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世界中医药学会联合会

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国际中医临床实践指南

腰椎间盘突出症

International Guideline for Clinical Practice of Chinese Medicine
Lumbar Disc Herniation

(征求意见稿)

(Committee Draft)

世界中联国际组织标准
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前 言

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引 言

为适应中医药国际化的发展趋势和要求,促进中医医师管理的规范化建设,提高国际中医医师队伍的学术地位和整体素质,保障其合法权益,增加社会认可度,保证中医医疗质量和医疗安全,特制定本文件。

本文件的制定,既要重视与世界各国医师管理法律法规相协调,又要充分反映中医专业技术人员诊疗规律;既要考虑世界各国中医药专业技术人员的现实情况,又要利于未来国际中医医师队伍的健康发展;既要与国际中医医疗市场需求相适应,又要有利于中医药学术发展和事业发展。

本文件在分析各国医师医学专业技术的诊疗成功经验的基础上,从前瞻性地引领和规范国际中医医师诊疗的视角,科学、合理地确定了疾病规律和相关指标体系;是根据中医整脊学研究发现腰椎间盘突出症是椎曲紊乱及临床经验而制定的。

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国际中医临床实践指南 腰椎间盘突出症

1 范围

本文件规定了腰椎间盘突出症的诊断、治疗、护理与预防。

本文件适用于腰椎间盘突出症的诊断与治疗。

2 规范性引用文件

下列文件中的内容通过文中的规范性引用而构成本文件必不可少的条款。其中，注日期的引用文件，仅该日期对应的版本适用于本文件；不注日期的引用文件，其最新版本（包括所有的修改单）适用于本文件。

SCM 60-2021 国际中医临床实践指南 腰椎滑脱症

3 术语和定义

下列术语和定义适用于本文件。

3.1

腰椎间盘突出症

由于外力作用、劳损或感受风寒湿邪引起腰椎骨关节旋转、侧弯、椎曲改变，导致椎间盘突出椎间孔或椎管，刺激脊神经或脊髓；或因骨关节错位、椎间孔移位，导致神经根移位与椎间盘产生卡压，引起腰椎活动障碍、腰痛、下肢放射性疼痛和感觉、运动障碍的疾病。

注：腰椎间盘突出症，属中医“腰痛”、“腰骶痛”范畴。

4 诊断

4.1 诊断要点

4.1.1 病史

本病多发于青壮年，中老年人多为反复发作，往往有腰部外伤、积累性损伤或外感风寒湿邪等病史。

4.1.2 临床表现

4.1.2.1 症状

腰腿痛或单纯性腰痛或下肢放射痛。腰部活动受限、侧弯，站立、行走疼痛加重。

4.1.2.2 体征

患者常出现脊柱姿势的异常改变，如腰椎过度前屈、腰椎生理曲度平直或反张、腰椎侧凸。患者的脊柱前屈、后伸、侧屈及旋转等运动均可有不同程度的受限，尤以后伸疼痛最明显。一般在病变棘突间隙及椎旁 1~2cm 处，有明显压痛点，常引起下肢放射性疼痛。直腿抬高试验及加强试验阳性多提示腰 3~4、腰 4~5 或腰 5 骶 1 椎间盘突出，但阴性不能排除腰 3、4 以上的椎间盘突出。股神经牵拉试验阳性多提示腰 2~3 椎间盘突出。受压神经根所支配的皮肤节段会出现感觉的改变。先为感觉过敏，后为感觉迟钝或消失。股神经受压，则膝腱反射减低；骶 1 神经根受压，则跟腱反射减低。某些病程长、反复发作的患者常出现患侧股四头肌及小腿肌萎缩。

4.1.2.3 影像学检查

4.1.2.3.1 X 线检查

常规拍摄腰椎正侧位片。正位片可见椎体旋转、侧弯；侧位片可显示椎间隙变窄，椎曲变小甚至反弓，椎曲分级多为Ⅲ级、Ⅳ级或Ⅴ级。中老年患者多并有椎间盘退化、骨质增生，X 线检查还可以除外骨关节的破坏、转移癌、骨结核、肿瘤、脊柱的先天畸形等。

4.1.2.3.2 CT 检查

可观察到突出物的直接影像及与神经根、硬膜囊的相邻关系，并可了解椎管容积、黄韧带、神经根管等情况。同时，还可从横断面图像测量椎管和侧隐窝的容积。

4.1.2.3.3 MRI 检查

可判断椎间盘突出的大小和硬膜囊与神经根受压的程度。

4.1.2.4 物理检查

主要为肌电图检查，它可对受损神经根进行定位。部分患者病程较长时，可出现相应受神经支配的肌肉部分神经元损伤征象。

4.2 诊断要点

4.2.1 腰痛合并下肢放射性窜痛，或腰僵，下肢放射性麻痹、疼痛，或双下肢麻痹、疼痛，大小便无力。

4.2.2 直腿抬高试验阳性或弱阳性，加强试验阳性。

4.2.3 X 线摄片有某一椎间隙变窄，椎曲变小、甚至消失，椎体旋转、侧弯；CT、MRI 显示椎间盘突出。

4.3 诊断分型

腰椎间盘突出症的分型方法较多，目前尚无统一的分类。

4.4 鉴别诊断

4.4.1 退变性腰椎管狭窄症

该症多发于中年人，起病缓慢，主要症状为腰痛、腿痛及间歇性跛行，站立行走时症状加重，休息、下蹲时症状可减轻。一般 X 线摄片、脊髓造影或 CT 检查可明确诊断。

4.4.2 腰椎结核

部分腰椎结核患者可出现以腰痛或坐骨神经痛为主的临床表现，易与腰椎间盘突出症相混淆。但结核常为缓慢发病，进行性加重，无间歇期，多伴有午后潮热、全身乏力，身体逐渐消瘦，且实验室检查多有血沉加快，肺部多有原发病灶。X线摄片可发现椎间隙变窄，椎体边缘模糊不清，相应节段多有骨质破坏及寒性脓肿，有时可见腰椎小关节的破坏。

