

Popular Threads on Solosez

My Back Hurts!

My doctor referred me to a physiatrist at The Spine Center. I am now in physical therapy "boot camp." Interestingly enough, they have found that stretching combined with lifting a milk crate filled with weights onto a shelf and back down (with straight legs) is the most effective way to handle back pain.

Mine came from carrying a laptop that was too heavy and pulling a muscle. Of course you should check things out with your doctor first.

It also sounds like you may be having some sciatic pain. Try sitting on a donut pillow. It may help.

Andrea Goldman, Newton, Massachusetts

You need to talk to your GP first, giving the best history you can as to the onset. A lot depends upon determining what caused it. If you started hurting after lifting your 50 pound dog, that's an important clue. If it just suddenly started, it could be something else, including something as simple as a bladder infection. It is amazing how many different conditions can cause lower back pain. So get a good physical and diagnosis before trying to figure out what kind of doctor should treat it.

Andy Simpson, Christiansted, St. Croix, U.S. Virgin Islands

I agree. IIRC the current understanding is that for many/most herniated discs, surgery does not speed recovery. And it can often cause more problems. The fact is that many/most problems related to herniated discs resolve within 6 months to a year without surgery.

Of course, we're all lawyers, not doctors, so you obviously listen to your doctor. And I am certain there are still situations where surgery for a herniated disc would be warranted. But I would caution against the idea of pushing for surgery if a couple of weeks of therapy doesn't improve your condition

Patrick W. Begos, Westport, Connecticut

Patrick is absolutely correct. Studies show that an MRI on a random population of people will reveal many of them have herniated discs, without symptoms. I've done a lot of work in this area in my legal practice, to the point where I am probably better able to diagnose the cause of a herniated disc than 90% of GPs and 30% of orthopedic doctors and



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99% of plaintiff's expert doctors. 

Here's the scoop:

1. Discs herniate as part of the degenerative process that we all go through. Because of the slow nature of the process, the nerves in the area of the degeneration are usually able to accommodate the herniation; plus, the degenerative process involves drying out of the tissue, such that although the disc is herniated, the tissue contracts, causing no impingement upon the nerve -- the nerve adapts, your body adapts, and typically you have no symptoms.
2. After you have an accident, an MRI is done. Guess what, you have a herniated disc and your back hurts. So a doctor concludes that the accident caused the herniated disc. However, a herniated disc caused by an accident produces very specific symptoms and the effects are immediate. Depending upon the disc that is herniated, you will have symptoms of pain, numbness, tingling, in very specific parts of the body that are enervated (serviced) by the particular nerve that is being pressed upon by the herniated disc. The areas of the body are so specific that tingling/numbness in the great toe versus the little toe will allow the doctor to zero in on the specific disc that is likely to be herniated. If you don't have those symptoms, either the herniation is not very bad or (more likely) the herniation is a result of the degenerative process and completely unrelated to the accident.
3. Similarly, a straight leg raise test will help diagnose a nerve impingement. Plaintiff's experts almost always say that the test is positive if the patient says s/he feels pain upon raising the leg. However, the test is actually only positive if raising the leg causes symptoms (again in specific locations) in the leg. The reason is that raising the leg causes the nerve to bend over the disc, which, if the disc is only slightly herniated, will cause the symptoms to appear even when they don't appear in the supine position.
4. If the symptoms are bilateral (both arms or both legs), that tells you that the herniation is centrally located. If they are one-sided, then you have a lateral herniation. I can't remember off hand which is which, but one is far more likely to result from an accident than the other.
5. Regardless of the cause of the herniation, a huge percentage (IIRC, 90%) will by symptom free within 6 weeks by doing nothing other than icing the back and being careful in your activities. (Bed rest, however, is often NOT the correct answer.) The reason people improve: the swelling around the disc caused by the initial injury recedes (just like any other swelling following an injury), which causes the pressure on the nerve root to stop, and viola, you are symptom free.
6. Surgery is NEVER indicated unless you are facing real quality of life issues. Reasons: (1) There are too many things that can go wrong; (2) all too often, the surgery does not address the reason for the pain (but the patient gets better because the rest/rehab following the surgery does help the root [no pun intended] cause; (3) there have been so many non-surgical advances to help people cope with pain that the surgery merely because

the patient is in pain is truly a last resort.

