



Clinical Questions

Ergo-Flex Technologies, LLC.

Back On Trac Questions

**ERGO-FLEX**
TECHNOLOGIES



**BACK ON TRAC**



Intended Use

Intended Use

The Back on Trac is intended for use in professional healthcare facilities, to relieve pressures on structures that may be causing pain of skeletal or muscular origin (cervical, thoracic, lumbar, hip, shoulder). The device may be used to manage, and reduce pain associated with the following conditions: facet syndrome, herniated disc, protruding disc, extruded disc, sciatica, spondylosis (degenerative disc disease & facet syndrome), and joint pain.

Vibration and heat are available options that can be utilized with the Back on Trac at the discretion of the healthcare professional. When activated, the vibration mode can provide muscle relaxation and temporary relief of minor aches and pains. The heat mode, when activated, can provide temporary relief of minor aches and pains. The local warmth temporarily stimulates local blood circulation in your lower back.

All data entry and validation of protocol parameters is performed by the trained healthcare professional according to a physician's order. Trained healthcare professionals included physicians, massage therapists, nurses, occupational therapists, physical therapists, physician assistants and service technicians. A user can also be for all humans that might handle, operate, or interact with the medical device. This includes installers, engineers, technicians, clinicians, care givers, cleaners, sales, marketing, production technicians and any members of Ergo-Flex Technologies, LLC.

The patient population ranges from young adults to senior adults.



Responses Provided by Trained Professionals

The information provided, is indented for educational purposes only. The responses provided by licensed Doctors of Chiropractic have shared their professional experience to best answer the questions referenced in this document.

Each patient is unique, and the results of chiropractic care may vary. The effectiveness of treatments depends on various factors. Including the individual's specific condition, health history, and adherence to the treatment plan.



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Back On Trac Clinical Question

Abdominal Aorta Stent Transplant

Question:

Is having stents going into the legs from the abdominal aorta a conflict with decompression? Stents are in right and left common iliac arteries.

Answer:

That is a question for the surgeon, but that should not be an issue. The Back On Trac doesn't distract enough to distort the blood vessels, so the stent should not be impacted.

Back On Trac Clinical Question

Abdominal Aortic Aneurysm

Question:

Is an abdominal aortic aneurysm a contraindicated for treatment on the Back on Trac?

Answer:

Out of caution, if any patient has any visible expansion of the abdominal aorta, I would avoid the Back On Trac. I have personally placed a patient on the BOT with an expansion, but it was only 1-2 cm. Also, keep in mind that an AAA isn't considered an aneurysm until it is around 3 cm and surgical until it is above 5.5.

It isn't so much the axial pull I would be concerned about as much as it would be the compressive forces of the abdomen as it was being pulled axially. You never know how sensitive an AAA is until it is too late.

Back On Trac Clinical Question

Aortic Femoral Calcifications and Femoral Stents

Question:

Are aortic and femoral calcification and femoral stents a contraindication to the Back On Trac?

Answer:

As long as the aorta does not have an aneurysm, calcifications are totally fine (and very common).

We've had that question before about the stent and after researching it and speaking with a few physicians, it is not a problem either.

Back On Trac Clinical Question

Artificial Disc

Question:

A patient asked me if the Back On Trac is safe for patients with an artificial disc?

Answer:

I would let the doctor know to be very careful answering this question from a public forum by someone they don't know. I would simply answer by saying, "Although patients have successfully and safely been treated with the Back On Trac, it would be best to consult with your surgeon. However, I would be more than happy to discuss it personally with him/her."

Back On Trac Clinical Question

Best Time of Day for Treatment

Question:

Just checking that for decompression it is best to do it at the end of workday compared to the morning and then performing heavy or repetitive lifting?

Answer:

I would agree that if a patient had to attend to a rigorous job immediately after the treatment, after work would be best. If they don't have a job that required heavy or repetitive lifting, a morning session may even produce a better outcome since they may be more relaxed.

Back On Trac Clinical Question

BOT vs Accu-SPINA

Question:

I'm wondering if you could share your perspective or experience working with Accu-SPINA vs. Back on Trac for treating degenerative conditions. I have experience with the former—it's a behemoth, but it does seem effective. I'm curious if Back on Trac provides similar results and whether it offers enough customization with its pre-set programs, etc.

