Letter: Unilateral low back ache – a personal opinion

To the Editor: Our backs maintain erect posture while allowing great mobility. We can raise our hands above our heads and we can touch our toes. When we bend, structures stretch: The skin stretches, the lumbar muscles stretch, the muscles attachments into bone are stretched at their enthesis and the inter-spinous ligaments stretch. All this stretching takes place, long before there is sufficient pressure exerted on the anterior fulcrum of the vertebral bodies, for intradiscal pressure to exceed normal range, with resultant prolapse of the nucleus pulposis.

It follows that the interspinous ligaments and muscles insertions take the greatest and most common repetitive strain. Therefore pain originating from these structures is commoner than pain originating from prolapsed disc problems. The cause cannot be seen with X Rays or scans.

Muscle or tendon insertion into bone is called an enthesis. Inflammation of this area is an enthesiopathy. The well known plantar fasciitis is such an enthesiopathy. So are tennis elbows. The same process can take place on a bigger scale where the Gluteus Maximus, Erector Spinae and the Quadratus Lumborum all insert into the posterior iliac crest.

Iliac crest enthesiopathy is not mentioned as a distinct condition in the South African Family Practice Manual[1] nor in the August 2008 CME[2] where it falls under the general classification of nonspecific back pain. Neither is it mentioned in the Distance Rheumatology Course of the FPD.[3] I believe that it is a distinct condition.

The pain of an iliac crest enthesitis is most commonly found along one or sometimes both posterior iliac crests, less commonly along the lateral iliac crests and it even occurs at the anterior superior iliac spines. This iliac crest pain seems to present in all populations. The demographics are different from spondyloarthropathy which occurs in young males aged 18–30 years.[3]

While the lower insertions of the lumbar muscles are the most commonly involved, the upper insertions into the 11th and 12th ribs can also be involved giving chronic pinpoint tenderness. The pain can always be localised by direct palpation by the examiner's finger.

Sometimes there is a palpable nodule of muscle spasm in the lower back, similar to those found often in the trapezius. The nodules are a separate condition caused by muscle spasm and should be injected with 0.5% lignocaine.

Many of my patients walk in the door, holding their hands on the posterior, superior rim of their pelvis. Confusingly, some call it kidney pain while others say it is hip pain. The front-page picture in the Aug 2007 SA Family Practice is exactly how they present. I have referred to this condition as 'the commonest condition seen in general practice that is not taught at Medical School!'

Less commonly pain is localised to the ileo-lumbar ligament. Local anaesthetic and steroid injections have been recommended for ileo-lumbar ligament sprain.[4]

Most of my patients with iliac crest pain have pain only along their iliac crests, usually unilateral. There are a very small minority whose pain could be referred (usually bilateral) and these people have other clinical signs as well. Most of the patients that I see in general practice with posterior iliac crest pain will never be referred to a rheumatology, orthopaedic or neurosurgical clinic. A single injection of long acting steroid together with local anaesthetic is usually curative.

No pills are needed, therefore there is no NSAID induced peptic ulcer or gastritis risk. In the few who do not improve, the pain could be referred and those patients should be re-examined.

I only inject where pain is severe, can be localised on palpation, interferes with their function and is chronic. A few days pain at the iliac crest I regard as a sprain of the insertion, which would be self-limiting.

Kirby H, MBChB, MFamMed
Correspondence to: Dr Henry Kirby, e-mail: hkirby@

vodamail.co.za

References

1. Mash B, Blitz-Lindeque J, Eds. South African Family Practice Manual 2nd Ed. Pretoria: Van Schaik; 2006.
2. Shipley JA. An approach to low back pain. CME 2008; 26(8):386–390.
3. Foundation for Professional Development. Distance rheumatology management course. Pretoria: FPD;2007.
4. Bruckner P, Khan K. Clinical Sports Medicine 3rd Ed. Australia: McGraw Hill; 2007.