My \$0.02.

If anyone out there >thinks< they have carpal tunnel syndrome, I can tell you about that and the effect of physical therapy on the scalene nerve in the neck, too. Many CTS doctors won't tell you about that until after the release surgery(ies) has(have) failed to do what they promised.

Andy (I'm not a doctor but I play one in depositions) Simpson,
Christiansted, St. Croix, U.S. Virgin Islands

The scalene muscle in the neck can cause symptoms that mimic CTS. Massage therapy to the scalene muscle can pretty quickly tell you whether or not it is the cause.

I did a quick Google search and this site appeared pretty helpful:

www.deeptissue.com

Specifically on the scalene, check out:

<http://www.deeptissue.com/learn/neck/scalene.htm>

As to other muscle groups that can mimic the wrist pain of CTS,

<http://www.deeptissue.com/learn/hand/carpal.htm>

There are legions of cases out there where people have had multiple CTS release surgeries, only to find out that it is not the cause of the pain.

Similarly, Dr. Andy suspects (but has never investigated the issue) that the failure of a cortisone injection would strongly suggest that the pain is referred from another region of the body, such as the scalene muscles. (Cortisone injections reduce inflammation. But if the pain is in the nerve in the wrist because another point along the nerve is impacted (e.g., up at the scalene), you are going to have pain without inflammation at the wrist joint. Thus, I suspect that multiple cortisone injections without relief strongly suggest that the pain in the wrist is referred from another location in the body.

Ed: If it were me, I'd find a good massage therapist to work on the muscles indicated at the last link (above) in this email. If that works, you've solved the problem. If not, you certainly haven't done any harm. And if it doesn't work, I'd then look for other possible sources of referred pain (e.g. the cervical spine).

Another diagnostic tool that I believe is used in this situation is a nerve block: Temporarily anesthetize the nerve coming from the neck and see if the pain in the wrist goes away.

I'd do the massage, then the nerve block, before I would ever let anyone operate on me for CTS. (Actually, before doing the nerve block, I'd

probably have an EFA: www.efaplus.com I worked with the inventor of this noninvasive test and believe that I was the first attorney to use it in litigation. The results she has had with diagnosing -- and successfully treating -- the underlying cause of wrist injuries in people diagnosed with CTS are pretty incredible.)

THIS EMAIL MAY CONTAIN PRIVILEGED AND CONFIDENTIAL ATTORNEY-CLIENT COMMUNICATIONS. IT AIN'T NO MEDICAL ADVICE, THAT'S FOR SURE!

Andy Simpson, Christiansted, St. Croix, U.S. Virgin Islands

Interesting, perhaps. But definitely not diagnostic of a herniated disc with nerve root impingement.

It is probably interesting to the doctor, because it suggests other possibilities -- just not what the test is designed for. I'm guessing now, but, for example, it might suggest a muscular issue -- if you strained a muscle in your back that is connected to bone on the right side but activated when your left leg is raised, that might explain your reaction and help diagnose the specific muscle that was sprained.

In so called medical-legal cases, an over reaction in the back to the leg raise test can suggest a faker -- very interesting, indeed.

Andy Simpson, Christiansted, St. Croix, U.S. Virgin Islands

I've never encountered that. Sounds like malpractice prevention more than anything. (Maybe they only do that when the patient is a lawyer!)

Call your insurance company and ask it. (Most health insurers have some sort of hotline where you can talk to a nurse and get some insight. Also, you might want pre-approval from the health insurer.)

Andy Simpson, Christiansted, St. Croix, U.S. Virgin Islands

Go see your GP for a referral. You might just need some Motrin and a day on a heating pad.

