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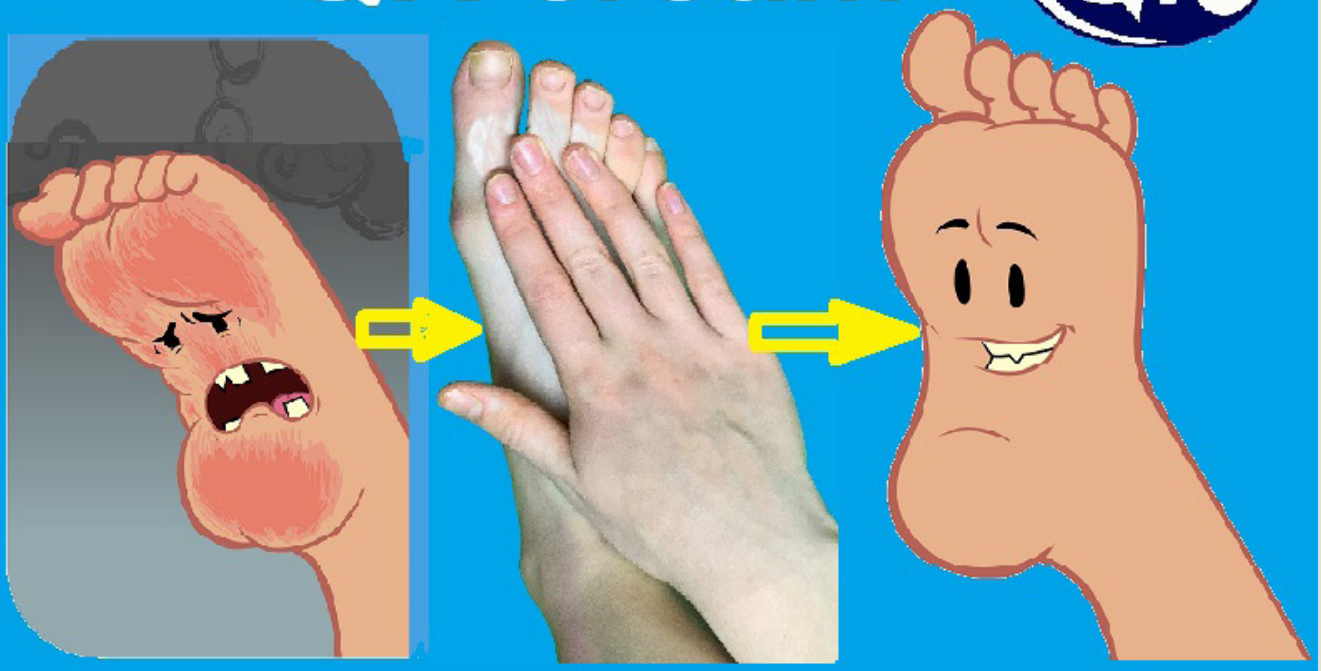

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INTRODUCTION

Dr. Bertrand studied medicine at Harvard University and McGill Medical School. Following her first pregnancy, she suffered 37 years of low back pain. After all the available treatments had failed, she decided to take the matter into her own hands. Her worst pain was not in her lumbar spine; it was lower, at the level of her sacroiliac (SI) joints.

These joints are so irregular they cannot be seen by medical imaging, and the physical examination tests for these joints just give information on whether they are causing the pain, not why or how they are causing it.

This e-book details what Dr. Bertrand discovered. It will explain why the SI joints are responsible for most low back pain, the simple examination that can be used to find the exact cause of the pain and, once the cause is established, the 2-minute corrective exercise that research has proved provides relief from low back pain to 90% of those who do it. It will also discuss the treatments that will prevent recurrences.