Answer:

I still use a decompression table as well as the Back On Trac, since there are benefits to both tables. I think they both work well for those types of conditions. If it is a matter of either or, and for degenerative/arthritis spines, the BOT would overall be a better choice since it is creating more movement in the spine overall with the lateral flexion component.

Another is that most of these patients will come back regularly for a degenerated spine and the Back On Trac fits in seamlessly with a regular "maintenance" adjustment. It is an easy and quick setup too.

You had also mentioned space, and it is a complete advantage over most every decompression table. You can put two Back On Trac's and produce twice the revenue if you can keep them full.

Back On Trac Clinical Question

BOT vs DRX

Question:

What's the perfect candidate to get relief from the Back on Trac? And how do you differentiate it in your market from the DRX?

Answer:

I still use both in my office, and usually reserve decompression for my really acute disc patients who need a gentler pull. I will even transition those patients after they complete the decompression program since it is great for maintenance patients.

Most everything else will go to the Back On Trac. As simple as the lateral flexion component is, it adds a big advantage proprioceptively, as well as mechanically which is why it is great for arthritic facet joints and really helps rehab the tissue.

As far as my maintenance patients, it added an additional therapy for those who only got the adjustment periodically. This is usually a large part of the patient base. Everyone sits too much, so it is a nice addition to the adjustment on a periodic basis. I let many of the patients trial the machine for 1-2 visits, and the majority want to keep using it afterward.

Back On Trac Clinical Question

Bulging Disc

Question:

What does the Back on Trac treat?

Answer:

The Back on Trac is intended for use in professional healthcare facilities, to relieve pressures on structures that may be causing pain of skeletal or muscular origin (cervical, thoracic, lumbar, hip, shoulder). The device may be used to manage, and reduce pain associated with the following conditions: facet syndrome, herniated disc, protruding disc, extruded disc, sciatica, spondylosis (degenerative disc disease & facet syndrome), and joint pain.

Back On Trac Clinical Question

Bent Knee vs Straight Knee

Question:

How does strapping the legs with a bent knee, versus a straight or slightly bent knee, provide an advantage?

Answer:

The knee being fully bent directly up against the machine or less bent with a support is equally effective. The key here is that the patient should be secure with the strap against the machine to provide maximum tension or pull. In our office, if a patient has knee pain, difficulty fully bending the knee due to previous surgery or injury, we use a premade pillows that go between your knees

Back On Trac Clinical Question

Cauda Equina Syndrome

Question:

I have a potential cauda equina syndrome patient who would like to try the Back on Trac. Since the machine is not true spinal decompression, can this patient try the equipment for a couple of visits before making a full judgment? While there has been no confirmed diagnosis of cauda equina syndrome by the patient's PCP or specialists, there is confirmation of a lumbar disc herniation and issues with urination control.

Answer:

If the patient wants to try it for a few visits and the CE hasn't been confirmed, I would certainly give them the opportunity. I would start on an easy protocol like B or C and then move up to a lateral flexion protocol. She may get the help she has been looking for. Even if it aggravates it slightly but is nothing intense, I would continue the trial.

Back On Trac Clinical Question

Cervical vs Lumbar Traction

Question:

Does cervical traction work simultaneously with lumbar traction?

Answer: Cervical traction and lumbar traction are designed to be performed separately with the Back On Trac and Cervi-Trac systems. While a patient may experience slight lumbar traction during a cervical traction session, the two areas are not intended to be targeted simultaneously. Each system is specifically engineered to provide focused traction to its respective region, ensuring optimal decompression and therapeutic benefits for either the cervical or lumbar spine. For best results, it is recommended to address these areas in separate sessions.

How do you specifically traction L5-S1? It seems all patients get it at thoracolumbar.

Answer:

To specifically traction the **L5-S1** segment using the Back On Trac (BOT), it's important to understand the mechanism of axial traction provided by the device. Unlike many traditional decompression/traction systems that stabilize the upper torso with a strap while the lower unit creates the pull, the BOT delivers a controlled, straight axial traction that effectively isolates the lumbar spine, including the **L5-S1** region.

