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It's a rare adult who hasn't suffered from sciatica at one time or another. Yet when these people seek care, most clinicians immediately think of disk disease or entrapment of the nerve root in the lateral recess (spinal stenosis). Many physicians unfortunately tend to overlook some of the common nondiskogenic *causes of low back pain with radiation to the leg, thereby subjecting patients to unnecessary invasive diagnostic and therapeutic procedures.*

Sciatica may well be a symptom of disk disease or root entrapment, but it may also portend a host of other common disorders. Many physicians consider low back pain and sciatica to be vague syndromes. As a result, a patient with sciatica may receive only generic treatment: bedrest, muscle relaxants, analgesics, and physical therapy. If these do not work, the patient often seeks a second opinion, and the diagnostic workup continues. Sooner or later—and as costs mount—the insurance company requests a second opinion, and then a third. Often, the patient undergoes a myelogram, CT scan, or laminectomy—procedures that exact considerable expense and/or misery and that frequently prove unnecessary.[1]

The truth is that most causes of sciatica lend themselves to specific and less costly therapy. Physicians who look for the non-diskogenic causes of sciatica can often clinch the diagnosis—and relieve the patient's pain—on the spot. However, the estimated 8 million Americans who are victims of low back pain and sciatica currently incur $5-6 billion dollars annually in diagnostic and therapeutic costs, not to mention $14 billion per year in days lost from work, worker's compensation, disability payments, and litigation.[2]

Dr. Namey's article helps physicians diagnose and treat the nine entities most commonly confused with disk disease or nerve root entrapment in a cost-effective manner. He emphasizes the clinical features of these disorders and helps distinguish among them with a minimum of expensive and invasive tests. For each entity reviewed, Dr. Namey addresses the question of how to provide specific therapy in an outpatient setting and return the patient to optimum function.

—Editor's Note

DIFFERENTIAL DIAGNOSIS AND TREATMENT OF SCIATICA: THE NON-DISKOGENIC CAUSES

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The Non-Diskogenic Causes of Sciatica

To provide specific therapy for patients presenting with sciatica, physicians must consider a host of other syndromes that frequently mimic lumbar disk disease and go unrecognized. These conditions—sacroiliitis, piriformis syndrome, iliolumbar syndrome, quadratus lumborum syndrome, trochanteric bursitis, ischiogluteal bursitis, facet syndrome, meralgia parasthetica, and fibrositis syndrome—may exist separately or in tandem with another back disorder. Each of these conditions (with the exception of meralgia paresthetica) occurs more commonly than a herniated nucleus pulposis.

Patients may also present with more than one underlying cause of sciatica. Degenerative disk disease often accompanies the lateral entrapment syndrome. Likewise, sacroiliitis, spondylitis, and paraspinal spasm sometimes occur in the same patient. Most physicians are also aware that back pain can mask psychological problems. Patients who are anxious, covertly depressed, or suffering from intrapersonal conflicts often present with a chief complaint of back pain.

Sacroiliitis: Possible Harbinger of The Seronegative Spondyloarthropathies

At least 2-3% of the population suffers from sacroiliitis, a frequent initial manifestation of one of the seronegative spondyloarthropathies. Most patients, however, do not develop manifestations of overt spine disease other than "lumbago," an old term for sacroiliitis.

Pathogenesis. Sacroiliitis presents most commonly in young people who are HLA-B27 positive and/or have ankylosing spondylitis, psoriatic arthritis, Reiter's disease, or arthritis related to inflammatory bowel disease.[3,4] Reiter's disease commonly causes sacroiliitis in young men, which frequently precedes or follows heel pain, plantar fasciitis, metarsalgia, or knee problems.[5] A recent history of venereal infection (gonorrhea, *Chlamydia*, or both) is significant. Also, women with sacroiliitis often have had a recent episode of cystitis, cervicitis (possibly asymptomatic), or tubal infection.[6]

The piriformis muscle is frequently the major site of pain in classic sacroiliitis (due to inflammation of its insertion into the lower third of the SI joint). Thus, piriformis syndrome may also occur secondary to sacroiliitis, causing classic manifestations of sciatica and complicating diagnosis (see below).

Diagnosis. Though sacroiliitis' onset is usually subacute, patients often attribute its symptoms to trauma or work-related activities (the "simplest cause and effect"