4.4.3 梨状肌综合征

其症状与腰椎间盘突出症很相似，但患者多无腰痛及脊柱体征，在梨状肌处有明显压痛及放射痛。直腿抬高试验抬腿 60° 以下疼痛明显，但超过 60° 疼痛减轻。梨状肌局部痛点封闭可使症状减轻或消失，此乃与腰椎间盘突出症的鉴别要点。

4.4.4 骶髂关节炎

其压痛在髂后上下嵴及骶髂关节处，骨盆分离、挤压试验均为阳性。X线摄片显示骶髂关节间隙模糊、硬化或狭窄。

4.4.5 马尾神经肿瘤

马尾神经肿瘤初期因侵及一条神经根，可出现根性痛，表现为腰痛、腿痛或腰腿痛，类似椎间盘突出的神经功能障碍。但肿瘤的生长是持续发展的，故其症状多呈渐发的持续性加重，无间歇，不因卧床休息而减轻。后期因肿瘤增大侵及多个神经根，故症状由一腿扩展到另一腿，出现双下肢自下而上的疼痛麻木，最终导致马鞍区麻木，直肠膀胱功能障碍，这与中央型椎间盘突出所出现的马尾神经障碍是不同的。马尾神经肿瘤患者腰穿多显示不完全或完全梗阻，且脑脊液检查蛋白含量增高，脊髓造影或磁共振检查可明确病变部位。

4.4.6 骶髂关节错缝症

多有骶尾部损伤史或生育后发病史，其压痛在髂后上下嵴及骶髂关节处，骨盆分离、挤压试验及“4”试验均为阳性。X线摄片显示骶髂关节间隙可不对称。

4.4.7 腰椎后关节错缝症

多有腰部扭转、闪腰或弯腰后立即直腰的病史，发病较急，伤后以腰部剧痛伴活动受限为主要症状，一般无神经刺激体征。X线摄片可见腰椎后关节排列不对称，腰椎侧弯或后凸，椎间隙左右不等宽等，但主要依据临床症状及体征。

5 辨证

5.1 湿热证

突发腰痛，腹胀，大便秘结，小便黄，舌苔黄腻，脉象弦滑或滑数。

5.2 血瘀证

腰腿疼痛如刺，痛有定处，日轻夜重，俯仰不便，转侧不能，咳嗽时加重，间有便结溏清，烦躁口干。舌质紫暗或有瘀斑，脉沉涩。

5.3 寒湿证

腰脊冷痛，肢冷无力，按有定处，有时觉下肢麻木重着，得寒痛剧，遇热痛减，溲溺清长。舌质淡，苔薄白或腻，脉沉紧。

5.4 风湿证

腰脊疼痛，痛引下肢，肌肤麻木，痛无定处，走窜不定，与天气变化有关，伴有微恶风寒。舌质淡，苔薄白或薄黄，脉虚细。

5.5 肾阳虚证

腰痛绵绵酸软，肢冷麻木无力，久治不愈，喜按喜揉，遇劳尤甚。常伴少腹拘急，面色白，畏寒，少气乏力。舌质淡，苔薄润，脉沉弱。

5.6 肾阴虚证

腰痛绵绵，酸软无力，久治不愈，遇劳则甚。常伴心烦不眠，口燥咽干，面色潮红，手足心热。舌红少苔，脉弦细数。

6 治疗

6.1 治疗原则

本病治疗首先宜卧床休息。可按急性期和缓解期分期论治，急性期以“理筋”为主，缓解期以理筋、调曲、练功为治疗原则，辨证施法。

6.2 治疗方法

6.2.1 急性期

6.2.1.1 刺血拔罐法

腰僵严重者，可选用腰部双侧腰肌刺血拔罐。

6.2.1.2 药熨法

在腰部和痛肢进行膏摩药熨。

6.2.1.3 针刺法

如可采用骨空针法，选用胸 12~腰 5 的华佗夹脊穴，加上髂、中髂，下肢选秩边、委中、承山、光明等穴位。

6.2.1.4 痛肢牵引

可采用二维调曲法，具体操作方法可参见附录 A。牵引时间为 30~40 分钟，每日 1 次。

6.2.2 缓解期

6.2.2.1 理筋疗法

可采用药熨法、推拿法、针刺法或针刀松解法治疗。可配合电针治疗，每日 1 次，每次 30 分钟，10 次为 1 个疗程，休息 1 日，再行第 2 个疗程。

6.2.2.2 正脊调曲疗法

6.2.2.2.1 正脊骨法

应用胸腰旋转法、腰椎旋转法、腰骶侧扳法调整椎体旋转，改善椎曲，操作方法、适应证及禁忌证可参见附录 B。

6.2.2.2.2 牵引调曲法

根据患者症状、椎曲改变，使用四维整脊牵引床辨证应用一维调曲法及四维调曲法以调整腰曲，操作方法可参照 SCM 60-2021 中附录 A.1 和 A.3 的具体要求进行操作。每日 1 次，10 次为一个疗程，休息 1 日，再行第二疗程。

6.2.2.2.3 调曲后路内镜下椎间盘切除术（PELD）及调曲经皮椎间孔镜下椎间盘切除术（PTED）

相对适应证为腰椎间盘突出症病史超过 6-12 周且经系统保守治疗 6-8 周后无效，或保守治疗过程中症状加重或反复发作；亦或是腰椎间盘突出症疼痛剧烈，或患者处于强迫体位，影响工作或生活。绝对适应证为腰椎间盘突出合并单根神经麻痹或马尾神经麻痹，或伴大、小便功能障碍。

