

## **THE IATROGENIC “SLIPPED DISC”**

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Each and every one of the last 27 patients to consult me directly or by reference from colleagues on being asked about his complaint has replied, “I’ve got a slipped disc.” Not one of them had!

The authors of three recent papers published in the *Journal* would appear, by their choice of title at least, to imply that disc protrusion is the major cause of the syndromes variously referred to as back strain, lumbago, sciatica, backache, and neckache.

Since the early thirties the majority of published papers dealing with this syndrome, and it is a single syndrome no matter which spinal segment is affected, has ascribed its occurrence to disc protrusion, herniation, or fragmentation.

As Troup<sup>1</sup> so rightly remarks, “slipped disc is now current idiom.” While obviously intending to de-bunk the use of the term, his alternative suggestion of inflammation due to sprain of an intervertebral joint permitted by “unilateral weakness of the muscles which support and activate the joint”, is hardly adequate to define a lesion which, in the acute stage, may produce agonising pain and, if untreated, pain and disability which may persist for months or even years. Such a degree of incapacity is hardly likely to be due to a “sprain incurred by pulling up one’s underpants.”

While thoroughly approving of Logan’s<sup>2</sup> advocacy of energetic early treatment by manipulation or traction, I remain unconvinced of the possible beneficial effects of sodium chloride therapy. It would seem that any acute upset of salt balance would be automatically adjusted long before subsidence of the symptoms either spontaneously or with treatment. I deplore the use of the terms “cervical disc”, “dorsal disc”, and “lumbar disc” as if disc protrusion were the undisputed cause of all pain of spinal origin, be it cervical, thoracic, or lumbar.

Bourke<sup>3</sup> endeavours to implicate “industrial compensation and psychosomatic factors” in the prognosis of what he unequivocally

refers to as the "disc syndrome". He also postulates the "sudden interposition of a disc causing the blocking of a movement". Interposition from whence and into what? His quotation of the patient who has suffered an acute "disc incident" as saying "I can't get up". "Please don't help me" with the suggestion that this is a psychogenic reaction would imply that he has been fortunate enough never to have suffered such an incident.

*Apropos* of his remarks on the existence of chronic conditions in the elderly, I wonder if he has ever encountered the elderly patient who almost reluctantly admits that he has had prolonged trouble with his back but has learned to live with his disability because he has been told that nothing more can be done about it? They are usually new patients who have previously been looked after by doctors who are not particularly interested in backache. I have found them to be intensely grateful for any help.

Perhaps, if I may be forgiven the personal illustration, the point of view of one who is interested in this syndrome, both as victim and therapist, might help to clarify the situation.

Following a fall at school nearly forty years ago, I have suffered from attacks of low back pain which, while not incapacitating, have on occasion been extremely uncomfortable. For about twenty years these attacks occurred four or five times a year and were usually relieved by analgesics, infra-red therapy, and so on.

During the next ten years the bad attacks became more frequent and interspersed with them were minor incidents frequently precipitated by situations which necessitated prolonged periods of semi-flexion, e.g. assisting at operations. These minor attacks only lasted a matter of hours and were relieved by hanging from the lintel of a door for a short period.

In 1948, while in the wilds of Zululand, my back "locked" completely while getting out of my car at a house where I had been invited for dinner. I was in considerable agony and my host, who turned out to be an "amateur osteopath", offered to manipulate my back. I declined his offer with thanks being sceptical of osteopaths either amateur or professional. However, later in the evening under the influence of a certain amount of "anaesthetic" I accepted his renewed offer. There and then, on the lounge floor, he performed what I now call a "pelvic roll", I experienced a "click" and my pain disappeared almost immediately. My interest in manipulation dates from that moment.

A month or two later I had a similar experience while helping to lift a patient on to a stretcher. After about half an hour two tablets A.P.C. had taken the edge off the pain sufficiently to permit me to drive some 20 miles over a corrugated dirt road to the house of my "osteopath". It took me over an hour to complete the journey and it was a most uncomfortable experience. My pain was again relieved by a repetition of the same procedure as before.

The pain of both these experiences was excruciating, it being quite comparable to the most intense toothache and was intensified by any attempted movement. On both occasions it was limited to the mid-lumbar region. After the second incident I continued to suffer the lesser attacks and, oddly enough, discovered that a round of golf, though uncomfortable to begin with, was the best means of cutting short the attacks of ache—ache, that is, as opposed to pain.

