Hamstring Tendinopathy

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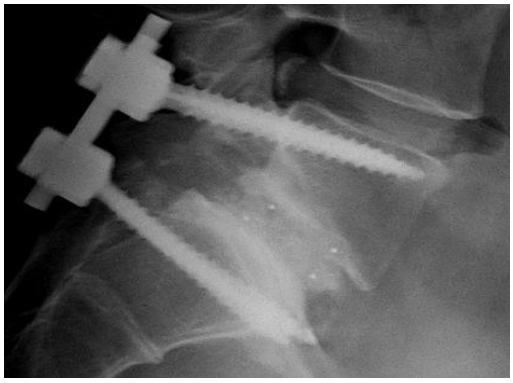
Interesting Case History – Hamstring Tendinopathy that almost led to Lumbar Spinal Fusion

'Fiona' had a one-year history of left SIJ / buttock and upper thigh pain. At times this extended into the lateral hip. The pain was aggravated by bending, particularly over the left hip. It was also aggravated by sitting, especially on hard or low chairs, or in the car. The lateral hip pain was aggravated by stairs, driving, and lying on either side at night. She saw a physiotherapist who prescribed flexion stretches and used lumbar traction. The stretches aggravated her pain. She was then referred to a neurosurgeon and subsequently for lumbar MRI. A previous X-ray & MRI revealed a Grade I spondylolisthesis at L5/S1, associated with disc degeneration and circumferential bulging. The report said this resulted in encroachment on the nerve roots bilaterally. The neurosurgeon recommended L5/S1 fusion.



What a lumbar spinal fusion looks like on a lateral X-Ray. Image Wikipedia

I saw Fiona soon after this. She was terrified at the prospect of facing spinal surgery and was hoping physiotherapy may be able to help her.

While she had a history of intermittent low back pain, this was not impacting on her daily life to any significant degree. The symptoms she described to me did not suggest lumbar spine referral. The pain was aggravated by direct compressive loading and deep hip bending. In addition, her pain was reproduced by palpation over the postero-lateral ischial tuberosity, and by resisted hamstring contraction with the hip flexed. She also had some tenderness of her gluteus medius insertion at the greater trochanter. I considered her pain to be due to hamstring origin tendinopathy, with mild gluteal tendinopathy. Fiona is peri-menopausal, and has a job that involves prolonged sitting. She also does a lot of driving. All of these factors were influencing her condition.

Treatment consisted of soft-tissue releases through the hamstring and posterior hip, and strengthening commencing with inner range isometric hip extension exercises. I recommended alterations to her seat including use of a wedge cushion at work. On her second visit I progressed her hip extension strengthening to short range isotonic exercises, and these have been progressed further at each visit.

I saw Fiona on 5 occasions between June and August. She noticed immediate improvement with her modified sitting, and has continued to improve on each occasion. On her last visit she reported being

95% recovered. She really only noticed the pain now if sitting on a hard surface. She could get around this by always having a portable dimple cushion with her.

Fiona gets intermittent low back pain, but manages this well. And the pain has not worsened over the past few years. I believe the findings on imaging were incidental, and this case demonstrates the pitfalls in basing diagnosis purely on imaging findings.

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