Barry W. Kaufman, Jacksonville, Florida

I'm not a doctor, nor do I play one on TV. This is based solely on personal experience.

How old is your mattress?

If you develop mysterious (or not so mysterious) back problems, ALWAYS check your mattress before you do ANYTHING else. Before

you spend a lot of money on treatment, try sleeping in another bed. Better yet, try the floor.

If your mattress is more than two years old (cheap mattress) to ten years old (top of the line mattress), it should be considered your prime candidate for guilty culprit. Also consider it if you have *recently* purchased a new mattress, as sometimes a mattress is a) defective, or b) though expensive, just not a good mattress.

I am particularly interested in the fact that as the day progresses, your back gets better unless you sit for long periods. This is a very good indicator (from my experience) of a bad mattress. Also the "localized" pain probably indicates a broken spring in the mattress (which is why your spouse is not suffering back pain, it's all on your side of the bed).

I have not ever heard of a doctor asking about your mattress, though it is probably *the* single most common cause of "sudden onset" chronic back pain. In most cases of which I am aware, including one person who was actually a candidate for vertebrae fusion surgery (?) after years of back problems, mattress replacement has resolved all or nearly all of the pain.

Your best option, if you are young enough, is to spend two or three nights on the floor. If you wake up the next morning in pretty good shape, you have your culprit. If it takes a couple of days, you still have your culprit. If you are still in pain after three or four days on a floor (you know, on a nice comfy pallet, but still the floor), you probably have some other problem. If in doubt, climb back into the subject mattress after at least two nights on the floor, and sleep the night away. If you toss and turn, and get down on the floor halfway through the night, dump the mattress immediately.

Can't sleep on the floor? Sleeping in another bed (especially in the same house) will not necessarily give you the right information. The mattress may be inferior to the one on your regular bed, or it may be old and broken down too. The box springs may be gone. You can try a hotel mattress (but make sure the mattresses have been recently replaced or a new hotel). Or, you can just order in a new mattress (and springs) and see if that solves your problem. Many places will let you try a mattress at home for a week.

Mattresses are one of those things where you generally get what you pay for. Uber cheap mattresses (under \$ 300) should be against the law. They won't last a year. Cheap mattresses (under \$500) have a life expectancy of less than five years, can be as little as 18 months. Less if you or your spouse are heavy, or active. Forget the guarantees--they aren't real.


Better mattresses (\$500-1500) can last 5-8 years, again depending on the environment and usage. Premium mattresses (\$1500 up) are often times guaranteed for twenty years. However, I wouldn't bet on it. More likely, you can expect a mattress life of 8-15 years (at best).

It is true, sometimes a mattress will last *much* longer than the ranges I've given you here. But often times, this is because the mattress is getting light use (guest room), is only being used by one (relatively light) person, never ever gets moved, or maybe you just got lucky and got a long-lived one.

I cannot comment on the life expectancy of new "space age" mattresses, and realistically, neither can anyone else, since the materials haven't been in use long enough in great enough numbers to have any idea how long they really will last. They seem promising, but pillows of roughly comparably material have a life of only ten years or so.

Keep in mind when evaluating "space age" mattresses that most of them are made out of two or three layers of differing material, each with a different projected life, and the mattress is only as good as the material with the shortest projected life. Also, don't pay for a "brand name" space age mattress, only pay for quality construction and secondary materials, as they all use the same polymers for the primary bed covering.

PS: when replacing your mattresses, don't forget your kids who are probably sleeping on twenty year old mattresses. And whatever you do,

Don't put that broken down mattress on the guest bed! 

Becki Fahle, San Antonio, Texas

It's impossible to tell without an examination.

But.

You might have disk herniation. Might be in the L-5/S-1 area. Do you have any shooting pain down either leg? Any tingling in the lower leg or foot? Commonly referred to as "sciatica", involving irritation of the sciatic nerve. That's not the cause, but rather a symptom.

Begin with conservative treatment: physical therapy, heat, ice packs, electro stim.

Sometimes chiro helps.