While the thoracolumbar area may experience some degree of traction due to the nature of the pull, the design of the BOT ensures that the majority of the traction force is applied to the lumbar spine. This is particularly effective for **L5-S1** because the straight axial pull focuses on elongating the lumbar spine without excessive movement in the upper torso or other segments.

The result is a targeted, gentle traction that decompresses the **L5-S1** area while minimizing strain on surrounding structures. This unique approach distinguishes the BOT from traditional systems and enhances its efficacy for patients needing decompression at this specific level.

Back On Trac Clinical Question

Cold Laser

Question:

I have a doctor who is considering the addition of the Back on Trac however he was advised by a rep at a laser company to only purchase a table that he can utilize the laser at the time of service. What are your thoughts and recommendations regarding this suggestion?

Answer:

Whatever device this salesperson from the laser company is suggesting would require the patient to lie in a prone position. The prone position for any traction is not ideal unless the patient can't lie supine with the legs at a 90-degree angle. There is much less pressure on the spine in the supine 90-degree than lying face down in a prone position, and by far more stress on the facet joints if prone. Most lasers (even the lasers at this laser company) are very short in terms of time, especially more powerful lasers which work much faster. I am curious what table the rep is referring to and what connection he/she has with the company. I personally would want the most effective treatment (supine) and would be willing to wait a few extra minutes to finish with the laser. Our personal protocol is first to do traction, spot cryotherapy and then laser. All done separately with spectacular results. That is what the patient prefers and not saving a mere 5-10 minutes.

Back On Trac Clinical Question

Compression at L2

Question:

A patient was in a car accident when he was 12. Compression at L2. He had no discomfort then fell flat on his back in the bed of his truck. It was in July of 2023 and there is still aching pain. Is it safe to do the Back On Trac and, if so, which protocol?

Answer:

If the pain is being generated from L2, then I think he would have more problems (soreness) lying on his back than any adverse effects from the Back on Trac. He should be totally fine to do the table.

If he has been hurting for that long, I would make sure he has an MRI before moving forward.

If the patient can tolerate the Back On Trac, any protocol would be fine to use.

Back On Trac Clinical Question

Consent Forms

Question: Do you have a consent form for patients to sign before using Back on Trac?

Answer:

Ergo-Flex Technologies does not supply a patient consent form.

Back On Trac Clinical Question

Degenerative Disc Disease and Bone Spurs at L5/S1

Question:

I have a 70-year-old patient with degenerative disc disease, and bone spurs at L5/S1. Her initial presentation is left sided sciatica. She has gotten better since she started 1 month ago. When I do B or A at 3 inches for lumbar decompression, she occasionally gets worse and then I adjust her again and it improves. I am concerned about foraminal stenosis on her left side.

Would sweeping or lateral bend to left side (O, U or Q) be appropriate?

Answer:

I would also be concerned about spinal cord compression, as well as the foraminal stenosis. Going laterally wouldn't make it any better if it is cord compression. If it is the foraminal stenosis, using a protocol like E or I that stays in right lateral flexion only may be an option until she is further along in care.

An MRI would be the only way to know the answer whether it is the cord or foramen.

Back On Trac Clinical Question

Encroachment from the Disc Material at L4/5

Question:

We have a new patient with the following, and I am hoping for advice on which treatment protocols are recommended for her condition:

Patient is 60 years old, in good health - MRI shows:

- L2-3 Mild flavum hypertrophic changes
- L3-4 Tight spinal stenosis due to facet and ligamentum flavum hypertrophic changes. Mild disc bulge more lateral to right than left. Mild right facet joint effusion
- Thecal sac diameters are narrowed to about 7 mm anterior to posterior
- L4-5 Tight spinal stenosis, greatest at this level than the level above almost completely obliterating the thecal sac on axial image 19 due to combination of the spondylolisthesis, facet of atrophic change, and ligamentum flavum hypertrophic change. There is disc material extending out laterally to both sides, to the right sagittal image 5 and to a slightly greater degree to the left sagittal image 11 encroaching upon the inferior aspects of the neural foramina.
- L5-S1 No disc herniation or spinal stenosis:
- IMPRESSION: Spinal Stenosis. Tight at the L4-5 level due to combination of the disc bulging/mild left lateral protrusion, facet atrophic change and ligamentum flavum hypertrophic change. These findings are seen to a slightly lesser degree at L3-4.

