CORRESPONDENCE

Dear Madam,

Having suffered from recurrent attacks of low backache for the past 20 years, I have developed an interest in the subject and have also been treated by several Orthopaedic Surgeons, Physiotherapists and a Chiropractor.

My Orthopaedic colleagues have been at a loss to explain the acute locked back and referred me for physiotherapy. Those physiotherapists, unable to manipulate and using Ultrasound or SWD alone, have usually been either ineffective or have aggravated the pain.

Those persons practising gentle repetitive manipulation (Maitland), have always been successful in 1 or 2 treatments in effecting a longlasting cure.

Having operated on many cases of disc prolapse, I am able to offer my interpretation of the acute locked back, and chronic backache.

The nucleus pulposus is normally a gelatinous material contained within the intervertebral joint by the flat surfaces of the vertebral bodies and the annulus fibrosis. The latter is reinforced by the anterior and posterior longitudinal ligaments. With age the nucleus pulposus loses its elasticity and takes on the consistency of fibrous tissue, which on removal looks like 'crabs meat".

At operation several features are interesting:

- The disc contents may have ruptured the annulus and dissected under the posterior longitudinal ligament.
- The herniation may be lateral, compressing a single nerve root, causing unilateral sciatica.
- The herniation may be central, causing either severe backache or bilateral sciatica.
- The disc contents may be totally sequestrated and lying free in the neural canal. I have removed a piece measuring 4 cm × 1 cm in diameter.
- On probing a prolapse, the disc contents may ooze through the hole like toothpaste or be teased out with a probe in a solid lump.
- A disc space may be found to be empty — probably the result of lateral sequestration.
- Prolapse of the disc, is more often than not at a level other than the one reported as narrowed on routine X-ray of the lumbar spine.

Plain X-rays are valueless in localising the symptomatic level. From these observations degenerate disc is solid and not gelatinous. The solid material within the intervertebral joint may be loose and squirm within that space. The disc contents are insensitive, but the surrounding ligaments are pain sensitive and cause the backache of a torn meniscus with locking, giving way, pain and swelling.

Squirming causes local protective muscle spasm which frequently localises to the sacro-iliac joint, the origin of part of the sacro-spinalis muscles. Should the contents squirm to one side, the back will lock and lean away from that side. Flexion, especially when associated with rotation, causes posterior squirming and stretching of the annulus and posterior longitudinal ligaments. When also associated with lifting a heavy weight, those ligaments will stretch or rupture with frank disc prolapse.

The acute locked back or small prolapse will respond to gentle repetitive manipulation and traction. Frank prolapse will be aggravated by traction and requires surgical removal. Forceful manipulation may cause frank prolapse, especially under anaesthetic.

Mild sciatica is caused by local oedema of the nerves.

Profound sciatica is caused by disc prolapse i.e. nerve compression.

One cannot localise the side of prolapse from looking at the sciatic scoliosis as this is dependent on whether the nerve root is compressed from above or below.

I have omitted to mention other causes of backache e.g. primary and secondary tumours, fractures, infections, instability and spinal stenosis, as space does not permit.

I am neither impressed with the vague diagnosis of strained muscles, ligaments or arthritis of the spine, nor do I believe that patients should be relegated to a lifetime in a corset or labelled psychological. Backache is very real, and when persistent, justifies proper investigation and treatment.

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Orthopaedic Surgeon

THE IMPORTANCE OF HANDS

Madam,

It is great concern for the image and future of physiotherapy that prompts me to write this letter. Over the years I have heard a variety of comments from members of the medical profession about the practice of physiotherapy, but none so disturbing as many I have heard more recently. I quote:

- While I was treating a general practitioner with bronchitis, which involved hard physical labour on my part in order to clear his secretions, he made the statement that "of course ultra-sound had made things so much easier for the physiotherapist because she no longer had to use her hands for massage".
- At a professional meeting, a thoracic surgeon stated that he did not call the physiotherapist into his intensive care unit any more, preferring to teach his sisters the routine he had learned from the physiotherapist in a previous unit. When questioned further, he explained that "the physiotherapist wheels along a Bird ventilator and asks for a suction tray; don't you know that the patient's own efforts at breathing and coughing are far more effective and less dangerous than any machine. Don't you learn to use your hands any more; they are of more benefit to my patients".
- A director of hospital services has been heard to say that he regards physiotherapy as unnecessary.

Hands are the best tools in the physiotherapist's kit. Mr G. D. Maitland has made us aware of our hands again with his mobilisations of spinal and peripheral joints. I would like to make a plea here for the return to the use of our hands in the treatment of chest disorders of all kinds, and to the neglected skills of massage. Machines, used intelligently, are merely a useful adjunct, without feeling.

At a time when we are seeking professional status with its commensurate increase in salary scales, is it not also the time to take a close look at our principles and practice of Physiotherapy?

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