Sometimes acupuncture helps.

When all such treatments don't help, cortisone shots might help, but make sure they are done under fluoroscopy, either by a neurologist or an anesthesiologist specifically trained for the procedure. It takes 5 minutes and affords immediate relief, because they also inject a pain killer. That wears off in a few hours and it sometimes takes 1-2 days for the cortisone to kick in. It works about half the time.

Last : get two books by Dr. Robert Sarno. His thesis is that most lower back pain is psychogenic. Have you been under more than usual stress lately? Work? family? spouse? Sarno is in NYC, as are you, so you might check it out.

Good luck and feel better.

Charlie Abut, New Jersey

An Expert Interview With Dr. John Sarno, Part I: Back Pain Is a State of Mind

Posted 06/07/2004

Editor's Note:

John E. Sarno, MD, is a pivotal figure in the arena of pain management because of his hotly debated approach to the diagnosis and management of back pain.

Dr. Sarno, Professor of Clinical Rehabilitation Medicine at New York University School of Medicine, and Attending Physician at The Rusk Institute of Rehabilitation Medicine at New York University Medical Center, is the author of 3 books that postulate the theory that most back pain is triggered by psychological origins instead of by a physiological defect.

This phenomenon, which is known as tension myositis syndrome, may also be the culprit in other pain disorders.

Dr. Sarno sat down with Medscape's Pippa Wysong to spotlight how he became interested in pain management and outline how he came to structure his precepts for freeing his patients from back pain.

This is the first of a 2-part interview.

Medscape: I think our readers would be interested in starting off with how you first became interested in back pain. What triggered your interest?

Dr. Sarno: I became interested in back pain when I came to the Rusk Institute here at the New York University Medical Center as head of the outpatient department. I was exposed for the first time in my medical career to large numbers of people with back pain. To make a long story short, after a few years of making the conventional diagnosis and administering the conventional treatments, I came to the conclusion that there was something terribly wrong, because my results were as poor as everybody else's. I found this frustrating and decided I'd better take a closer look at this and really question the diagnosis.

Medscape: In your opinion, what was wrong with the diagnoses of back pain? What did you find?

Dr. Sarno: When I started to look into it, I found that large numbers of people in whom the pain was being attributed to some structural abnormality actually had a totally different disorder. It was a disorder in which the pain was very real, but it was initiated by emotional factors.

Medscape: Emotional factors such as...?

Dr. Sarno: It primarily had to do with the stresses in patients' lives and, interestingly enough, the stresses that they put on themselves. Once I began to make this diagnosis and to deal with it accordingly, for the first time I began to have success. And of course that's why I started to write books about this. But here in the United States virtually no one in the

medical profession is willing to consider this diagnosis. That's, incidentally, very, very important. I do not have an approach to dealing with pain but rather the stresses that cause it.

Medscape: Are the stresses that lead to back pain, as you say, very common?

Dr. Sarno: It is more than back pain. What we can refer to as stress-related disorders have turned out to be more widespread: It's low back, upper back and neck; it's pain involving the knees, pain involving the feet. From what I understand from an article in the New York Times, there were 10 million people in the United States with foot pain, which is an epidemic. And all of these pain syndromes have spread in epidemic fashion in the United States over the last 30 years -- precisely because they are mind/body disorders that have been incorrectly diagnosed, and therefore, as far as I'm concerned, incorrectly treated. I want to make that clear: The major factor is not what treatment one employs but what diagnosis one makes.

Medscape: Can you describe some of the diagnostic features you use? What about the physiology?

Dr. Sarno: Let me tell you very briefly about the physiology. I've based my findings on clinical experience and the way patients reacted to conventional treatments, as well as through material from the clinical literature. What is actually causing the pain in these people is not the herniated disc, or some of those other structural things, but a condition of mild oxygen deprivation, which is brought about by the brain simply altering the blood flow to a particular area. This mild oxygen deprivation is what causes pain in muscle.

