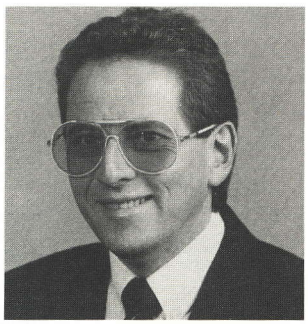
By Dr Saville Furman MBChB MFGP (SA)

MY ACHY breaky BACK

Backache is a common reason for patients presenting to their family practitioner. When they cannot be "cured" patients tend to "shop round" for help. This was personally experienced by the author and the purpose of the article is not only to relate the frustration at not finding a "cause" or a "cure" but more important to alert fellow practitioners to the condition entitled "Piriformis Syndrome".

S Afr Fam Pract 1994;15:166-8.



Curriculum Vitae

Saville Furman graduated at UCT in 1973 and has been in active general practice for the last 18 years. He obtained his MFGP (SA) in 1977. He has a wide field of interest in Family Medicine, the main being the "Doctor-Patient Relationship". He is on the Executive Committee of the Council of the Academy of Family Practice/-Primary Care and serves as the Chairman of the Research Committee. He is President of the SA Balint Society, part-time lecturer in the Departments of Community Medicine and Paediatrics (UCT) and is very active on the Editorial Board of SA Family Practice.

Introduction

Backache is the 7th most common reason males present to their GP in Canada and the UK.[1,2] The South African figures are similar (South African Sentinel Practitioner Network 1991 - unpublished data).

Although rarely recognised, the "Piriformis Syndrome" appears to be a common cause of buttock and leg pain as a result of injury to the piriformis muscle. The pain is aggravated by sitting or activities of the lower extremities. The syndrome is probably more common than has been recognised to date. It may well show up in the practice of any physician (including family practitioners, neurologists, rheumatologists and neurosurgeons) who routinely see cases of low back pain.[3] It may present to gynaecologists as dyspareunia or to gastroenterologists with rectal pain exacerbated by bowel movements.

The major findings include buttock tenderness extending from the sacrum to the greater trochanter and piriformis tenderness on rectal or pelvic examination. Symptoms are aggravated by prolonged hip flexion, adduction, and internal rotation, in the absence of low back or hip findings. Minor findings may include leg length discrepancy, weak hip abductors, and pain on resisted hip abduction in the sitting position. Myofascial involvement of related muscles and lumbar facet syndromes may occur concurrently. The diagnosis is primarily clinical as no investigations have proved definitive.

KEYWORDS

Case Report;

Backache;

Physicians,

Family.

Until August 1992 I prided myself on practicing what I preached by keeping physically fit. However, on that fateful day as I stood up to show a patient out of my consulting room, I experienced a sharp, shooting pain in my lower lumbar spine which lasted the rest of the day. The next morning it had disappeared and I went for my usual morning run, suffering no discomfort whatsoever.

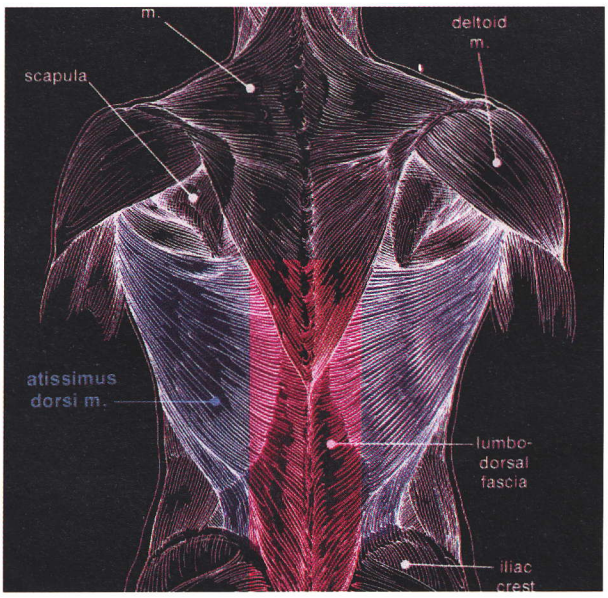
During the next few days, the pain became constant and I visited a physiotherapist who works in the same building. (Health provider No 1) who diagnosed an inflamed facet joint (Diagnosis No 1) and treated me accordingly. Despite the pain during the day, I was still able to run 6 to 10 kilometres daily. One evening at a social function the pain became so severe, that I was unable to drive and coerced a GP friend to give me a Voltaren injection (Health provider No 2).