Four years ago, one Sunday morning, my back locked as I bent forward to turn off a bath tap. The sensation then experienced is of some interest. It consisted of a feeling as if something was being extruded to the left of the mid-line in the mid-lumbar region. This was not painful but gave the impression that straightening up would correct whatever had occurred. An attempt to do this

was foiled by the onset of a spasm of intense pain localized in the same region. Having been helped from the bath, I literally crawled back to bed on all fours and had to "climb up myself" to get on to the bed. The acute pain disappeared once the supine position was achieved, but *any* movement, *even of hand or foot*, precipitated another spasm of intense pain. Analgesics were of little benefit. Next day, with the aid of two sticks, I struggled to my car and was driven to town. I was quite unable to extend my spine, not only because of pain, but because of what felt like a mechanical locking. I consulted a specialist (in physical medicine) who prescribed short wave diathermy, massage, and traction, the latter for 20 minutes. This had no beneficial effect, rather the reverse and I was more or less carried to my car. On the Tuesday, I could not get out of bed, though a further treatment had been suggested. On the Wednesday, with a struggle, I went in again and submitted to similar treatment. On this occasion, having given the matter considerable thought, while still under prone traction and after about fifteen minutes, I raised my left leg and threw it backwards—there was a "click" then no pain. When released I climbed down from the table and walked normally with little but a slight ache remaining. It was then discovered that my right leg was  $\frac{1}{2}$  in.— $\frac{1}{4}$  in. shorter than the left and raising of the heel was suggested. This was done and, with the exception of one occasion, there has been no recurrence.

The one occasion was two years ago while I was travelling to a medical congress at which I was to deliver a paper on manipulation. The car engine misbehaved on the first day of the journey and having stopped overnight at an hotel, I went down next morning to have a look at the engine. While raising the bonnet I suffered a spasm of the same acute pain as in the bath incident except that it was on the right side. It was so severe that I literally collapsed in the gutter and had to be carried back to my room where I was placed prone on the bed. Under my direction, my wife raised my right leg sharply meanwhile pressing her other hand on my mid-lumbar region. A momentary agonising pain was accompanied by a "click" and complete relief. Six hours and 250 miles later, on arrival at our destination, only a mild ache remained. This was gone next morning.

Incidentally, numerous x rays of the offending region have consistently been reported "N.A.D." I have never suffered from referred pain in the lower limb. This would surely exclude a prolapsed disc and Troup's suggestion of annular fragments in the foramen. The only remaining structure which can be blamed is the zygapophyseal joint (L3-4) and I am convinced that the mechanism of symptom production is mechanical locking of the joint due to (a) arthritic changes in the articular surfaces, (b) intervention of synovial fringe, or (c) intervention of a loose body. Either of these would produce localized pain referred through the distribution of the posterior ramus from which, *via* Stilwell's Plexus<sup>4</sup>, the nerve supply of the joint is derived.

I have seen and treated numerous similar incidents in others and I have yet to see an *acute* lesion which has failed to respond to early manipulative treatment. The lesion which has existed for weeks, months, or years before coming to my notice is much more difficult to treat, particularly if the common root or anterior ramus has become involved by the extension of the inflammatory process. In addition to manipulation these may require auxiliary treatment in the form of injections of local anaesthetic, with or without the addition of hyalase and hydrocortisone, epidural block, or the injection of

glycerin and phenol<sup>5</sup> or "prolotherapy"<sup>6</sup>. Even recurrences following surgical treatment have been relieved by such methods.

Being convinced that something under one per cent of spinal pain is caused by disc pathology, I would suggest that the sooner we cease attributing all spinally originating pain to the "slipped disc" the better for both our patients and our reputation as a profession.

I have been criticized for the introduction of a new terminology to describe the lesions considered here, being unrepentant, I would suggest the use of "spondylodysarthria" or "spondylalgia" as alternative terms and a closer study of the anatomy and pathology of the intervertebral joint complex as the basis for treatment.<sup>7</sup> The mis-nomer "slipped disc" should be immediately and for ever discarded from our vocabulary.

#### REFERENCES

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