Take sciatica as an example. There are a number of spinal nerves going into the leg via the sciatic nerve and the brain would mildly oxygen-deprive them. That would then, of course, give you pain in the leg, and give patients feelings of numbness and tingling. It would also produce actual weakness. But doctors have assumed that these changes and symptoms in the leg were the result of some damage to nerves in the low back -- as a result of herniated discs and things of that sort.

Medscape: What exactly does the oxygen deprivation do?

Dr. Sarno: It produces symptoms. Oxygen is a crucial substance for normal function. You can't do without it for more than a few minutes or cells begin to die. When there is even a minimal reduction in the oxygen supply to a tissue, say a muscle, a nerve, or a tendon -- those are the 3 tissues that we realized the brain might target in order to produce this disorder.

Medscape: Are you saying that this oxygen deprivation is the underlying cause for all back pain?

Dr. Sarno: The underlying thing in this diagnosis, yes. If it involves a tendon around the knee, for example, the patient will have a painful tendon there. Invariably a magnetic resonance imaging (MRI) study will be done and doctors may find a minor tear of the meniscus, the cartilage, in the knee and say, "That's where the pain is coming from."

Invariably there are alternative explanations. For example, shoulder pain is very common now. With MRI studies demonstrating abnormalities of the rotator cuff, immediately doctors and radiologists will say, "That's causing the pain." So, for every area in which people have pain, one can find structural abnormalities of one kind or another.

Medscape: According to your theory, structural abnormalities don't even contribute to the condition.

Dr. Sarno: In my experience they have nothing to do with the problem in many cases. I can't say in 100% of instances, but in many, many cases I've concluded that they have nothing to do with the problem. Of course, my proof is that my patients get better. They couldn't possibly have gotten better if the pain were due to the structural abnormality.

Medscape: If there is a structural abnormality, doesn't it need attention?

Dr. Sarno: No, no, no, no, no, that's the whole point. From what I've been able to gather, you see there's so much material in my books and really we're trying to capsulize this now.

Here's an example: There was a paper published in 1994 by a doctor and her colleagues in the New England Journal of Medicine. They performed MRIs on about 98 people who had no history of back pain. The researchers found normal discs in only 36% of the people. Everyone else had bulges, herniations of various kinds, and so on, and yet no pain. That's the kind of information that doctors in this country totally ignore.

Medscape: Who was the lead author of that study?

Dr. Sarno: Maureen Jensen. This and other studies are referenced in my books.

Medscape: Do you have a name for this oxygen-deprivation disorder?

Dr. Sarno: Yes. Incidentally, it's a name that's become somewhat obsolete, but, since I've used it in 3 books I continue to use it -- tension myositis syndrome (TMS). It's called a syndrome because it has so many different manifestations. In the late 1980s, I realized that nerve involvement was also part of the syndrome and then later, tendons, too. In fact, I now believe that nerve involvement is much more important in the syndrome than muscle involvement.

Medscape: Can we back up and see how you came to the idea that oxygen deprivation was behind all of this?

Dr. Sarno: First of all, there are some papers that suggest that. Clinically it was because I had observed, when I was doing conventional treatment in prescribing physical therapy, that the things that seemed to relieve the pain temporarily, but pretty definitely, included deep heat in the form of ultrasound, deep massage, and active exercise. All 3 of these increase the local circulation. I said to myself, "That probably is what the brain is doing to produce the pain; it is reducing the blood flow."

Medscape: Do you have physiological studies or cellular samples to show what's going on, as proof?

Dr. Sarno: The studies that were done to demonstrate this were done by a rheumatologist on fibromyalgia. In my experience, fibromyalgia is nothing more than a severe form of TMS. Rheumatologists got interested in fibromyalgia in the 1980s and did studies. One group in Sweden did 2 studies that made it very clear that mild oxygen deprivation was the reason for the pain in the muscles in people with fibromyalgia. This supported what I had concluded on clinical grounds.

Medscape: Can you elaborate?