Answer:

The only suggestion I will make is to start the patient off with a simple protocol such as C with a minimal pull to see how well she tolerates it. Most patients, that aren't dealing with major muscle spasms or an antalgic lean, can jump into the more aggressive protocol immediately, so she shouldn't have any issues by starting with C. Once she is ready to move up, O and U are both good ones to use for stenosis. Since she does have some encroachment from the disc material at L4/5, I would monitor for any increase in radicular patterns into the leg.

Back On Trac Clinical Question

Femoral Artery Stent

Question:

I have a 70+ year old patient who has what appears to be a leg femoral artery stent that was placed in the early 2000s.

Is there any contraindication to him having lumbar decompression therapy?

Answer:

Your question is referring to lumbar decompression but I'm assuming you mean the Back On Trac. That being said, it is safe to use the Back on Trac with this stent. It's not going to do enough traction to affect the stent. I usually explain to the patient as if they could do any sort of stretching or yoga positions with the stent. That actually has more of a stretch than the Back On Trac.

Back On Trac Clinical Question

Fused Sacrum

Question:

We have a patient who is fused L4-L5, L5-S1 so the sacrum is fused. Would she still be a candidate for the Back On Trac?

Answer:

You can still benefit from the Back On Trac for the joint levels above the fusion. It will not negatively impact the fusion. If the symptomatic nerve root or area is above the fusion, this would be a great therapy to include in the care plan.

Back On Trac Clinical Question

Healed T12 Compression Fracture

Question:

I have a patient who has a healed T12 compression fracture (2016). Is the Back On Trac contraindicated?

My instinct is to do a test session and slowly proceed.

Answer:

Those would be more for acute or subacute fractures. An old compression fracture at T12 would be fine, but I would still proceed cautiously to monitor the patient response.

Back On Trac Clinical Question

Hip Replacements

Question:

Is there a contraindication to using the Back On Trac for patients with hip replacements? We have 2 patients now that asked, and I wasn't sure what the correct answer was.

One of them had the replacement about 2.5 months ago.

Answer:

I wouldn't pull on a 2.5-month-old hip, but I would pull on a hip replacement that is older than 6 months old.

Back On Trac Clinical Question

Implant

Question:

A patient has a Coflex implant between L4 and 5 which was placed about 4 years ago. Is it safe to put him on the Back On Trac?

Answer:

That should not be a problem at all, especially after 4 years. These devices allow much more mobility than a spinal fusion. She would probably get more separation of the spinous process by bending forward to touch her toes than he would on the Back On Trac. I would still monitor her for any adverse reactions, but this should not be a problem.

Back On Trac Clinical Question

Inches to Pounds

Question:

Do you have a conversion table from inches to pounds?

Answer:

Yes.

Inches to pounds to kilograms Equivalency Chart

Inches	Lbs	Kgs
1.0	10.5	4.8
1.5	19.0	8.6
2.0	27.0	12.2
2.5	34.5	15.6
3.0	42.5	19.3
3.5	51.0	23.1
4.0	58.5	26.5
4.5	67.0	30.4
5.0	75.5	34.2
5.5	91.0	41.3

Back On Trac Clinical Question

Initial & Progressing Protocols

Question:

Do you progress with both time and inches? I assume starting points would be much different for lumbar than cervical as well. So, with me now understanding all of the individual protocols themselves, and for what conditions (these would be all of the lettered protocols), I am just needing some clarification on starting points for time and inches, and how to progress them on subsequent visits for the patients.

Answer:

Any time we look at changing any setting on the Back On Trac, we only change 1 at a time (either letter, or distance, or time). We NEVER change 2 at the same time because we need to know what is causing the problem if they respond negatively.