上述两个方法，必须调曲，如果椎曲不改善，容易复发。

6.2.3 方药治疗

6.2.3.1 湿热证

治法：清热除湿，活血通便

主方：大成汤《理伤续断方》加减

6.2.3.2 血瘀证

治法：活血化瘀，理气止痛。

主方：身痛逐瘀汤（《医林改错》）加减。

6.2.3.3 寒湿证

治法：温经散寒，祛湿止痛。

主方：乌头汤（《金匱要略》）加减。

6.2.3.4 风湿证

治法：祛风除湿，宣痹通络。

主方：独活寄生汤（《备急千金要方》）加减。

6.2.3.5 肾阳虚证

治法：温补肾阳，通经活络，强筋壮骨。

主方：右归饮（《景岳全书》）加减。也可配合口服仙灵骨葆胶囊 [6, 7]。

6.2.3.6 肾阴虚证

治法：滋阴补肾，舒经活络，强筋壮骨。

主方：左归饮（《景岳全书》）加减。

6.2.4 外用药物

选用中医传统膏药，敷贴痛处。利于活血化瘀，改善循环。

6.2.5 练功疗法

常用的练功疗法有“健脊强身十八式”中的第十三式、第十四式和第十五式。

7 注意事项

7.1 一般2个疗程显效，复查X线摄片观察椎曲恢复程度，临床疗效观察为2~4疗程。

肌肉神经功能恢复需自主练功。

7.2 急性疼痛期不宜手法治疗。

7.3 不宜麻醉下行正骨推拿法治疗。

8 护理

8.1 医务人员及家属应向患者说明发生本病的原因及治疗方法，充分调动患者的主观能动性，坚持正确的治疗方向，争取早日康复。

8.2 许多腰椎间盘突出症患者发病与长期不良姿势相关，故应指导此类患者以卧姿为主。

8.3 急性期患者要绝对卧床休息，宜卧硬板床。下床活动佩带腰围。

8.4 注意保暖，避免受凉，夏季尽量避免使用空调。

8.5 翻身活动时注意全身以脊柱为轴缓缓滚动，下床时要俯卧位，一侧先着地，另一侧再着地，然后全身站起。坐起及如厕时要佩戴腰围，以减轻椎间盘的压力，保持脊椎骨之间的稳定关系，减轻疼痛。

8.6 患者在进行各种治疗前后不要进食过多，防止过饱。

8.7 腰椎间盘突出症有些患者久治不愈或反复发作，情绪抑郁或焦虑，甚至失眠，需及时开导，必要时找心理咨询师疏导。

9 预防

9.1 改正不良的劳动和生活姿势。

9.2 改善居住环境，避免久卧湿地，做到饮食起居有节。

9.3 加强腰背肌及腹肌的功能锻炼。

附录 A
(资料性)

治疗腰椎间盘突出症常用的正脊手法和牵引调曲法

A.1 常用的正脊手法

A.1.1 腰骶侧扳法

A.1.1.1 操作方法

患者取侧卧位。以左侧卧位为例，医者面向患者站立，右手或前臂置于患者右腋前，左手前臂置于患者右臀部，在患者充分放松情况下，两手相对同时瞬间用力，力的交点在腰骶枢纽关节处。右侧卧位与此相反。

A.1.1.2 适应证

腰骶侧扳法的适应证包括腰椎后关节错缝症、腰椎间盘突出症、腰骶后关节病、骶髂关节错缝症。

A.1.1.3 禁忌证

A.1.1.3.1 不明确诊断，未排除骶骨、髂骨结核、肿瘤者。

A.1.1.3.2 椎弓峡部不连、椎弓崩解、椎体滑脱者。

A.1.1.3.3 骨质疏松患者。

A.1.1.3.4 孕妇。

A.1.1.3.5 胸腰椎手术后。

A.1.3.4 注意事项

A.1.1.3.4.1 侧卧体位，躯体和下肢在一中轴线上。

A.1.1.3.4.2 如怀疑一侧椎间孔压迫神经根者，应取健侧卧位，而且不宜左右侧扳。

A.1.1.3.4.3 腰僵者慎用。

A.1.2 过伸压盆法

A.1.2.1 操作方法

患者取俯卧位，医者立于患侧，用一肘托起患侧大腿，使其后伸，另一手与托腿手相握，肘部按压患侧骶髂关节处，后慢慢使患侧下肢后伸至极限，按压之手肘部稍用力往下按压，听到“咯嗒”声，复位成功。

A.1.2.2 适应证

过伸压盆法的适应证包括骶髂关节错缝症、腰骶后关节病、骨盆倾斜者。

A.1.2.3 禁忌证

同腰骶枢纽侧扳法禁忌证（见 A1.1.3）。有髋关节病变者也不可使用时过伸压盆法进行治疗。

A.1.4.5 注意事项

后伸下肢注意保护髋关节，防止过伸导致股骨颈骨折。

A. 1. 3 手牵顶盆法

A. 1. 3. 1 操作方法

患者侧卧位，患侧在上，健侧屈膝，医者用一足跟蹬住健侧小腿，双手握住患侧踝部，待患者放松后，手足同时协调突然用力上牵下蹬动作。

A. 1. 3. 2 适应证

同过伸压盆法适应证的相关要求（见 A.1.2.2）。

A. 1. 3. 3 禁忌证

A. 1. 3. 3. 1 诊断不明者。

A. 1. 3. 3. 2 椎弓裂、脊椎滑脱者。

A. 1. 3. 3. 3 孕妇。

A. 1. 3. 3. 4 有下肢疾患者慎用。

A. 1. 3. 4 注意事项

患者身体与下肢保持在同一水平位，手足用力协调。

A. 2 诊断分型

A. 2. 1 椎间孔型

椎间盘突出于后外侧椎间孔部位，压迫神经根。症见单下肢放射性疼痛、麻痹。直腿抬高试验阳性。CT 检查可显示椎间盘突出压迫椎间孔。

A. 2. 2 退化刺激型

椎间盘退化，自身的炎症刺激脊神经，引起以腰痛，并单下肢放射性麻痹。直腿抬高试验阳性或弱阳性，此类型往往反复发作。X 线摄片椎曲轻度改变，侧弯不明显；有唇样增生，CT、MRI 检查可显示突出的椎间盘是否破坏或有囊性气泡。