Dr. Sarno: Now let me tell you something interesting. Having said this, it wouldn't make any difference if there were a half a dozen other explanations for the pain, as long as it was clear in one's mind that the brain was doing this. That the brain was producing symptoms -- and this is the heart of the matter and this is what's extremely important -- we haven't gotten into the psychology yet. But the brain was producing symptoms in order to protect the patient from psychological trauma, turmoil, something of that sort. And I came to that conclusion only after many, many years. I wasn't ready to say that until I published my book, *The Mindbody Prescription*, in 1998.

Medscape: So we're shifting from a physical cause to a psychological cause?

Dr. Sarno: What has been clear right from the beginning is that people were responding to stressful situations in their lives. Even more interesting, people were responding to the pressures and the stresses that they put on themselves. I came to realize that people who tend to be perfectionists -- that is, hard-working, conscientious, ambitious, success-oriented, driven, and so on -- that this type of personality was highly susceptible to TMS.

Later, I realized that there is another kind of self-induced pressure, and that is the need to be a good person. This is the need to please people, to want to be liked, to want to be approved of. This, too, like the pressure to excel or to be a perfectionist, is a pressure and seemed to play a big role in bringing on this disorder.

Medscape: How would you say this all plays a role?

Dr. Sarno: You might say, "What is wrong with trying to be perfect and trying to be nice and good?" Nothing is wrong in terms of our conscious lives. However, in doing this work I had to become very knowledgeable about the unconscious mind. Sigmund Freud's work is critical in this regard because he introduced us to the idea of the unconscious. I realized that these self-imposed pressures were causing some difficulty inside our minds. There's a leftover child in all of us that doesn't want to be put under pressure, and indeed it can get very, very angry. It began to look as though the primary factor psychologically here was a great deal of internal anger to the point of rage.

Medscape: So this is the crux of your theory, that it has to do with

internalized pressure and rage?

Dr. Sarno: Self-imposed pressure is one of the sources. It's difficult to understand because one has to think in terms of what's going on in the unconscious mind. There are other kinds of pressures that are equally important, the ones that life puts upon us. Pressures from our jobs, our personal lives, our marriages, our children, and so on. It turns out that these pressures were equally disturbing to this leftover child inside of us.

Then a third category, which is also extremely important, are the angers that might be left over from childhood. These can extend all the way from outright abuse to what I call subtle abuse. Say, parents that expected too much of a child, or parents who didn't provide enough emotional support.

Medscape: These all contribute to pain?

Dr. Sarno: Things of this sort could contribute to a reservoir of rage that I believe we all carry around inside of us. This is part of the human condition in Western society. It's because we're all under such pressure, and so many of us are conscientious and hardworking.

Medscape: So you're saying it's a psychological problem?

Dr. Sarno: It turns out that the rage is the primary difficulty.

Medscape: This is a very different approach from other back-pain professionals.

Dr. Sarno: Yes, it is.

Charlie Abut, New Jersey

Did you get a new chair? You might try a D.O., Doctor of Osteopathy. They can prescribe, manipulate and operate if need be. I was delivered by a DO. Chiropractors cannot prescribe or operate, thus some tend to steer patients toward manipulation.

Craig McLaughlin, Irvine, California

I certainly am not a physician, nor do I have medical training. The circumstances described could be related to muscle issue, kidney issue, cervical spine or nerve injury, or many other potential issues. Your personal history is a key part of the diagnosis.

I would start with your family physician and get specific referrals from there. Diagnosis will likely involve the elimination of alternate causes to narrow what should be done.

Recently a staff member had severe lower back pain that appeared related to a new exercise program. It turned out to be an inflamed / infected kidney in addition to sore muscles. You may be able to logically deduct a

potential cause, but going for the testing and diagnosis is important.

Darrell G. Stewart, San Antonio, Texas

I, too, had weeks and weeks of physical therapy following by injections near my spine of, essentially, steroids. None of that helped me. Eventually, I had surgery which, for me, proved to be a miracle.

Good luck and get well soon!!!

