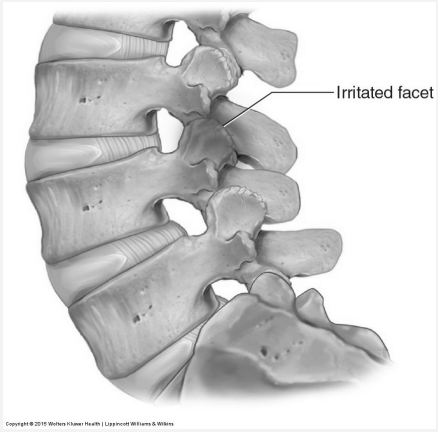
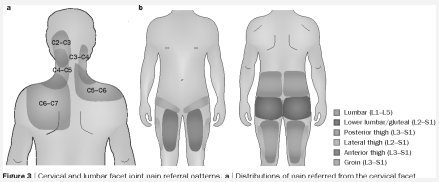
Anatomy



- Sagittal orientation of upper facets help to limit rotation
- Frontal orietation of lower facts resist forward displacement
- Richly innervated by medial branches of dorsal rami + mechanorecetors + 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 procces 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

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 positiion

DDx

- Intersegmental joint dysfunction
- Myofascial Pain
- Spondylolysis
- Spondylolisthesis
- Sprain/Strain
- Disc lesion
- F#/compression f#
- DJD/DDD
- Stenosis
- Neoplasm
- Infection
- Inflammatory Arthopathy
- 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
- Flexability 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 activites, sleep positions, shoe wear)
- Consider Radiofrequency ablation if: failure to show improvement with conservative care