Some Comments from YouTube:

A better way to diagnose and treat lower back pain

OVER 80% of adults at some time in their lives are afflicted by lower back pain (LBP).[i] Despite the availability and wide use of diagnostics based on imaging (ultrasound, CT scans, MRIs, x-rays), and laboratory tests, between 85% and 95% of the time, this pain is diagnosed to be “nonspecific”, which means that “we don’t know the cause”.[ii iii] As a result, the treatment of most LBP does not address a properly diagnosed cause. Because of the lack of proper diagnostics, many different treatments are used, mostly without lasting success, so that lower back pain is now the commonest cause of disability in the world.[iv v]

This e-book describes a reliable and easy way to find a cause for most LBP and suggests a specific treatment for it that is non-invasive, quick, safe, and simple to administer. People with this condition can treat themselves in 2 minutes with a 90% chance of finding relief.

The basic problem

The diagnosis of nonspecific lower back pain is challenging. Medical imaging tests are used to assess LBP, but the diagnoses of lumbar spine instability, spinal stenosis, and degenerative disc disease most often do not lead to treatments that result in lasting relief, much less a cure.[vi vii viii ix x]

My clinical experience has led me to discover that the dominant cause for LBP is sacroiliac (SI) joint displacement, which originates in the buttocks, just below the spine, where the anatomy makes the condition impossible to see using routine medical imaging or to feel through normal physical examination.[xi xii xiii xiv xv]

I have developed a way to examine the SI joints to find out in what direction the pelvic bones are displaced. Depending on how they are displaced a simple corrective exercise to realign the joints can be done.

About the SI joints

The method I use for diagnosing the cause of LBP can best be understood by considering the shape and location of the SI joints in the body, which are shown in the following illustration from Frank Netter: *Atlas of human anatomy*.[xvi]

Figure 1 shows the location of the pelvic bones (ileum), which are joined on either side to the sacrum, forming the sacroiliac (SI) joints. The weight of the upper body rests on the pelvic bones and tends to push them away from the sacrum. The hip joint, which is inside the pelvic bone, moves the pelvic bones every time the legs are used. These 2 facts mean that the SI joints are under more stress than any other joint in the body and because of this, they need to be held in place by the body’s largest network of ligaments as you can see on Figure 2.

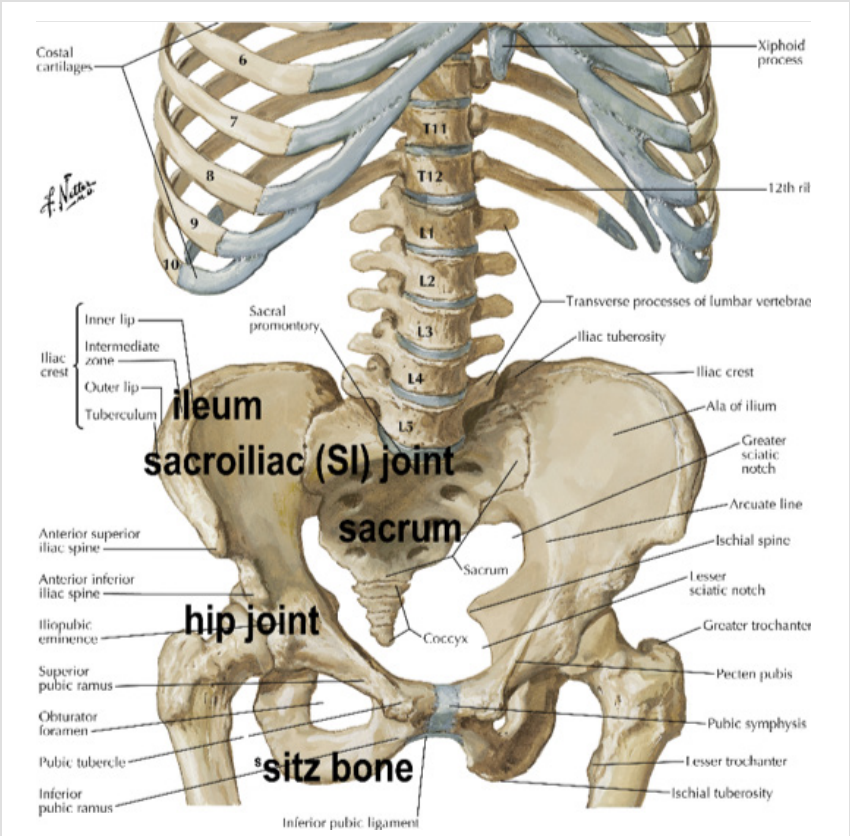

Figure 1: image of a skeleton showing the lumbar spine, the pelvis, and their connections.

