% of these people lost time from work! Almost half of these individuals were off work for more than a month (Source: EnviroNics).

So the survey says...

Back problems are not likely related to a 'slipped disc'. They are most commonly due to joints not working properly and the muscles not doing the job that they should be. The good news, is that most of these episodes of these back pains will respond to conservative care and that surgery is not indicated or required.

Conservative approaches to back problems benefit the majority of individuals. So consult with your health care professional and ask about how to approach your back problems from a conservative point of view and prevent recurrent problems.

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