A few days later, I developed a pain in my right buttock during my morning run, and after one kilometre, I had to walk home. The physiotherapist was unable to localise the source of the pain. That night I attended a Sports Medicine lecture and was telling one of the speakers after the meeting of my problem. He lay me over the table (Health provider No 3) and proclaimed that I had a classical case of torn hamstrings (Diagnosis No 2) and suggested my physiotherapist should perform cross-friction as well and that I purchase a ring cushion to sit on. The next day I duly went off to the Pharmacist (Health provider No 4) and purchased this article that I'd previously recommended to patients with haemorrhoids and bed sores!

A patient, who has an orthopaedic appliance company, noticed the cushion and when he learned of my plight (Health provider No 5), recommended I wear a lumbar corset and try a special chair. He also lent a lumbar support for my chair and a special seat for my car.

After ten (10) different health providers and four (4) different diagnosis, I though I just had to live with it.

Noticing my various orthopaedic aids and discomfort, a concerned pharmaceutical representative (Health provider No 6) offered me a belt with little pads which, when activated, became warm. This so far offered the most relief!



In the meantime, I was rapidly gaining weight and due to not running, my endorphin metabolism underwent a change and I became extremely irritable.

At about this time there was an orthopaedic conference in Cape Town, and we had a friend from overseas staying with us. I asked him to have a look at my back (Health provider No 6). He nearly dislocated my hip joint and told me it was my sacro-iliac joint (Diagnosis No 3) and suggested I have an MRI scan to exclude any secondary deposits! How reassuring!

Finally I decided it was time to visit my GP and I telephoned, only to find he was away for two weeks, so I self-referred myself to an orthopaedic surgeon (Health provider No 7) who asked me first to have an Xray (Health provider No 8). After taking a full history and doing a thorough examination, he thought that I'd probably had a disc herniation (Diagnosis No 4) and told me it could take up to 3 months to recover and suggested alternate means of exercise. Having a "label" was wonderful and in the next few weeks I was more empathetic to patients with backache.

One morning I was called out at 3 am to a patient who'd slipped his disc". His wife said she couldn't move him, would I come and help and pull him up off the bathroom floor! I didn't think it appropriate to tell her of my similar problem, so reluctantly got out of bed, gave him an injection, sat with him in the bathroom for half an hour, and

between his wife and myself, we managed to put him to bed (did this contribute to my inguinal hernia that manifest itself a few days later?)[4]

By now my GP was back and I went to visit him (Health provider No 9) and asked him specifically to treat the pain only. The therapy chosen was acupuncture and after two weeks little progress was made. We now felt that I'd earned my MRI scan (Health provider No 10) which of course was normal.

By now my inguinal hernia was confirmed and we decided that the enforced post-operative rest probably would be the best therapy for my back. This proved to be the case, however after 3 days of resuming work, the buttock pain was back, and I resigned myself to the fact that I'd have to learn to live with it.

I had previously arranged a talk on "Pain" at a monthly Milnerton Academy group meeting with the head of the Pain Clinic of an academic hospital as the resource person. He noted my absence from the annual Medical Ten race. When I explained the reason, he offered to see me at his clinic (Health provider No 11). After another thorough examination, he diagnosed a problem with my piriformis muscle (Diagnosis No 5) and promised to send me an article. I was given specific stretching exercises without success and returned for a local anaesthetic injection into the muscle which also didn't help. Despondency once again set in and then the promised article arrived. It accurately described my symptoms. In fact, one of the patients quoted in the article was also a doctor who ran marathons and our case histories were virtually identical. I was recommended to a physiotherapist (Health provider No 12) who worked with him at the pain clinic. Now, with an exact anatomical diagnosis, she vigorously set to work).

She explained that the constant pounding on the road had probably caused overstretching of the capsules of the facet joints causing tearing of the fibres. The chain of events causes the piriformis to go into spasm. She worked on the facet joints and gave intramuscular stimulation into the piriformis muscle at the sacral end and near the attachment to the greater trochanter with a 3 inch dry needle into the trigger-points, being careful to avoid the sciatic nerve. I must confess that at first I was a bit sceptical of this, and you can imagine my fear when she started digging her elbows into my buttock! She informed me that this was necessary as my gluteus medius and minimus were also in spasm as well as having a tight Quadratus Lumborum. To add insult to injury, after about three tortures, I mean treatments, my L2/3 facet joints also decided to become inflamed and she had to start working on this area as well. I was now growing accustomed to my physioterrorist sessions. Despite any reservations I may have had to what I initially thought was unorthodox therapy, I was able to run once again without any discomfort.

Finally after eight months of numerous diagnoses and even more Health providers I was back on the road to recovery and could once again resume my morning run. However four months later the pain recurred, but after a few treatments the pain resolved.

Since relating my experience at the S A Family Practice Writers' Workshop other colleagues have also diagnosed the syndrome. During the recent college examinations, a patient presented to my candidate with this syndrome. The examinee assessed the patient as malingering and thought the actual reason that the patient came to the day hospital was for a sick certificate!

References

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