The SI joints have a very important function. They protect the spine by absorbing the shock to the hip joint transmitted by the leg every time the foot hits the ground. To carry out this shock absorber function, unlike the other joints in the body which are smooth, SI joints are full of irregularities. This makes it impossible to judge their alignment and position with medical imaging (X rays, CT scans, MRIs). I believe that the displacement of SI joints and accompanying strains on the ligaments holding them in place is the primary cause for the non-specific LBP that has puzzled so many clinicians.

Causes of SI displacement

SI displacement is usually caused by common events such as falls landing on the buttocks, rear-end car accidents where the foot on the brake jolts the hip joint, landing hard from a jump, long or downhill runs, going down long flights of stairs, wrong sleeping position etc.… When the weight of the upper body pushes the pelvic bones away from the sacrum the SI joint becomes unstable: prolonged sitting, lifting weights or being overweight can displace them.

LBP originating with the SI joints can also be the result of uneven leg length (you land harder on the shorter leg, jolting its SI joint) or lower spine fusion putting strain on the SI joint.[xvii] People with weaker ligaments also have trouble keeping their SI joints together. Collagen, that ligaments are made of, is weakened by pregnancy hormones needed to allow passage of the baby's head through the pelvis. People who inherit overly elastic collagen, which causes them to be double jointed, often sprain their SI joints. The commonest cause of collagen loss is aging, which often leads to sagging skin and to weaker ligaments, resulting in arthritis and displaced SI joints.[xvii]

These conditions lead to lower back pain because when the SI joints are displaced, the nerves in the overstretched ligaments around the SI joints transmit pain signals to the brain, which is nature's way to get people to stop engaging in activities that stress the joints.

Determining the Direction and Size of SI joint displacements

Strain on the SI joints is caused by displacement of the pelvic bones, and medical imaging cannot indicate the direction and size of this displacement. It must instead be found by physical examination, which involves the following procedure.

Move your finger along the iliac crest to find the Posterior Superior Iliac Spine (PSIS), which is a small, hard bump on either side of the anal cleft (the crack). How to find the PSISs. Once found on both sides of the back, the locations of the PSIS should be marked with a pen so their levels can be compared. Pressing down on the underside of the PSIS will elicit pain if the pelvic bone is displaced.

Next, compare the relative heights of the PSISs. If they are the same, the patient's LBP is not caused by SI joint displacement and cannot be relieved by the procedure described below.

However, in my experience, most patients with LBP have PSISs at different heights. This difference is important for reducing the displacement discussed below. On the side where the PSIS is higher the pelvic bone is displaced towards the front. On the side where it is lower the pelvic bone is displaced backwards.