A. 3 牵引调曲法

A. 3. 1 仰卧骨盆牵引法

A. 3. 1. 1 操作方法

患者仰卧在牵引床上，将上端牵引带束于胸下部，下端牵引带束于髌骨上，然后根据病情、体重等来调整重量进行纵轴牵引。

牵引时间为 30-40 分钟，牵引重量为 20-40 公斤，每日 1-2 次。临床上牵引时间和重量均从最小值逐渐增加作持续性牵引，儿童患者据体重酌减，最大牵引力不能超过体重的二分之一。

A. 3. 1. 2 适应证

A. 3. 1. 3. 1 胸、腰、骨盆损伤。

A. 3. 1. 3. 2 腰骶关节移位，腰 4、5 椎体旋转位移者。

A. 3. 1. 3. 3 青年人腰椎间盘突出症。

A. 3. 1. 3. 4 腰椎后关节错缝。

A. 3. 1. 3. 5 腰骶关节病

A. 3. 1. 4 禁忌证

A. 3. 1. 4. 1 诊断不明确，未具备 X 线照片诊断骨关节力学改变者。

A. 3. 1. 4. 2 腰椎间盘突出症急性期牵引后疼痛加重者。

A. 3. 1. 4. 3 合并严重高血压、心脏病、哮喘及甲亢者。

A. 3. 1. 4. 4 孕妇及严重骨质疏松患者。

A. 3. 1. 4. 5 腰椎手术后患者。

A. 3. 1. 4. 6 脊柱骨结核。

A. 3. 1. 4. 7 脊柱骨髓炎。

A. 3. 1. 4. 8 脊柱骨肿瘤。

A. 3. 1. 5 注意事项

A. 3. 1. 5. 1 禁用突发性牵引。

A. 3. 1. 5. 2 慎用在牵引时扭转骨盆。

A. 3. 1. 5. 3 牵引时密切关注患者感觉，牵引重量不能过重。

A. 3. 1. 5. 4 牵引后需卧床休息与牵引相同的时间。

A. 3. 2 二维调曲法

A. 3. 2. 1 操作方法

患者俯卧于四维脊柱牵引仪上，按照一维调曲法固定好上、下两端牵引带，然后用单下肢牵引带束于有症状的下肢，并使其外展 30°角，如图 A.1 所示。先按照一维调曲法调整好重量，牵引重量为 20-40 公斤，再调整痛肢牵引重量至 6-8 公斤，儿童患者重量酌减。牵引调整好重量后，根据患者腰椎曲度异常情况，进行加压调曲治疗，可参见 SCM60 附录 A.1 的一维调曲法进行操作。牵引时间为 30-40 分钟，每日 1 次。



图 A. 1 二维调曲法示意图

A. 3. 2. 2 适应证

二维调曲法的适应证包括腰椎间盘突出症伴有单侧下肢麻木或疼痛者；腰椎滑脱症伴有单侧下肢麻木或疼痛者；腰椎管狭窄症伴有单侧下肢麻木或疼痛者；脊柱侧弯症骨盆倾斜者。

A. 3. 2. 3 禁忌证

同仰卧骨盆牵引法禁忌证（见 A3.1.4）。

A. 3. 2. 4 注意事项

应符合 SCM 60 中附录 A.1.4 的要求。患肢有严重骨性关节炎病者应慎用。

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ANNEX A (Informative) Common spinal orthopedic techniques and traction
adjusting spine curvature therapy

Bibliography

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Foreword

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Introduction

This document is formulated to adapt to the trend and requirements of the internationalization of traditional Chinese medicine, promote the standardization of TCM physician management, improve the academic status and overall quality of the international team of TCM physicians, protect their legitimate rights and interests, increase their social recognition, and ensure the quality and safety of traditional Chinese medicine.

The formulation of this document should: first, coordinate with the laws and regulations on physician management in the world, and meanwhile fully respect the diagnosis and treatment rules of TCM professionals. Second, take into account the actual situation of TCM professionals in the world, and be conducive to the development of the international team of TCM physicians in the future. Third, adapt to the needs of the international TCM market, and be conducive to the academic and cause development of traditional Chinese medicine.

On analyzing the successful experiences of doctors from various countries in using medical expertise, this document scientifically determines the rules of the disease and relevant index system with the aim of guiding and standardizing the approaches of diagnosis and treatment of international TCM physicians. This document is made based on the TCM spinal orthopedics's findings that lumbar disc herniation originates from spine curvature disorder and the relevant clinical experiences.

The issuing authority of this document should note that the conformity of declaration with this document may involve the use of patents related to “spinal orthopedic and spine curvature adjusting traction bed”.

The issuing authority of this document has no position on the authenticity, validity and scope of the patent.

The patent holder has assured the issuing authority of this document that he is willing to negotiate with any applicant on patent licensing if given reasonable and non-discriminatory terms and conditions. The statement of the patent holder has been filed with the issuing authority of this document. Relevant information can be obtained through the following contact information:

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Please note that in addition to the above patents, some other contents of this document may involve the use of patents. The issuing authority of this document does not bear the responsibility of identifying patents.

International Guideline for Clinical Practice of Chinese Medicine Lumbar Disc Herniation

1 Scope

This document specifies the diagnosis, treatment, nursing, and prevention of lumbar disc herniation.

This document applies to the clinical diagnosis and treatment of lumbar disc herniation.

2 Normative references

The following referenced documents are indispensable for the application of this document. For dated references, only the dated edition applies. For undated references, the latest edition of the referenced document (including any amendments) applies.