All in all, to answer the question: Time is completely dependent on patient flow in the office and clinical presentation. If the patient only gets relief on the Back On Trac, let them be on the BOT for longer periods of time! If they get a good amount of relief with the time you're currently using, realize there are likely other modalities you are utilizing that may prevent backups on flow or help them clinically. As well as changing the letter setting and distance (I feel) can have a larger positive effect on the patient's clinical recovery than amount of time on the chair.

Back On Trac Clinical Question

Is L3, L4, L5 Discectomy a Contraindication

Question:

I have a patient that has had a discectomy L3 L4 L5 area. Would this be a contraindication for the Back On Trac?

Answer:

This is not a contraindication to the Back On Trac. I have seen laminectomies that have created instabilities in the spine because they took out too much bone, but that is very rare these days.

Back On Trac Clinical Question

Is Left Sciatica a Candidate

Question:

Is a patient with left sciatica a candidate for Back On Trac and if so, what protocol? Subjective: left sciatica, more numbness than pain, surgeon has suggested that he is ready if patient feels like pursuing surgery.

Provided Document:

S-shaped scoliosis. Stable severe disc space narrowing L1-L2 with --
-- marrow endplate change. Severe disc space narrowing at L3-L4 with extensive reactive marrow endplate edema is slightly worse. Several millimeters of retrolisthesis at this level and at L4-L5 unchanged. Normal appearing conus terminates appropriately. No aggressive marrow lesions. Visualized retroperitoneal structures are normal. Following disc levels are outlined below: At T12-L1 no canal or neural foraminal narrowing. Mild facet arthropathy.

At L1-L2 stable disc bulge with mild spinal canal narrowing. The neural foramen are patent.

At L2-L3 canal and neural foramen are patent.

At L3-L4 disc bulge and facet arthropathy with stable mild central spinal canal narrowing. Subarticular recess narrowing is moderate on the right and severe on the left. Neural foraminal narrowing is mild on the right and moderate on the left similar compared to prior. At L4-L5 disc bulge and severe facet arthropathy with bilateral facet effusions results in severe narrowing of the right subarticular recess and right neural foramen similar compared to prior. Left neural foramen is patent. At L5-S1 no significant canal or neural foraminal narrowing.

Answer: This patient is 100% a candidate for the Back On Trac. I don't have the full history or the actual MRI images, but I don't see any indication for a surgery with this patient. The fact that it is mainly numbness and not pain, says a lot. Surgery is indicated for people with intractable pain or loss of function. It doesn't sound like this patient has either of those.

She does have scoliosis, but that shouldn't change any protocol used since it is a simple s-curve. As far as the protocol to use, she shouldn't be restricted in any way. You can start with a C protocol (straight axial pull) and then progress to the O or U protocols if she can tolerate it. She should notice improvements within 2-4 weeks, but the numbness may take several months for it to diminish.

Back On Trac Clinical Question

Laminectomy

Question:

We have a patient who is 8 months post laminectomy/decompression surgery and are wondering if he is able to use the Back On Trac?

Answer:

For a patient who had a *laminectomy*, it's generally safe to wait at least **90 days post-surgery** to begin using the Back On Trac device. However, the most critical factor is obtaining clearance from the surgeon, confirming the patient has been released for normal activities. Always follow the surgeon's recommendations and adjust based on the patient's comfort and progress. *Laminotomies* are more common these days and do not require the significant removal of bone, so the recovery time is much quicker. The patient can use the BOT in as little as 4 weeks.

Back On Trac Clinical Question

Marketing as Decompression

Question:

Can the Back On Trac be marketed as decompression?

Answer:

Spinal traction is the process of gently applying force to the spine to create decompression, relieving pressure on spinal discs and nerves. While decompression and traction are often used interchangeably, they are not the same. The Back On Trac is a traction device that, when used with the appropriate protocol, can produce a decompressive effect on the spine.

It's important to note that traction is the mechanism, and decompression is the result of properly applied traction. For marketing purposes, the best approach is to focus on the conditions being addressed (such as back pain or spinal pressure) rather than the device itself.