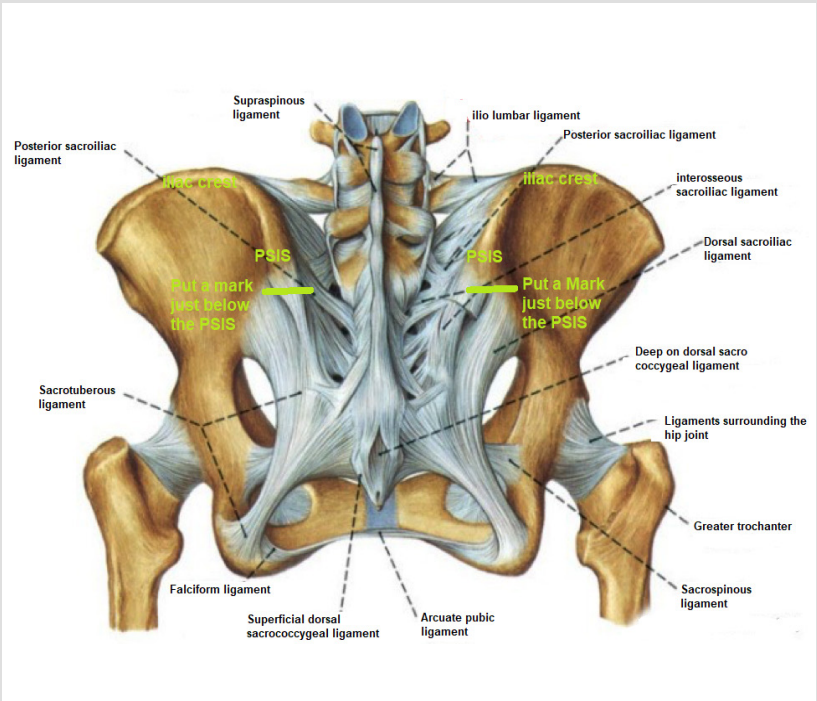

Figure 2: the sacroiliac joints seen from the back. Notice the multitude of ligaments holding the SI joints compared to those surrounding the hip joints., Observe the location of the PSISs and where to put the mark indicating their level.

The size of the difference in the height of the two PSISs indicates the extent to which the SI joints are displaced and can be seen easily, but for more precision it can be measured with the help of a spirit level.

Correcting the SI Joint Displacement

The following description of the corrective exercises can be understood more easily by looking at Figure 3, which shows a patient engaged in repositioning a pelvic bone that is tilted forward on the right and backwards on the left.

To reposition a higher PSIS, which means the pelvic bone is tilted forward, it needs to be pushed backwards using the thigh. The leg on the affected side is bent with the foot on the floor. The patient leans forward and places the hands on the floor on either side of the foot. This position causes a strong backward pressure of the left thigh on the pelvic bone, which may be uncomfortable but essential to push the bone back into its normal position.

To reposition a lower PSIS, meaning the pelvic bone is tilted backwards, the bone will have to be pulled forward. The muscles which attach to the front of the pelvic bone and to the leg will pull the pelvic bone forward as the thigh is stretched, pulling on these muscles.

With the left knee on the ground and the right foot on the floor, they lean forward and slide their knee backwards until a strong pull is felt in the groin. The pull can be uncomfortable but is essential to get the SI joint to move to its normal position.

These exercises must last two minutes during which patients may experience discomfort, making the two minutes seem very long. Note the patient looking at his cell phone timer on the floor in front him. However, holding the position for 2 minutes is essential for the success of the procedure.

One important feature of the corrective exercise just described is that, once they understand the procedure, people with recurrent LBP can treat themselves with occasional help from relatives or friends who can assess the relative height of their PSISs. There is no cost for this treatment.

After the treatment, the position of the PSISs must be re-assessed. If they are level and the pain is gone, the treatment has been successful.

In some cases, the PSISs are level but the LBP persists. This means that the SI displacement was not the only cause of LBP. The patient needs further medical assessment.

If, after the treatment, pain persists and the PSISs are not level, the treatment needs to be repeated. Some people who are double-jointed (hypermobile) can sometimes move their PSISs in the opposite direction with the exercise. In this case, the exercise should be done in the opposite direction but only for 1 minute, and that should, from now on, be the time they use for doing the exercise.

Figure 3: Man doing the corrective exercise to reposition a higher PSIS on the right and a lower PSIS on the left.

Some patients experience repeated episodes of lower back pain. This indicates that their SI joints are unstable because the ligaments holding them are weak, torn, or excessively stretchy. Such patients benefit from wearing a pelvic support belt like the widely available Serola belt. The belt must be worn below the bones that can be felt in front of the iliac crest and below the PSISs, directly over the SI joints. Higher positions of the belt can lead to increased joint displacement and LBP.

