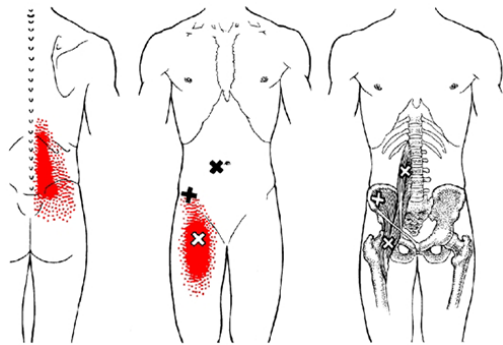


THE LOW BACK MASQUERADERS

Two structures that cause low back pain after a crash, and are almost never the ones being treated

Most low back pain after a collision gets attributed to the disc. The MRI is ordered, a bulge is found (they are found in most adults), and treatment aims there. Meanwhile two other structures, both of which refer pain into the low back and leg, go unexamined. They are the psoas and the sacroiliac joint. They are the masqueraders.

Masquerader One: The Psoas



Anatomy:

The iliopsoas is two muscles, the psoas major and the iliacus. They are the primary hip flexors, but the psoas also attaches directly to the lumbar discs and vertebrae.

Why that matters:

Because of that attachment, the psoas is a massive stabilizer. When it contracts, it COMPRESSES the lumbar discs and joints. In a healthy back that is stability. In an injured back it becomes crushing pressure.

The mechanism:

In rapid deceleration, the body is thrown forward while the lower body is fixed by the seatbelt and the floorboard. The psoas fires hard, and it does not let go.

Where the Psoas Refers Pain

The psoas is tricky because it rarely hurts in the abdomen, where the muscle actually lives. It refers pain to three zones instead:

- Vertical low back:** A deep ache running up and down alongside the spine, in the paraspinal area.
- Groin:** A deep ache in the front of the hip or the groin crease.
- Front of thigh:** A vague ache or burning travelling down the quadriceps.

The giveaway symptom.

Difficulty standing up straight after sitting. Patients describe having to "unfold" their hips before they can walk comfortably. A disc does not do that. A psoas in spasm does.

Treating the Psoas

The psoas is deep inside the abdomen, behind the organs, which is why it is so often skipped. Treating it takes a specific approach.

- 1. Manual release:** Skilled manual therapy reaches the psoas through the abdomen. Often uncomfortable, but it can give immediate relief when the muscle lets go.
- 2. Lengthen & strengthen:** Once the spasm releases, lengthen the hip flexors and strengthen the glutes, the opposing group, to hold the new alignment.
- 3. Hydrostatic IMS:** For stubborn cases: a fine needle into the muscle belly, then sterile saline. The hydrostatic pressure gently expands the tight fibers and forces them to release their grip on the spine.



MASQUERADER TWO: THE SACROILIAC JOINT

It feels exactly like sciatica, so the search goes to the lumbar spine, and stops there

The sacroiliac joint is where the bottom of the spine (the sacrum) meets the hip bones (the ilia) on both sides. After a collision, SI pain is common, and psoas reactivity often travels with it as part of the same movement pattern.

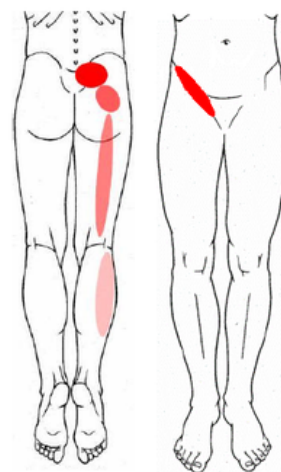
Crash Mechanics: Vertical Shear

SI symptoms show up especially when:

the two vehicles are different heights (a car struck by an SUV), or the struck vehicle has a tow hitch. The height mismatch drives vertical shear and torsional loading through the pelvis. That is why buttock-to-lateral-thigh pain and anterior hip or groin tightness so often arrive together.

Typical Pain Patterns

Location:	Buttock, radiating down the OUTSIDE of the thigh toward the knee.
Triggers:	Pain with standing, sometimes with sitting. Bending backward often hurts more than bending forward.
Sensation:	A deep ache, burning, or tingling extending down the lateral leg.
Mistaken for:	Sciatica, every time. But an EMG in these patients shows normal nerve function, because the nerve was never the problem.



Disc Pain vs. SI Pain

The literature lists discogenic pain as the most common cause of low back pain. In real-world crash mechanics, sacroiliac involvement shows up more often, because of seatbelt asymmetry and vertical shear.

Discogenic:	Intradiscal disruption, small tears. Deep, CENTRAL back pain, but rarely leg symptoms. Responds best to conservative rehabilitation. Epidural steroid injections usually fail here, because the problem is inside the disc, not a pinched nerve.
Sacroiliac:	Buttock and lateral thigh pain, worse standing and with backward bending. Responds to a targeted joint injection, not to disc-directed care.

Why I Inject the SI Joint Early

A single steroid injection is often curative.

SI joint injections are most effective done EARLY, typically within one to ten months of injury. In my experience, one well-placed steroid injection is often curative for this form of pain. If relief lasts only three or four weeks, that pattern usually points to ligamentous laxity, and I transition to prolotherapy or PRP for longer-lasting stabilization.

The point of naming both masqueraders is simple: a normal lumbar MRI does not mean nothing is wrong. It means the problem is somewhere the MRI was not looking.