Back On Trac Clinical Question

Nausea

Question:

A patient that is 91 years old and is going through a neuropathy program with the Back On Trac as part of the therapy. He said about an hour and a half after her second therapy on the BOT she was at the grocery store and felt nauseous. He wanted to know if we have heard of a patient getting nauseous before or after using the Back On Trac. He wouldn't be worried about it if she wasn't 91.

Answer:

Not really. The only patients that sometimes have an issue with anything similar to that is when they have a lot of degeneration in the cervical spine, and they sometimes need a pillow to elevate their head slightly because it causes some dizziness. Outside of that, not an issue.

Back On Trac Clinical Question

Peripheral Neuropathy

Question:

With a focus on peripheral neuropathy, we get a lot of low back patients. I need a good understanding of the strengths and weaknesses of the Back On Trac and how to use it...as an example; when patients come in for primarily severe low back stenosis, I refer them out to a clinic that has a spinal decompression machine. I'd like to speak with someone with more experience so we have a better idea of what patients we can help with the Back On Trac, or when we should refer them out (or do we need to at all?)

Answer:

Back On Trac & Stenosis

I get a bit snooty about this in regard to, How Is the Stenosis? If it's a true anatomical stenosis (meaning the neural foramen is growing inward/closing) then I don't believe decompression is the way to go. In those, more rare cases, I'd refer to a neurosurgeon for a consultation.

In most cases the stenosis is from improper curvatures and ligament laxity causing slippage anteriorly and/or posteriorly. This offset creates a functional stenosis. Not from the diameter of the neural foramen stenosing but from the alignment of the neural foramen above and/or below not lining up well and causing potential cord crowding or crowding to the anterior spinal artery (which will affect the anterolateral spinothalamic that carry pain and temperature...which most neuropathy cases have). This is where the Back On Trac is an incredible tool. Especially since it can provide distraction while adding lateral flexion patterns.

Back On Trac & Neuropathy

One function I love is using the Back On Trac while simultaneously applying Hako Med on Neuropathy settings. The Back On Trac also offers settings of adding vibration and heat to the session. Beside the comfort value, way more important is the afferentation from the vibration and distraction and lateral flexion all while using the HakoMed. From a neuropathy focus, things that fire together wire together. Exercising the nerve pathways while on the BOT not only saves a lot of time, it offers enhanced clinical outcomes. Because of the vibration feature, that can happen with or without HakoMed.

Back On Trac Clinical Question

Pregnancy

Question:

Can you use the Back On Trac on ladies that are pregnant and if this is a contraindication for 1st...2nd...3rd trimester?

Answer:

Pregnancy isn't an issue until they have difficulty lying on their back for long periods which will be at the 3rd trimester for most people.

Question:

Is vibration on the Back On Trac okay to use on pregnancy?

Answer:

Absolutely. As long as the patient can tolerate it and doesn't have to excessive SI joint instability. It feels great!

Question: Can you share with me some Back on Trac protocols you use for your pregnant patients, length of time, heat or vibration used and when to use specific protocols depending on how far along, they are?

Answer:

For pregnant patient's I use protocols C, U, and O. Usually the earlier in pregnancy we just follow the normal U protocol for acute pain and O for more chronic and wellness. We do 8-10 minutes in the early stages with vibration and no heat. Once they get into the 30's weeks and if their bellies are bigger then we do the same protocols and pulls just make sure to keep an eye on how long they are on their back just in case they start to feel the pressure on the abdominal or iliac blood flow areas. (Tingling legs, light headedness, etc.) I have been able to go the full 8-10 minutes the entire pregnancy, even at the end but my belly does not get that big and I don't have an overabundance of amniotic fluid. So just pay more attention to them and ask for feedback. I usually keep the pull around 4 in during pregnancy.

Back On Trac Clinical Question

Request for X-Rays

Question:

I have a few questions, one is if you have any case studies that show a patient with a disc bulge or herniation with before and after therapy imaging, X-ray or MRI? And how many treatments it took to achieve those results, as to build a treatment package. The videos are great, but I was hoping for document information I could read through.