Prolonged sitting causes the displacement of the Si joint and LBP because the weight of the upper body pushes the pelvic bones away from the sacrum. Sitting on a "doughnut" – shaped inflatable cushion keeps the sitz bones inside the hole in the center of the doughnut and prevents the pelvic bones from moving apart, away from the sacrum, thus avoiding LBP that otherwise would develop.

Patients with chronic SI and LBP problems can also use prolotherapy to rebuild the ligaments holding the SI joints.[xix] They can use surgery to have their sacrum and ileum bolted together, which closes the SI joint permanently.[xx] These interventions require well-trained professionals and are very costly. Surgery involves the risk of complications and increased strain on the lumbar spine because fusing the joint eliminates its shock absorbing function.

This LBP complete video describes the SI joints, how to find someone else's PSISs, how to check their level, how to do the different corrective exercises, how to apply a pelvic support (Serola) belt and what happens to the people who do the 2-minute exercise.

Clinical Experience and Research

For 12 years I focused my family practice on treating people with chronic pain. Many were referred to me from other physicians who had been unable to deal with their pain.

My work was very rewarding. After the 2-minute procedure, some people would get up, test their back, and exclaim: "this is a miracle!" Over the years, they had tried so many treatments and this was the only one that provided them with such immediate relief.

I reviewed the charts of those I had treated for lower back pain between 2015 and 2017. In those 3 years, I saw 180 new patients suffering from this condition. I found that 14, 9%, had LBP caused by conditions other than displaced SI joints. I treated the remaining 164 patients with the 2-minute corrective exercise, 141, or 86% experienced immediate pain relief.

In 2019 and 2020, I did a study on 62 new patients with a displaced SI joint, which were randomized into three groups:[xxi]

1. 21 received the corrective exercise.
2. 21 used the pelvic support belt.
3. 20 received their usual treatment: chiropractic manipulation, physiotherapy, massage, painkillers etc.

All participants completed questionnaires in which they indicated their level of LBP, between 0, no pain and 10, the worst imaginable pain.

At the first visit, group one, who received the SI corrective exercise, came in with an average pain score of 5.24 and, as soon as they had finished the exercise, the average pain score was down to 2. Group two, when they started wearing the Serola pelvic support belt, saw their pain go from an average of 4.48 when they arrived at the office to 2.33 after they put on the belt. Pain relief was still present when the corrective exercise and the pelvic support belt groups came back a month later while the people getting their usual treatment showed almost no difference in pain score. At that second visit, everybody got both the corrective exercise and the belt and 56 of the 62 participants (90%) experienced immediate lower back pain relief after the corrective exercise which was still present when they came back a month later.

At the 2-month visit, everybody had used the corrective exercise and the pelvic support belt for a month. They redid the exercise in the office. Following this, the average pain score in group 1 was 0.64, in group 2 it was 1.36 and in group 3, it was 0.61. All of them had found relief from their LBP with the corrective exercise and the belt. This leads me to believe that most patients suffering from LBP because of displaced SI joints can relieve their pain with corrective exercise and by wearing a pelvic support belt.

If you want to know more than what is in this presentation, here is a 45-minute Zoom Meeting on Low Back Pain you can check out.

Find research summary
Debilitating chronic LBP affects a very large proportion of people during their lifetime. The pain is disabling and costly to those who suffer. It affects their work, their emotions, their sleep, and their ability to function.

Unfortunately, current standards of care do not address the most common cause of this so-called “non-specific” LBP: the displacement of the pelvic bones stretching the ligaments of the SI joint, causing the nerves in these overstretched ligaments to send LBP signals to the brain.[xxii]

I have discovered a non-invasive method to assess in what direction and how much the pelvic bone on the painful side is displaced and have developed a simple, safe procedure to return the pelvic bone to its normal position. This relieves the strain on the SI joint and ends the back pain, indicating that “nonspecific” lower back pain is, in fact, usually caused by displaced pelvic bones.