Brian Davis

P.S. For temporary pain relief, I used to lie on my stomach with a bag of ice on the injured part of my back. Good way to read advance sheets, watch TV, whatever. Numbed the pain without dizzying the mind!

How about riding a bike or swimming? That's far less painful than squatting!

A new one (for me) is doing core work with a ball (65 cm). Now that's an exercise or two! And it really works.

Ed Poll, California

There are all kind of exercises that are possible; there's more than one book even with exercises with the ball ... The ones I do depend on the mood of my trainer, but basically they are push ups, stomach crunches and even sitting on the ball, doing curls with light weights. My objective is to strengthen the "core" (stomach and back muscles). I find it interesting that the trainer does an exercise for one part of the body and then immediately, not later, makes me do another exercise for the other side of the body ... in other words, balancing the body strength. I never appreciated before that the back gets stronger only when the stomach does as well.

Ed Poll, California

Be careful of the diagnosis Years ago, I was told that I had a herniated disc (or tendency to same) and was going to go in for surgery. I recovered enough not to warrant the surgery at that time and have been taking care of myself since then But, not long ago, I was told that I never had a herniated disc (or tendency to same)! Kind of scary ...

BTW, with exercise and diet, I feel great even though my back is stiff and I have to be careful ... but then I'm not 20 years old any longer either ...

Ed Poll, California

Dear Dr. Andy, please do talk about CTS ... (especially when one already has had the max. 2 or 3 cortisone injections) ...

Ed Poll, California

...and of course, it depends on the cause of the back pain...mine was caused by hamstrings so tight that they were pulling by back muscles out of alignment. so for me, although physical therapy did include some strengthening exercises, it consisted largely of various hamstring and quadricep stretches, as well as a couple of exercises designed to put things back into alignment (and fwiw - and most of you who've been through PT will appreciate this - i continue to do the stretches almost daily, 7 years later...and will occasionally add in the alignment exercises, when i feel things getting out of place)

Laurie Gienapp

Sorry to hear the tentative diagnosis. I respectfully disagree with some others and urge you to do everything possible to avoid back surgery. I'm not a physician, but having been in healthcare and health law for over 20 years, I can tell you that while they may be successful and technology continues to improve, many back surgeries are unsuccessful and leave the patient with little or no relief or even a worsened condition, e.g., greater pain. Moreover, my anecdotal experience suggests that the lower on the spine the surgery is, e.g., lumber versus thoracic or cervical, the more likely it is that you will require additional spine surgery. If surgery is unavoidable, due diligence in finding a top surgeon is extremely important. In my wife's case it was the chief of neurosurgery at a well-respected hospital who had performed her neurologist's own back surgery six month's earlier. Good luck.

Mark S. Kopson, Rochester Hills, Michigan

One of the things you find in the medical literature is that herniated disc does not necessarily equal pain or any other problem.

Apparently, when MRIs became more widespread, disc surgery increased dramatically, because MRIs would show a herniated or bulging disc, and, because all doctors knew they caused back pain, that disc must have been the casue of the back pain. So ... surgery.

Then doctors started noticing that the surgery did not always solve the problem. It seems basic in hindsight, but it became standard practice NOT to operate unless, at a minimum, the patient's complaints correlated to the particular disc that was herniated. Also, the MRI can show whether the herniation is compressing the nerve root, or whether it is of a size or position to make it unlikely to be the cause of the problem.

What MRIs also showed is that people have herniated discs that are completely symptom free. It is pretty uniformly recognized that if you do MRIs on a random sample of symptom free people, you'll find all manner of nasty looking things in their backs. And, our discs naturally decay as we get older (grandma really is shorter than she used to be!)

By the same token, as I think I mentioned in the last post, there are studies showing that, on average, most people with back pain tend to recover in about the same amount of time regardless of whether you have surgery or not (I can't remember whether it's 6 months or a year).

Of course, there are times when surgery is the right option

Patrick W. Begos, Westport, Connecticut

Has anyone suggested or had an experience with VAX-D ?