SCM 60-2021 International Guidelines for Clinical Practice of Chinese Medicine Lumbar Spondylolisthesis

3 Terms and definitions

For the purposes of this document, the following terms and definitions apply.

3.1

Lumbar disc herniation

Exogenous factors, strain, or being attacked by wind, cold and dampness evils lead to the rotation and lateral bending of lumbar vertebrae joints and changes in spine curvature, resulting in the lumbar disc herniating from the intervertebral foramen or spinal canal, stimulating spinal nerves or spinal cord. Or, the dislocation of bone joints, displacement of intervertebral foramen lead to the displacement of nerve roots that causes compression to the lumbar disc, resulting in lumbar movement disorders, low back pain, radiating pain in lower limbs, sensation disorders, and movement disorders.

Note: Lumbar disc herniation falls into the category of "low back pain" and "hip pain" in traditional Chinese medicine.

4 Diagnosis

4.1 Key points of diagnosis

4.1.1 Past medical history

The disease mostly occurs in young adults, and becomes recurrent for middle-aged and elderly people who often have waist traumas, cumulative injuries, been attacked by exogenous wind, cold and dampness evils, or other history.

4.1.2 Clinical manifestations

4.1.2.1 Symptoms

Low back and leg pain, simple low back pain, or radiating pain in lower limbs, limited waist movements, scoliosis, and pain worse when standing and walking.

4.1.2.2 Physical signs

The patients often have abnormal changes in the spine position, such as hyperlordosis, straight or reverse lumbar physiological curvature, and scoliosis. The movements of the spine such as flexion, extension, lateral flexion and rotation are limited to varying degrees. The pain is most obvious when doing extension. Generally, there are obvious tenderness spots in the interspace of diseased spinous process and 1-2cm beside the vertebrae. This often causes radiating pain in lower limbs. The positive results in the straight leg raise test usually indicate herniated intervertebral disc L3-4, L4-5, or L5 S1, but the negative results cannot exclude the herniation of intervertebral disc above L3 and L4. The positive results in the femoral nerve stretching test usually indicate L2-3 disc herniation. The dermatomes supplied by the compressed nerve roots will experience sensory changes. The changes are initially hyperesthesia, and then dysesthesia or anesthesia. Compressed femoral nerve will lead to decreased knee-jerk reflex. Compressed S1 nerve root will lead to decreased achilles tendon reflex. Quadriceps femoris muscle amyotrophy and calf muscle amyotrophy often occur in patients with long courses and recurrent episodes.

4.1.2.3 Imaging tests

4.1.2.3.1 X-ray

Take routine front and lateral radiographs of the lumbar. Vertebral rotation and scoliosis can be seen in front radiographs. Narrowed intervertebral space, and decreased and even reverse spine curvature can be seen in lateral radiographs. Most of the spine curvature grades are grade III, grade IV or grade V. Middle-aged and elderly patients mostly have intervertebral disc degeneration and hyperostosis. X-ray examination can also exclude bone joints rupture, metastatic cancer, bone tuberculosis, tumor, congenital spinal malformation, etc.

4.1.2.3.2 CT

To observe the direct radiography of the protrusion and its positional relationship with nerve roots and dural sacs. To know about the volume of spinal canal, the condition of ligamentum flavum and nerve root canal, etc. At the same time, the volume of spinal canal and lateral recess can be measured from cross-sectional images.

4.1.2.3.3 MRI

To tell the size of intervertebral disc herniation and the degree of dural sac and nerve root compression.

4.1.2.4 Physical examinations

Mainly electromyography (EMG), which locates the damaged nerve roots. Neuron injury in the corresponding muscles of damaged nerves may appear in patients with longer courses.

4.2 Key points of diagnosis

4.2.1 Low back pain combined with radiating scurrying pain in lower limbs, low back stiffness, radiating paralysis and pain in lower limbs, paralysis and pain in both lower limbs, and weak urination and defecation in some cases.

4.2.2 Positive or weak positive in the straight leg raise test, and positive in the strengthening test.

4.2.3 A narrowed intervertebral space, decreased or even absent spine curvature. Finding vertebral rotation and scoliosis in X-ray radiographs and intervertebral disc herniation with CT and MRI.

4.3 Diagnosis classification

There are many classification methods of lumbar disc herniation, and there is no unified classification at present.

4.4 Differential diagnosis

4.4.1 Degenerative lumbar spinal stenosis

This disease occurs mostly in middle-aged people and starts slowly. The main symptoms include low back pain, leg pain, and intermittent claudication. The symptoms aggravate when standing and walking, and relieve when resting and squatting. General X-ray, myelography or CT examination can make a definite diagnosis.

4.4.2 Lumbar spine tuberculosis

Some patients with lumbar spine tuberculosis may have low back pain or sciatica, which makes lumbar spine tuberculosis is easily being confused with lumbar disc herniation. But tuberculosis often has a slow onset, progresses with no intermission, and is often accompanied with hot flashes in the afternoon, fatigue, and gradual weight loss. Accelerated ESR and primary lesions in the lung can be found by laboratory examinations. Narrowed intervertebral space and blurred edge of vertebrae can be seen in X-ray radiographs. Usually, bone destruction and cold abscess can be found in corresponding segment. And sometimes there are lumbar facet joint injuries.

4.4.3 Piriformis syndrome

The symptoms are similar to those of lumbar disc herniation, but most of the patients have no low back pain or spinal signs, and have obvious tenderness and radiating pain at piriformis muscle. In the straight leg raise test, the pain is obvious below 60 °, but eases above 60 °. Local block on piriform muscle can relieve or eliminate the symptoms. It is the key point to differentiate piriformis from lumbar disc herniation.

4.4.4 Sacroillitis

Tenderness is found in the posterior superior and inferior iliac spine and the sacroiliac joint. Positive in pelvic separation and compression tests. X-ray shows blurred, sclerotic or narrow sacroiliac joint space.