I hope that health professionals will begin to use this technique for treating LBP and that public awareness of the technique can be increased so that those with LBP can learn how to treat themselves.

The study presented here is small and the follow-up is short, only two months. It was going to be replicated in Kochi, Kerala, India. As I was leaving Kochi, having trained 6 physicians so they could carry out the research, they told me they had never seen so many people with LBP leave their office with a big smile on their face. Unfortunately, one month later in March 2020, Covid put an end to this project. I am planning a larger trial with a longer follow-up on a different population, to establish the global significance of this procedure. If you are interested in carrying out such a project, please reach out to me.

A future solution to treat lower back pain
A new way to assess the levels of the SI joints and a quick and effective treatment to correct their displacement. Could this be a solution for most LBP?

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BIOGRAPHY

Hélène Bertrand, MD, CM, CCFP

I was born in 1943 and raised in Montréal by my French-Canadian parents. They sent me to school at a French lycée, College Marie de France, from which I graduated with a BA at age 17. I then attended medical school, first at Université de Montréal, a 5-year course.

At the end of my second year, at age 19, I was married, and my husband was going to Boston, so I redid my second year at Harvard Medical School, a 4-year course. At the end of the year, as my husband wanted to go back to Montréal, I finished my studies and got my medical degree from McGill University (also a 4-year course) in 1965. After a rotating internship at the Royal Victoria Hospital in Montréal, I gave birth to my first child, Claire. My 2 other children, Paul and John, were born in 1968 and 1973.

I started working part-time as a family practitioner as an assistant to my father, Claude Bertrand, a neurosurgeon. All my life I have enjoyed helping solve my patients' complex problems. In 1974, as I was breastfeeding my youngest, I concentrated my practice on breastfeeding mothers and started trying new ways to treat their problems. This resulted in 2 publications on how to treat mastitis and breast abscess.[i ii] I also taught health professionals about breastfeeding all over the province of Québec. I did this for 9 years. In 1974 only 6% of babies were breastfed for 6 months. When I left the province of Québec in 1983, 26% of babies had 6 months of breastfeeding. I also started giving babies swimming lessons, and infant stimulation classes to their mothers at the Westmount YMCA. A few years later, these classes started being taught at Montréal

Children's Hospital and one of my former students gave these classes in Ottawa.

In 1983 my first husband decided to move to Victoria, where I worked for alcohol and drug programs. In 1987 I left my first husband and started working, at first for alcohol and drugs, in North Vancouver. At the time, it occurred to me that people suffering from addictions had deficient dopamine systems as they had used substances that forced the release of dopamine, the pleasure transmitter. Their brains had reacted by decreasing the number of dopamine receptors that could be stimulated. I decided to try bromocriptine, a medication for Parkinson's disease which stimulates dopamine receptors, on smokers trying to quit. I had them come to my office at 8 AM craving a cigarette and I would give them progressively larger amounts of bromocriptine until their need to smoke stopped. It worked beautifully and, 6 months later, 35% of those who were given bromocriptine and used it to stop their craving, were still off cigarettes. Unfortunately, I did not publish this as I was too busy. I did present this in October 1992 at the 36th annual Internal Medicine Update at St. Paul's Hospital: Medications for smoking cessation. I was on the staff at Lions Gate Hospital in North Vancouver, from 1988 until I retired.