Answer:

1. Increased disc space – Even on other decompression tables, I never have a goal of increasing disc space. The main objective is to stop the disc degeneration or to slow it down. This can be visualized on a radiograph, but not for several years after.
2. Reduction or elimination of the herniated disc – this would obviously take an MRI to determine, but unless we have free access to an MRI, most patients, do not follow up scans. Furthermore, the body will naturally reabsorb the material overtime. This has been studied, and the institutions have done pre-post MRI proving this be the case. It would be misleading to say that a decompression unit did the work when the body can accomplish this naturally, so I do not give that expectation for the patient.
3. Improvement on abnormal position or curvature of the spine – this can be visualized on x-ray as we see it all the time. However, it is a collection of therapies we use to make these improvements, including the Back On Trac. We typically have anywhere from 10% to up to 40% change.

As far as studies that have been performed, we have enough studies with existing traction/decompression units to know that this type of therapy works, and it works well. However, none has the advantage of lateral reflection as the Back On Trac does. If you understand the anatomy of the spine, you can appreciate the effect this would have on facet joints and the surrounding soft tissue in comparison to a straight axial pull.

Patient improvement and satisfaction – the Back On Trac has been in operation since 2011, and our doctors have treated tens of thousands of patients. The patients have both objectively and subjectively improved their conditions. This cannot be understated since this is the ultimate goal with patient care whether there is a visual change on an x-ray or an MRI.

Doctor satisfaction – the Back On Trac continues to grow in popularity, and not through marketing strategy, but because of very satisfied doctors. Not only due to the improvements their patients have gained, but the return on the investment they received from the Back On Trac.

Back On Trac Clinical Question

Scoliosis

Question:

Is there a video anywhere that explains how to best utilize the Back On Trac for a patient who has scoliosis in the lumbar spine?

Answer:

My thoughts may be too simplistic on scoliosis, which is not a corrective protocol for the curvatures, but that is more directed toward comfort and making sure I am creating maximum movement of the spine. Basically, you want to pull the spine in the direction of the sacrum. For example, if someone has a lumbar scoliosis where the “convex side” is toward the right (dextro- scoliosis), I may start with the Back On Trac positioned to the left only, as it is a more comfortable pull than trying to force the spine to open with a straight axial pull or lateral flexion to the right forcing the curve to open. As the spine improves in motion (which is what you need for change), I will begin moving toward more aggressive protocol that includes lateral flexion bilaterally. Someone that is utilizing specific protocols for scoliosis may have a much more complex answer.

Back On Trac Clinical Question

Spinal Arthritis

Question:

I have a patient that has severe spinal arthritis, and I would like to restore disc height. Would protocol C work best for this?

Answer:

I wouldn't claim to any of my patients that I would restore disc height. With the Back On Trac or any traction table. But to help with increasing mobility of the joints and helping to maintain hydration and strength in the ligaments to help prevent further degeneration or loss of disc height, that we could say. Protocol C is a great way to help with patients in this scenario.

Back On Trac Clinical Question

Spinal Stenotic with Abbott Stimulator

Question:

We have a severe spinal stenotic patient who had an Abbott stimulator surgery for her pain in early September. Prior to her surgery she did get a little bit of relief from the Back On Trac. We are wondering if she is still a candidate for it and if someone has a "best protocol." She is very limited with walking, sitting is fine, no loss of leg strength except when walking.

Answer:

Please let the doctor know that I have had many conversations with pain doctors about the possibility of any adverse reactions to using the Back On Trac with a stimulator and the answer is always "no." The leads are usually implanted higher than where the Back On Trac distracts the spine. As far as the protocol, I would use a protocol that includes lateral flexion, like O or U, with a light pull the first few times to monitor her reaction. Even with stenosis, if the foramen isn't too involved, lateral flexion shouldn't be an issue. If it is, you can isolate lateral to only one side or stick with the C protocol. The main objective is to pull lightly and move up accordingly.

Back On Trac Clinical Question

Spinal Fusions

Question:

Is there a limit to how many fusions a person has that we should not use the Back On Trac?

Answer:

It does not matter how many fusions a patient has they are still able to use the Back on Trac. I would only clarify the statement with patients with fusions are able to use the Back On Trac after 1-year post-surgery, however, it is the doctor's responsibility to determine whether the patient is able to use the device since they are more familiar with a patient's surgical history. Multi-level fusions are still considered stable after one year but consider the limitations in movement before proceeding.

