LUMBAR SPONDYLOLISTHESIS AND SPINA BIFIDA OCCULTA – CLINICAL CASE

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LUMBAR SPONDYLOLISTHESIS AND SPINA BIFIDA OCCULTA- CLINICAL CASE (Abstract): The patient, 30 years old, male, is coming to the medical recovery for a lower lumbar pain with irradiation on the lower right foot, where according to the anamnestic data of the clinical exam of speciality and paraclinical investigations the positive diagnosis is: Antherolisthesis L5/S1 level 1, chronic stage; Spina bifida occulta; Lumbar Polydiscopathy L2-S1, phase IV, chronic stage, degenerative disc disease with pain (spondylodiscarthrosis); L5 sacralisation. Key words: LUMBALGIA, ANTHONEROLISTHESIS, SACRALISATION, SPINA BIFIDA

INTRODUCTION
Sacral lumbar-pain localized or associated with a root syndrome, represents over 50% of the cases encountered in the medical recovery service. The common lumbargia is the most frequent sign of mechanical origin and it can be investigated after reducing all the important lesions of the spine (global or partly lesions), the therapeutic solution for the recovery, that uses physical and kinetic methodologies, being totally justified (1). It is correct that for most of the cases, the identification of the lumbar pain it is difficult. Above all this, efforts must be done for the identification of the principal causes of the lumbar pains, for the understanding of the physicalpatological layer and for establishing a logical program of treatment and recovery (2).

Sacralisation is the hypertrophy of the transverse process of the last lumbar vertebra, which tend to take the form of the sacral wings, arriving to be in contact or being neoarticulated with this ones. The hight of the disk space L5-S1 is reduced in different degrees (3). It is a congenital suffering with possible pseudarthrosis appearing in the contact point between the sacrum and the ischium bone. The sacralisation L5 has a 17% frequence (4), instead Castellvi gives a 14% regularity in 1983, Sharma 14,1% in India, in 2011 and Kubavat reported a 11,1% regularity, in 2012, in Gujarat (5).

Spina bifida or posterior rachischisis is known for the lack of the vertebral arch and the incomplete closing in that region of the neural tube. The most common location is the lower lumbar region and sacral (3). The regularity of the spina bifida occulta is 10% of the population. This can exists in two forms:
1. spina bifida occulta, when the surface tegument is intact;
2. opened spina bifida, when the edges of the neural tube continue with the skin, being also a myeloschisis. If the fault of the vertebra arch allows the entrance in the layers of the marrow, we encounter also a meningocele, other times the herniation of the marrow is produced, in this diverticular meningeal cavity and we speak about myelomeningocele (3).

The lumbar spondylolisthesis is an anterior gliding of a vertebral body, by which this one oversteps in sens the previous vertebral body on which it glides, the sleded vertebra moving under it, all the vertebra situated under, all these keeping its common alignment. The gliding is produced normally at the level of the intervertebral space L5-S1, at L4-L5 and at L3- L4 (2). In the case of the population, the isthmic spondylosis is encountered in 5-7% and the lumbar spondylolisthesis in 2-4% (6,7).

Lumbar discopathy is a suffering caused by a diversity of causes (1). The chain of pathological case of degenerative type that are pro-
duced at the level of the intervertebral disk determines the apparition of important modifications, at the level of the fleshy nucleus of the disk but also to the fibrous ring. During the continuous decay of the disk structures, it exists, a phase in which the turn produced into the disk are in an intermediary phase, in connection with the state of the disk that has lacerations of the fibrous ring, that means existence of lumbar disk hernia. In the intermediary phase of the disk degradation it is the discopathy phase II (2). The fibrous ring cannot be crossed by the fleshy nucleus, and it is carried forward by the last in displacement, producing bulging, a swell (3). Lumbar sciatica appears in 80% of the cases.

MATERIAL AND METHODS

The patient C.T.C, 30 years old, male, from the urban environment, presented himself on the 20th of March 2017, at the Sanamed Clinic, Medical Recovery, with a pain with mechanical character at the level of the sacral–lumbar column, with irradiation on the lower right foot.

Lifestyle and work: the patient has a sedentary life, spending the majority of his time, on the chair, he makes sport frequently, consumes alcohol occasionally, without chronic treatment, for the moment.