During my first pregnancy, I developed terrible bouts of lower back pain which made it difficult for me to walk, bend over, go up or down stairs or even get into or out of bed. These bouts kept recurring and could be incapacitating. One day, in 2003, I was at a seminar on the diabetic foot with a friend of mine, Dr. Murray Allen, a sports medicine physician. As we sat down, I said, "my sacroiliac joints are killing me!", to which he replied, "come and see me, I'll do prolotherapy on you". I said "prolo what?" … A few days later, I got my first prolotherapy treatment. After 3 treatments, my back pain was gone. I started sending him a lot of pain patients. Most of them came back enthusiastically telling me how much better they were feeling. Unfortunately, 6 months later, Murray told me he was retiring. I said, "you can't do this to me! What am I going to do with all my patients who are suffering?" To which he replied, "I'll teach you how to do it". Friday was my day off, so every Friday for 3 months, under his supervision, I treated between 6 and 10 of my patients, helping rebuild their ligaments, tendons, and joints with prolotherapy. I then took a multitude of continuing education courses on how to do prolotherapy and started to treat people who needed it. Realizing there was not much research on the subject, in 2009, I got a WorkSafe BC grant to carry out a randomized, controlled study comparing people with sore shoulders. One group got physiotherapy, the second group got sham injections, and the third group got prolotherapy: injections of concentrated sugar water where their blood vessel poor ligaments and tendons attach on the richly vascularized covering of the bone. This caused inflammation which generated the growth of new blood vessels into the poorly supplied ligaments and tendons. These new blood vessels were the roads the repair cells took to reach the injuries into these ligaments and tendons and deposit collagen, scar tissue, there. Since ligaments and tendons are made of collagen prolotherapy injections could repair them. After 9 months, those who received the prolotherapy had less pain and had far fewer problems using their shoulder than those who were treated with physiotherapy.[iii]

In 2010, as I was doing the research project, I decided to limit my practice to treating only people in pain. In April 2011, at the meeting of the American Association of Orthopedic Medicine, Dr. John Lyftogt gave a seminar on injecting sugar water around nerves which could stop them from sending a pain signal to the brain. We were obviously skeptical until, at the end of the seminar, he asked for people in pain to come up to the stage and be treated. Every single person he treated got immediate pain relief from the sugar injections! As soon as I got back to the office, I started using his technique. Unfortunately, a lot of the people I was treating were diabetics with peripheral neuropathy, burning hands and feet caused by their persistently high blood sugars, which were in the process of destroying their nerves. I couldn't see myself injecting around these nerves with sugar water, so I decided to inject around these nerves with a mannitol solution. The mannitol molecule is a sugar molecule to which one OH (half a water molecule) has been added. I got the same results: immediate and complete pain relief.

Marylene Kyriazis, a pharmacist interested in chronic pain was observing me and said, "I've never seen pain go away so fast and so completely, but people don't like injections, why don't we make this into a cream?" We tried 16 different bases before finding one that allowed the mannitol to penetrate through the skin to get to the nerves sending pain signals to the brain. I started using this on all my pain patients. I would give them a 50 g container of the cream, which Marylene was making in her kitchen, together with a questionnaire asking the date, time, how bad was their pain between 0 and 10, before they put on the cream and 30 minutes later, how long it took for the relief to start and how long the pain relief lasted. I did a chart review of the 235 patients with 289 different pain conditions who received this cream between 2015 and 2017. Their average pain relief was 53%. Not bad considering narcotics give 36% pain relief, diclofenac 23%, acetaminophen 13%. I wanted to know how the mannitol produced such quick and complete pain relief, so I did a research project. My patients were clamoring for more of the cream, so I asked them to participate. I applied some capsaicin (hot pepper) cream on their upper lip.

When the burning reached 8/10, I removed the capsaicin cream and on one side of the upper lip I applied the base cream, on the other side, the base cream with the mannitol. I didn't know what I was applying. A pink Q-tip went to the right upper lip and a blue one for the left. Every minute they had to write down on a graph how bad their pain was from 0 to 10. On the mannitol side, the pain level went away quickly. On the other side, even by 10 minutes there was still pain and everyone knew which side had the mannitol.[v] Tess Debelle, a medical student doing a stage in my office did a research project which showed how effective the mannitol was in providing relief to those suffering from postherpetic neuralgia, the terrible pain that can follows shingles.[vi] Marylene and I formed a company, MaryHelene Enterprises Inc. We decided to manufacture the cream and to start selling it. We called it QR cream (for Quick Relief and QR: pronounced as cure).

