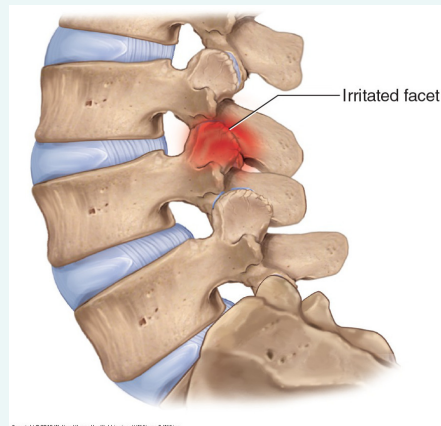
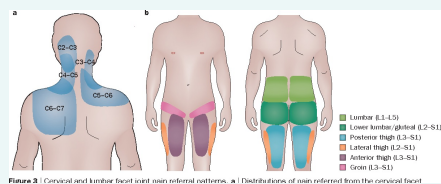


### Anatomy



- Sagittal orientation of upper facets help to limit rotation
- Frontal orientation of lower facets resist forward displacement
- Richly innervated by medial branches of dorsal rami + mechanoreceptors + nociceptors (can be hypersensitised by inflammatory process)

### Referral Patterns



### Causes

- Repetitive capsular stress/ low level trauma
- Compression and extension of lumbar spine (causes inferior articular process to pivot about the pars and stretch the capsule)
- Causes inflammation and joint dysfunction + intraarticular adhesions + degeneration of the facet joints
- OA
- Hx of trauma
- Systemic arthropathy
- Obesity



By Siffi (Siffi)  
[cheatography.com/siffi/](https://cheatography.com/siffi/)

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### Presentation

- Nociceptive stimulation causes back/leg pain
- LBP radiating to flank, hip and thigh
- Consider other pathology if there are radicular complaints
- Ipsilateral fashion due to the medial branch of dorsal ramus does not cross the midline
- Stiffness/morning stiffness common (degenerative changes)
- Relief with recumbancy
- -ve Valsalva, normal gait with no muscle spasm
- Localised tenderness over the affected facet joint
- Muscle guarding
- ROM - ext
- +ve Kemps test
- Check for postural imbalances and gluts (extra pressure on facet joints)
- +ve Spinal percussion
- Neurological exam normal
- VAS, ROBDI, RMBDI, RAND 36, BDQ

### Imaging

Only if red flags:

Severe/progressive neurological deficits

Hx of cancer

Unexplained Weight loss

Bone Disease

Systemic Disease

Inflammatory Arthropathy (AS)

Steroid use

Immune Suppression

Fever

Nocturnal Pain

Prior Lx surgery

Severe congenital defect/instability

Pain is severe, progressive, prolonged or unaffected by position



### DDx

- Intersegmental joint dysfunction
- Myofascial Pain
- Spondylolysis
- Spondylolisthesis
- Sprain/Strain
- Disc lesion
- F#/compression f#
- DJD/DDD
- Stenosis
- Neoplasm
- Infection
- Inflammatory Arthropathy
- SI Dysfunction
- Hip OA/pathology
- AAA
- GI, GU referred pain

### Management

- SMT Tx, Lx, EMT for SI and Pelvis - produces facet joint gapping and breaks up adhesions (12 visits over 6 weeks)
- Criteria for effectiveness for SMT:
  - pain lasting >16 days
  - No symptoms distal to knee
  - Low fear avoidance (FABQ <19)
  - Hip internal rotation >35 degrees
  - Hypomobility of at least one lx segment
- Myofascial release of Lx Erectors, QL, Hip flexors, hip rotators, gluteal muscles, piriformis, hamstrings, iliolumbar ligament
- Flexibility exercises - knee to chest and hamstring stretch
- Rehab = neutral spine posture + Spinal stabilisation exercises (side bridge, dead bug, bird dog, hip abductor strengthening)
- Postural correction
- Heat/Ice
- Ultrasound
- Limits on heavy activity (lifting mechanics, work activities, sleep positions, shoe wear)
- Consider Radiofrequency ablation if: failure to show improvement with conservative care