From the medical history we retain that he consulted a rheumatologist doctor on the 8th of March 2017 for a pain with mechanical character at the level of the sacral–lumbar column, with irradiation on the lower right foot, started by a continuous and important physical effort. He was recommended medical treatment (anti-inflammatory, pain-killers, vascular neurotrophic, gastric protector) and the realization of a MRI of the lumbar spine. The MRI showed: swayback, L5 sacralisation with right neoarticulation discretely sized, soft anterolisthesis L5/S1, level 1 Meyerding, small margins of the disks L2-S1 with the layered print of the dural sac, without radicular pressure, possible hidden spina bifida (fig.1).

The objective exam with the device and systems reveals: patient in a normal cardio-respiratory status, without pathological elements, fact that allows to reveal the major procedures. The local exam shows: negative bilateral Laseque, ROT alive at the level of both lower feet, no superficial and profound sensibility, no dura syndrome, no musculo-ligamentary syndrome, no psychological and emotional break-up syndrome. The walking on toes and heels is possible. The moderate static vertebral syndrome presented with the highlight of the lumbar swayback. The dynamic vertebral syndrome presented with the index finger-soil at the lower half of the shank. The local exam of the hip joint creates pain at the level of the right one. The muscular analysis it is normal to every muscular groups. Functionally, the patient can run all his daily activities.

RESULTS AND DISCUSSIONS

According to the anamnestic data, of the clinical exam and specialization and of para-clinical investigations the diagnosis is: L5/ S1 Anterolisthesis level I, chronic stage; Spina Bifida Occulta; Lumbar Polydiscopathy at L2-S1 phase IV, chronic stage, pain released; L5 Sacralisation.

The general objectives of the treatment are: the pain release, the growth of the spine mobility and of its alignment, the restoration of the dynamic balance between the benders and the extenders of the spine, the prevention of the complications (fracture), the integration to the family and professional life.

The methodology of treatment is formed by:
- hygienic and dietetic diet rich in fibers, low caloric value, normal water consume (minimum 2 liters per day);
- the medical treatment is composed from: antiinflamatory treatment (Neodolphiase, Arcoxia, Celebrex), muscular relaxing treatment (Mydocalm, Chlorzoxozone), vascular neurotrophic treatment (Pentoxi retard, Milgamma, Alanerv), gastric protector;

Fig. 1. Anterolisthesis L5/S1
kinetic balneo-physical treatment: local thermotherapy for relieving the pain, sedative, relaxing, and general relaxation, electrotherapy (galvanic current for the relaxation effect, vascular trophic; magnetotherapy for sedative effect, anxiolytic; diadynamic current in relaxing formula; ultrasound for the anti-inflammatory effect, pain-killers, fibrinolytic), veno-lymphatic turn massage at the level of the lower right foot, sedative massage at the lumbo-sacral column level and hip joint, kinetotherapy: Williams program I, II, III and exercises for the toning of the abdominal zone.

Evolution and prognosis:
The evolution is favorable with the relieving of the pain and growth of the spine mobility. The ad vitam prognosis by the lack of the co-morbidities is positive. The ad functionem and ad laborum is sensitive, taking into consideration the short treatment administration. Long term prognosis is not advisable, because if continuous recovery treatment and kinetotherapy is done at residence, the evolution could be positive.

Recommends after the recovery treatment:
• hygienic and dietetic diet rich in fibers, low caloric value, normal water consume (minimum 2 liters per day);
• he will avoid cold air currents, coldness exposure, humidity, intense physical effort, psychic stress, long standing, long monotone vertebral positions, especially in bending, lifting and carrying of heavy weights;
• he will continue the kinetotherapy at his residence and will respect the initial rules of hygienic-orthopedia of the spine learned during the recovery treatment;
• periodic medical visit;
• 6 months recovery treatment reiteration.

CONCLUSIONS
The Lumbar Spondylolisthesis is frequently associated with spina bifida and transition anomaly. Spina bifida occulta is a congenital malformation with no clinical manifestations, as the Lumbar Spondylolisthesis, it is discovered very often by doing an imagistic investigation, due to a sacral-lumbar painful syndrome, appeared in the adolescence.

The young patient with lumbar polydisco-pathia L2-S1, anterolisthesis L5/S1, level 1, with L5 sacralisation and spina bifida occulta underlined by imagistic investigation is presented by feeling a lumbar-sacral pain with irradiation on the lower right foot and associates to the clinical image, secondary right coxalgia of the lumbar-sacral spine pathology.

Medical recovery is very important because its purpose is the patient recovery to his daily activities, with the cast out of the symptoms, the growth and maintenance of the muscular force, the correction of the spine’s posture and the prevention of its injury also, the complications prevention.

BIBLIOGRAPHY