<http://www.vaxd.net/>

Glenn Reisman

I used to have similar recurring pain, started doing big straight leg dead lifts and the pain went away. It might just be that your trunk is weak. Some people will tell you that dead lifts are bad, those are the same people that tell you to lift with your legs and not your back (c'mon think about it, ever row a boat, same movement, but there is little chance of one screwing up the form for rowing bad enough to hurt themselves). It's almost become a mantra, but if you're back is strong you're not going to injure it by using it, as long as you maintain form and don't try twisting half way through a 300 lb lift.

Stretching also will help a lot with the pain. Put on some Bengay or similar, wait for a little analgesia and start stretching.

Steve O'Donnell

A good reason to consider a DO instead of an MD. I'm generalizing here, but DO's try to identify the condition and treat it; while MD's treat the symptom in an effort to identify the condition, using a "rule out" diagnosis. If the first attempt to treat the symptom doesn't work, then they rule out that condition, and try to treat the symptom with the appropriate medication/therapy of the next condition on the list. And so on . . .

Andy Simpson, Christiansted, St. Croix, U.S. Virgin Islands

Doc, you're onto something. Wherever you hurt, look somewhere else.

Once-injured scalene can be fragile in stressful times. Sometimes a knot

or some swelling will impinge on a nerve that'll sent messages to seemingly unrelated places. Based on my limited experience, I'd consider chiropractic solutions (chronic low back pain, got great exercises that did the trick), physical therapy (for the scalenes), and definitely semi-long term weekly massage therapy.

C.J. Stevens, Lolo, Montana

Just to add to this -- I have two herniated disks from a car accident back in 1989. The most helpful treatments I got were from and/or through a DO, who I consulted when the MD-ordered treatments weren't being helpful enough. His direct treatments were good (he specialized in body manipulation/adjustment-type treatments), and I also benefited very much from "the Alexander Technique," a very subtle treatment that retrains your body to hold itself with proper posture and movement.

Gini Nelson

I got an Anderson Ultimate Mattress about two years ago. I now sleep great and don't wake up in the middle of the night like I used to. Separate settings for myself and spouse, so we each get a bed set the way we want - - but there is not a divide down the middle of the bed, either.

I'm a light sleeper and when my wife shifts in her sleep, it would wake me up. One of the things I love about this bed is the fact that motion does not carry through from one side to the other. Now my wife can actually get out of bed in the morning without waking me up. Impossible before this.

If you go with their mattress, get your own pedestal/headboard, etc. The furniture side of what they sell is serviceable, but looks more like it belongs in a dorm.

Andy Simpson, Christiansted, St. Croix, U.S. Virgin Islands

If you get a memory foam mattress, be careful about getting one that's TOO thick. Our mattress is high density memory foam that's something like 2 feet thick. While I have no problem sleeping on it because I'm a pretty big guy, my petite wife (and my petite mother-in-law who visited) both complained that they felt like they were being swallowed up by the mattress and couldn't easily roll over or get out of the mattress.

One great thing about memory foam mattresses - vibrations don't carry from one side to the other. So when one of us gets up in the middle of the night, the other side of the mattress doesn't jostle the other person awake.

Gene Lee

Depends on the mattress. Some of the "advanced" mattresses have special zones and textures on the side that's supposed to face up. I'm not sure that it really makes much of a difference, though.

Gene Lee

If the culprit is your mattress, and you decide to replace with memory foam (if that's what Becki meant by "space age"), save yourself some money. Instead of getting the whole mattress, which can cost \$\$\$, get a mattress topper - 4" is plenty. We found a decent quality 4" memory foam mattress topper on the internet for about \$180. Plopped it on top of our \$800 mattress (that was NEVER comfortable) and hubby and I are both sleeping better.

Lisa Collins

Really bizarre everyone. I woke up this morning with my lower back killing me, and then I read this topic.

Go figure!

Norman Gregory Fernandez, Chatsworth, California

Try yoga....it works wonders

Bikram is the best.

Yisrael Yechaskel

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