4.4.5 Cauda equina tumor

Cauda equina tumor may cause radicular pain in the early stage due to invading a nerve

root. The manifestations are low back pain, leg pain (or both), and nervous functioning disorders similar to intervertebral disc herniation. But the growth of tumor is continuous, so the symptoms often progress gradually with no intermission, and do not reduce because of bed rest. In the late stage, the tumor enlarges and invades multiple nerve roots, so the symptoms will extend from one leg to the other, resulting in pain and numbness in both lower limbs from bottom to top, and eventually leading to saddle anesthesia and rectum and bladder dysfunction. This is different from cauda equina nerve dysfunction caused by central intervertebral disc herniation. Lumbar puncture in patients with cauda equina tumor shows incomplete or complete obstruction, and increased protein in cerebrospinal fluid. Myelography or MRI could determine the diseased location.

4.4.6 Sacroiliac joint dislocation

Most of the patients have a history of sacrococcygeal injury or postpartum morbidity. Tenderness is found in the posterior superior and inferior iliac spine and the sacroiliac joint. Positive in pelvic separation and compression tests and "4" test. And X-ray shows asymmetric sacroiliac joint space.

4.4.7 Lumbar posterior joint dislocation

Most of the patients have a history of straightening their waist immediately after twisting the waist, having a lumbar sprain, or bending. The onset of the disease is acute. The main symptoms are severe low back pain accompanied with limited movement. Generally, there are no signs of nerve stimulation. X-ray shows asymmetric lumbar posterior joints, lumbar scoliosis or kyphosis, and the intervertebral space being uneven in width. But the diagnosis should be mainly based on clinical symptoms and signs.

5 Syndrome differentiations

5.1 Damp heat syndrome

Sudden low back pain, abdominal distention, constipation, yellow urine, yellow and slimy tongue fur, string like and slippery pulse or slippery and rapid pulse.

5.2 Blood stasis syndrome

Low back and leg pain like being stabbed, pain with a fixed location, mild pain during daytimes and severe at night, difficult to bend forward and backward, and unable to turn sides, the pain gets worse when coughing, constipation, clear urine, dysphoria, and dry mouth occasionally, dark purple tongue or having ecchymosis, deep and rough pulse.

5.3 Cold damp syndrome

Cold pain in the back. Cold and weak limbs. The pain has a fixed location when being pressed, and aggravates by cold and relieves by heat. Feeling numb and heavy in lower limbs occasionally. Clear and long urine. Pale tongue, thin and white(or slimy) tongue fur, deep and tight pulse.

5.4 Wind damp syndrome

Back pain extending to lower limbs, numbness in the skin, pain without fixed location and worse with the weather change, mild aversion to wind or cold, pale tongue, thin and white tongue fur or thin and yellow tongue fur, vacuous and fine pulse.

5.5 Kidney-yang deficiency syndrome

Continuous low back soreness and pain. Cold, numb and weak limbs. Fail to recover after long-term treatments. The location of pain likes pressure and rubbing, and the pain aggravates by physical work. Often accompanied with hypogastric spasm, pale face, fearing of cold, asthenic breathing, and fatigue. Pale tongue, thin and moist tongue fur, deep and weak pluse.

5.6 Kidney-yin deficiency syndrome

Continuous low back soreness, pain, and weakness. Fail to recover after long-term treatments, and the symptoms aggravates by physical work. Often accompanied with vexation, insomnia, dry mouth and pharynx, tidal reddening of the face, and heat in the heart of the palms and soles. Red tongue with little tongue fur and stringlike fine rapid pulse.

6 Treatment

6.1 Principles of treatment

The primary treatment of this disease is bed rest. The treatment can be divided into acute phase and remission phase. In acute phase, tendon regulation is the main treatment method, while in remission phase, the principles of treatment are tendon regulation, curvature regulation, and exercise therapy.

6.2 Treatment

6.2.1 Acute phase

6.2.1.1 Blood pricking and cupping therapy

Blood pricking and cupping therapy in left and right lumbar muscles can be performed for patients with severe low back stiffness.

6.2.1.2 Medicated ironing therapy

Apply ointment and perform medicated ironing therapy to the waist and painful limbs.

6.2.1.3 Acupuncture

For example, use bone hollow acupuncture. Acupuncture Hua Tuo's paravertebral points in T12-L5, Shangliao (BL31), Shangliao (BL31), and Zhibian (BL54), Weizhong (BL40), Chengshan (BL57), Guangming (GB37) in lower limbs, and other acupuncture points.

6.2.1.4 Traction on painful limbs

Two-dimensional curvature regulation can be used. See Annex A for detailed operation methods. The traction time is 30-40min, and once every day.

6.2.2 Remission phase

6.2.2.1 Tendon regulation therapy

Medicated ironing therapy, Tuina, acupuncture, or acupotomylysis can be used. Electro-acupuncture can be added into the treatment. The treatment should be given once a day and 30 minutes each time. 10 times forms a course of treatment, and after 1 day of rest, perform the second course of treatment.

6.2.2.2 Spinal orthopedics and curvature regulation therapy

6.2.2.2.1 Spinal orthopedics therapy

Use thoracolumbar rotation method, lumbar rotation method and lumbosacral side-boarding method to adjust vertebral rotation and improve vertebral curvature. See Annex B for operation methods, indications, and contraindications.

6.2.2.2.2 Traction adjusting spine curvature

According to the symptoms and changes in the spine curvature of the patient, use four-dimensional traction bed to perform one-dimensional curvature regulation therapy or four-dimensional curvature regulation therapy. See Annex A.1 and A.3 in SCM 60-2021 for operation methods. The treatment should be given once a day. 10 times forms a course of treatment, and after 1 day of rest, perform the second course of treatment.