Meanwhile, a lot of my low back pain patients couldn't afford to be treated with prolotherapy as this treatment was not paid for by the government's health care coverage. Because displaced sacroiliac joints, the commonest source of low back pain, were often far away from the skin surface, the mannitol in QR cream would be too dilute before it reached the painful overstretched nerves in the ligaments surrounding the sacroiliac joints. I had to teach them how to get rid of their pain themselves and how to prevent it from returning. Having, myself, tried and failed at a multitude of treatments from chiropractors, physiotherapists, massage therapists, acupuncturists, Pilates practitioners, physicians doing IMS, pain medications, meditation etc., I decided to find a way to truly diagnose in what direction the pelvic bones were displaced and to devise a treatment to help replace them.

I devised a simple way to find out if the pelvic bone was displaced forward or backwards. I found that, if the pelvic bone was displaced forward, the thigh, flexed against it, could be used to push it backwards. If it was displaced backwards, it could be pulled forward with the extended thigh. As this bone moves slowly, my patients had to hold the corrective position for 2 minutes. I did a chart review of those I had treated this way between 2015 and 2017 and showed that 91% of low back pain sufferers had displaced sacroiliac joints and that 86% of those found relief with the 2-minute exercise.[vii] I devised an improved exercise and did a randomized, controlled research project on this, which showed that 90% of those with displaced sacroiliac joints found relief with this exercise.[viii] The research project was to be duplicated in Kochi, Kerala, India, and I went there in February 2020 to teach 6 physicians how to examine and prescribe this test to low back pain patients. Before I left, they told me that they had never seen so many low back pain patients leave their office with a big smile. Unfortunately, these were public health physicians and Covid struck. I do hope someone will want to do the research as, as of November 1, 2020, I retired. At my age (77), Covid could disable or even kill me. I had practiced medicine for 55 years.

There is one more research project I would like: in 2014, a physician referred me a patient for treatment to her severely painful shoulder. She came into the office, scratching her hairless head, which was covered in plaque psoriasis.I told her, "I can take away your

> **I devised an improved exercise and did a randomised, controlled research project on this, which showed that 90% of those with displaced sacroiliac joints found relief with this exercise"**

shoulder pain but if you keep scratching, you keep injuring your shoulder, your pain will return." She replied, "I can't stop scratching, doctor, the itch is unbearable". I said, "why don't you try my cream?" Her answer was, "I've tried every possible treatment, and nothing helps!" To which I replied, "this won't cost you anything, just try it". 3 minutes after she applied the cream, her itch was gone. I gave her a container of the mannitol cream I was testing and, when she came back, 5 weeks later, she had 2 cm of hair on her head and no psoriasis.[x]

Of course, this is an N of 1 study. I would like to find 10 people with intractably itchy plaque psoriasis who would be willing to use the cream for 3 months. If it relieves their itch, then, a randomized, placebo-controlled study would be indicated. As I have retired, and as I am biased because I am selling QR cream, which is made with mannitol, another physician, Dr. Corina Ciolacu has agreed to do the research. Do you know someone with plaque psoriasis and intractable itch? Please refer them to her.

At age 80, I work at furthering the sale and distribution of QR cream. I love skiing at Whistler in the winter and, after the snow has melted, walking there and in the beautiful, forested parks where I live in North Vancouver. I enjoy showing the people I meet who have low back pain how to get rid of it, and seeing their look of pleasure and surprise when they get up after the 2 minute exercise and their pain has disappeared. My husband, Herbert Grubel, a well-known economist, former finance critic in the Canadian government, and I have traveled a great deal. Our next travels, this year, will take us to Iceland and to Taiwan.

Hélène Bertrand, MD, CM, CCFP

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