

Maigne Syndrome

- Irritation of thoracolumbar posterior ramus - T9-L2
- Due to facet joint dysfunction & degeneration
- Superior cluneal nerve divided into medial, intermediate/middle, and lateral)
- Occurs at osteofibrous orifice - nerves penetrate thoracolumbar fascia before innervating cutaneous regions of iliac crest and buttock
- Increases neurodynamic tension on dorsal nerve root - ischemia and hyperexcitability
- Can co-exist with double crush
- Common in 55-68 yo population - slightly higher prevalence in females

Presentation

- LBP
- Pain, numbness/paresthesia to lumbosacral, iliac crest or groin
- Chronic, constant, unilateral (can be both sides)
- Can cause pseudovisceral pain (testicles)
- Aggravated by activities that stress the TL junction (slouching, prolonged walking, repeated/sustained extension) + transitional movements (arising from a seated position, squatting, rolling in bed)
- TTP of TL junction and site of entrapment
posterior iliac crest 3-4cm (medial branch)
7-8cm (middle branch) from the midline
- Side to side shear + PA shear painful
- Contralateral LF relieves
- Hyperextension movements (slump)
- Skin rolling/pinching over iliac crest can cause hyperalgesia over flank and iliac crest
- Tapping over entrapped nerve may produce shock like symptoms
- Assess for dysfunctional breathing - contributes to TL stress
- Assess for gait dysfunction (diminished/asymmetrical arm swing (loss of GH motion), loss of hip extension, short stride length)
- MP can reveal hyper/hypomobile of spine

Imaging

Not usually needed unless red flags are present

DDx

- Mechanical pathology of SI/LS (joint dysfunction, facet syndrome, disc lesion, spondylolysis, spondylolisthesis, degeneration, stenosis)
- Myofascial pain
- F#
- Infection
- Neoplasm
- Viscero-somatic referral - GU system (UTC, kidney stone)

As the TL junction pain is a red flag, caution should be advised



Management

- Electrical stimulation
- Ice
- NSAIDs
- If hypermobile - build stability - if hypomobile , open intervertebral foramen
- Myofascial release of TL aponeurosis + distribution of cluneal nerve
- Nerve mobilisation of dorsal rami and cluneal nerve
- Early rehab - flexibility exercises of erectors and iliopsoas
- Standing hip flexor stretch
- Half kneeling psoas stretch
- Lats stretches
- Pelvic tilt exercises
- Prone plank
- Core stability
- Dysfunctional breathing
- SMT/EMT of Lx, Tx, costovertebral regions
- Mulligan's NAGs/SNAGs
- Anesthetic nerve blocks and steroid injections if no improvement
- If no improvement with injections, surgery may be considered



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