6.2.2.2.3 Percutaneous endoscopic lumbar discectomy (PELD) and percutaneous transformational endoscopic discectomy (PTED) after curvature regulation

Relative indications: 6-8 weeks of systematic conservative treatment fails for patients with over 6-12 weeks of history of lumbar disc herniation; the symptoms aggravate or reoccur during conservative treatment; severe pain caused by lumbar disc herniation; being in a compulsive position that affects work and life. Absolute indications: lumbar disc herniation accompanied with mononeural paralysis or cauda equina paralysis, probably accompanied with urination and defecation disorders.

The two methods above must be used with curvature regulation. The symptoms are very likely to reoccur if spine curvature is not improved.

6.2.3 Prescriptions treatment

6.2.3.1 Damp heat syndrome

Therapeutic methods: Clear heats, eliminate dampness, quicken the blood, and promote bowel movements.

Main prescription: modified Dacheng decoction (*Prescription for Treating Injuries and Mending Breakages*).

6.2.3.2 Blood stasis syndrome

Therapeutic methods: promote blood circulation and remove blood stasis, rectify qi and relieve pain.

Main prescription: modified Shentong Zhuyu decoction (*Corrections on the Errors of Medical Works*).

6.2.3.3 Cold damp syndrome

Therapeutic methods: warm meridians and disperse cold, dispel dampness and relieve pain.

Main prescription: modified Wutou decoction (*Synopsis of Prescriptions of the Golden Chamber*).

6.2.3.4 Wind damp syndrome

Therapeutic methods: dispel wind and eliminate dampness, remove obstruction and free the collaterals.

Main prescription: modified Duhuo Jisheng decoction (*Valuable Prescriptions for Emergency*).

6.2.3.5 Kidney-yang deficiency syndrome

Therapeutic methods: warm and tonify kidney yang, free channels and activate collaterals, strengthen tendons and bones.

Main prescription: modified Yougui Yin (*Jing Yue's complete work*). Or combine with taking Xian-Ling-Gu-Bao capsule orally [6, 7].

6.2.3.6 Kidney-yin deficiency syndrome

Therapeutic methods: nourish yin and the kidney, free channels and activate collaterals, strengthen tendons and bones.

Main prescription: modified Zuogui Yin (*Jing Yue's complete work*).

6.2.4 Topical medication

Apply traditional Chinese medicine plaster to locations of pain. It helps promote blood circulation, remove blood stasis, and improve circulation.

6.2.5 Exercise therapy

The commonly used exercise therapies include the 13th, 14th and 15th of the "18 exercises to strengthen the spine and body".

7 Matters needing attention

7.1 Generally, effect can be seen after 2 courses of treatment. Observe the recovery degree of spine curvature with X-ray. The clinical therapeutic effect should be observed for 2-4 courses. The recovery of muscle and nerve function needs independent exercise.

7.2 Manipulation is not suitable in acute phase.

7.3 Spinal orthopedics therapy and Tuina should not be performed with anesthesia.

8 Nursing

8.1 Medical staffs and the patient's families should explain the cause and treatment of the disease to the patient, in order to motivate the patient to adhere to the correct treatment

and strive for an early recovery.

8.2 The lumbar disc herniation of many patients is caused by long-term bad posture, so such patients should be guided to mainly use lying position.

8.3 Patients in acute phase should have absolute bed rest and preferably lie on hard beds. The patient should wear a waist support belt in out-of-bed activities.

8.4 Keep the patient warm to avoid getting cold. Better to avoid using air conditioner in summer.

8.5 When turning over, roll the body slowly with the spine as the axis. When getting out of bed, stay in prone position, let one leg touches the ground first, then the other, and then stand up. Wear a waist support belt when sitting up and going to the bathroom to reduce the pressure to intervertebral disc, maintain stability in vertebrae, and relieve pain.

8.6 The patient should not eat too much before and after various treatments.

8.7 Some patients who couldn't recover after long-term treatments or have recurrent diseases may experience depression, anxiety, and even insomnia. They need to be comforted in time. If necessary, advise them to go to a psychological counselor.

9 Prevention

9.1 Correct bad posture in physical work and life.

9.2 Improve the living environment, avoid lying in the wetland for a long time, and have a regular routine and diet.

9.3 Strengthen the functional exercise of lumbodorsal and abdominal muscles.

WUJIAO

Annex A
(Informative)
Common spinal orthopedic techniques and traction adjusting spine curvature therapy in treating lumbar disc herniation

A.1 Common spinal orthopedic techniques

A.1.1 Lumbosacral side-boarding

A.1.1.1 Operation methods

Lay the patient to lateral position. Take left lateral position as an example, the doctor stands facing the patient, puts his right hand or forearm in front of the patient's right armpit, and puts his left forearm on the patient's right hip. When the patient is relaxed, exert force at opposite directions with two hands at the same time, and the intersection of force is at the lumbosacral joint. The operation in right lateral position is the opposite.

A.1.1.2 Indications

The indications of lumbosacral side-boarding include lumbar posterior joint dislocation, lumbar disc herniation, posterior lumbosacral arthropathy, and sacroiliac joint dislocation

A.1.1.3 Contraindications

A.1.1.3.1 Patients with unclear diagnosis. Patients who have not excluded sacral tuberculosis, iliac tuberculosis, and tumor.

A.1.1.3.2 Patients with vertebral arch disconnection, spondylolysis, and spondylolisthesis.

A.1.1.3.3 Patients with osteoporosis.

A.1.1.3.3 Pregnant women.

A.1.1.3.5 After thoracolumbar surgery.

A.1.3.4 Matters needing attention

A.1.1.3.4.1 In lateral position, the body and lower limbs should share a central axis.

A.1.1.3.4.2 If it is suspected that the nerve root is compressed by one side of intervertebral foramen, the position on uninjured side should be taken, and do not pull the patient in left and right directions.

A.1.1.3.4.3 Patients with low back stiffness should use with caution.

A.1.2 Lumbosacral hyperextension and pelvic pressing

A.1.2.1 Operation methods

Lay the patient in prone position. The doctor stands on the diseased side, holds up the thigh of the side with one elbow to extend it backward, holds the two hands together, presses the sacroiliac joint of the diseased side with the elbow, then slowly extends the lower limb of the side backward to the limit, presses the elbow with a little force downward. And the reduction is successful on hearing a clicking sound.

A.1.2.2 Indications

The indications of Lumbosacral hyperextension and pelvic pressing include sacroiliac joint dislocation, posterior lumbosacral arthropathy, and pelvic tilt.

A.1.2.3 Contraindications

Same as the contraindications of lumbosacral side-boarding (refer to A1.1.3). Patients with hip joint disease should not use this method.

A.1.2.4 Matters needing attention

Protect the hip joint while extending the lower limb backward to prevent femoral neck fracture caused by hyperextension.

A.1.3 Pelvic pulling with hands while against with foot

A.1.3.1 Operation methods

Lay the patient in lateral position with diseased side up and knee on uninjured side bent. The doctor pedals the calf of the healthy side with one heel, and holds the ankle of the diseased side with both hands. After the patient is relaxed, pulling with hands while against with foot at the same time.

A.1.3.2 Indications

Same as those of lumbosacral hyperextension and pelvic pressing (refer to A.1.2.2).

A.1.3.3 Contraindications

A.1.3.3.1 Patients with unclear diagnosis.

A.1.3.3.2 Patients with spondylolysis and spondylolisthesis.

A.1.3.3.3 Pregnant women.

A.1.3.3.4 Patients with lower limb diseases should use it with caution.

A.1.3.4 Matters needing attention

The patient's body and lower limbs should be kept at the same level, and the hands and feet should exert force at the same time.

A.2 Diagnostic classification

A.2.1 Intervertebral foramen type

The intervertebral disc protrudes from the posterolateral intervertebral foramen and compresses the nerve root. Symptoms include radiating pain and paralysis in unilateral lower limb. Positive in the straight leg raise test. Finding herniated intervertebral disc compresses intervertebral foramen in CT scan.

A.2.2 Degenerative stimulus type

Degenerated intervertebral disc and inflammation stimulate spinal nerves, leading to low back pain and radiating paralysis in unilateral lower limb. Positive or weak positive in the

straight leg raise test. This type often reoccur repeatedly. X-ray shows slight changes in spine curvature and unobvious scoliosis. The patient may have lip-like hyperplasia. CT and MRI can show whether the herniated intervertebral disc is injured or has cystic bubbles.

A.3 Traction adjusting spine curvature

A.3.1 Supine pelvic pulling

A.3.1.1 Operation methods

Lay the patient in supine position on the traction bed; attach the upper traction band on the lower chest and the lower traction band to the iliac bone. Adjust the weight of longitudinal traction based on the patient's condition and weight.

The traction time is 30-40 minutes and the traction weight is 20-40kg. The traction should be performed 1-2 times a day. The traction time and weight should be gradually and continuously increased from the minimum value. For children, reduce the weight according to the weight of the child, and the maximum traction force should not exceed half of the body weight.

A.3.1.2 Indications

A.3.1.3.1 Thoracic, lumbar and pelvic injuries.

A.3.1.3.2 Lumbosacral joint displacement, and L4, 5 vertebral rotation displacement.

A.3.1.3.3 Lumbar disc herniation in young people.

A.3.1.3.4 Lumbar posterior joint dislocation.

A.3.1.3.5 Lumbosacral arthropathy.

A.3.1.4 Contraindications

A.3.1.4.1 Patients with unclear diagnosis. Patients with no X-ray radiograph to diagnose bone joint dynamic changes.

A.3.1.4.2 Patients with acute lumbar disc herniation whose pain aggravates after traction.

A.3.1.4.3 Patients with severe hypertension, heart disease, asthma and hyperthyroidism.

A.3.1.4.4 Pregnant women and patients with severe osteoporosis.

A.3.1.4.5 Patients who just had lumbar surgeries.

A.3.1.4.6 Patients with spinal tuberculosis.

A.3.1.4.7 Patients with spinal osteomyelitis.

A.3.1.4.8 Patients with spinal bone tumor.

A.3.1.5 Matters needing attention

A.3.1.5.1 Sudden traction is forbidden.

A.3.1.5.2 Be cautious with twisting the pelvis during traction.

A.3.1.5.3 Pay close attention to the feeling of the patient during traction, and the traction

weight should not be too heavy.

A.3.1.5.4 The patient should have bed rest for the same time as the traction.

A.3.2 Two-dimensional traction

A.3.2.1 Operation methods

Lay the patient in prone position on the four-dimensional spinal traction instrument. Attach the upper and lower traction band according to one-dimensional traction method, and attach then the unilateral lower limb traction band to the diseased lower limb and make it abduct 30°. (See Figure A.1) Adjust the traction weight according to one-dimensional traction method. The traction weight is 20-40kg, and then adjusts the traction weight on painful limbs to 6-8kg. The traction weight for children should be reduced. Then perform pressure curvature regulating treatment according to the condition of the patient's abnormal lumbar curvature. Refer to the one-dimensional traction method in Annex A.1 of SCM60 for operation. The traction time is 30-40min, and the traction should be performed once every day.



A.3.2.2 Indications

The indications of two-dimensional traction include lumbar disc herniation accompanied with unilateral lower limb numbness or pain. Lumbar spondylolisthesis accompanied with unilateral lower limb numbness or pain. Lumbar canal stenosis accompanied with unilateral lower limb numbness or pain. Scoliosis with pelvic tilt.

A.3.2.3 Contraindications

Same as the contraindications of supine pelvic pulling (refer to A3.1.4).

A.3.2.4 Matters needing attention

It shall meet the requirements of Annex A.1.4 in SCM 60. Use with caution in patients

with severe osteoarthritis in diseased limbs.

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