Question:

66 y/o male patient with a spinal fusion. Is he a good candidate?

Answer:

If the surgery is more than 1 year old, you can try the Back On Trac. There will not be much axial traction in the lumbar spine with this aggressive of a fusion. Although you will get some separation of the facet joints, most of the relief is going to come from the stretching of the paraspinal muscles. If you decide to move forward with the BOT, start with a straight axial pull (B or C) with a gentle pull. If he tolerates that well, then you can progress him to one that includes lateral flexion.

Question:

This patient is 73 years with spinal fusion. The doctor feels there is sufficient space on either end of this for some movement but would like a second opinion. This patient would appreciate any small improvement.

Answer: Most definitely okay to do. You may want to start the patient on any of the protocols that do not use the right and left lateral flexion the first handful of times to make sure they do not get sore from the spondylosis. But this patient with the midline long axial traction could benefit from the BOT. Sometimes with this amount of degeneration cryotherapy and laser treatment also helps.

Back On Trac Clinical Question

Spinal Stimulator Implant

Question:

Is it safe for a patient with a spinal stimulator to use the Back on Trac and Cervi-Trac? However, the stimulator was planted down lower in the pelvis all the way to her cervical spine. So, I wanted to make sure that this would still be valid despite the positioning.

Answer:

That should be ok since the leads typically have a lot of slack.

Back On Trac Clinical Question

Spinal Rod

Question:

We have a patient who is looking into what type of rod she has, but in the meantime, we are aware of the rod in the training that is ok, but is there any type of rod that would exclude a patient from being a good candidate for treatment?

Answer:

When it comes to rods, it is more about position and if they are healed after being put in. If they are healed, you are good to go in most situations. Now, I am not sure what type of rods this doctor is referring to but if they are harrington rods for scoliosis, as long as they are in the thoracic and upper lumbar spine, the patient is good to go on the Back On Trac.

If they are referring to the cage (rods) for spinal lumbar fusions, again you are good to go as long as they are healed and as long as not all spinal segments aren't fused or fused to the sacrum. It wouldn't hurt the patient, but it wouldn't really benefit them in that situation either as it would all be fused.

Back On Trac Clinical Question

Treatment Post Discectomy

Question:

Patient is 3 months post discectomy, has reticular symptoms and nerve pain that came back pretty quick after surgery.

Answer:

I would avoid Back On Trac for that patient.

Back On Trac Clinical Question

Treatment after Gastric Sleeve

Question:

Do you know if a gastric sleeve surgery recently is a contraindication to Back On Trac treatment? We have a patient that is getting it soon.

Answer:

Wait 6 weeks and start them on axial traction before doing any lateral or bilateral flexion. Low, slow and straight.

Back On Trac Clinical Question

Treatment Protocol for Grade 1 Spondy

Question:

Need a treatment protocol for a young patient (18y/o)

L5 Grade 1 Spondy + L5 Pars defect and previous fractured femoral head with surgical repair and surgical artifacts.

Answer:

The Grade I Spondy should not be an issue at all with the Back On Trac, however, I would start the patient with a straight axial pull (C) to monitor toleration for 1-2 sessions, and if she does well then proceed to any protocol that includes lateral flexion bilaterally (M, O and U). My main concern would be the hardware from the previously fractured hip causing an irritation. Most do not, but it is common enough to mention it.

Back On Trac Clinical Question

Stage 4 Degeneration with Natural Fusions

Question:

If someone has stage 4 degeneration, with natural fusions. not surgery, are they a candidate for the Back On Trac?

Answer:

Yes, even with a surgical fusion, a patient will benefit tremendously from the Back On Trac. The only caveat is to be cognizant of any soreness afterward. It usually isn't terrible, but the patient needs to know that soreness may be part of the initial stages of breaking down the spine. Patients with severe stenosis should be monitored for any increases in radicular pain. Other than that, most patients experience a lot of mobility improvements, as well pain reduction.

Back On Trac Clinical Question

Traction at L5-S1

Question:

How do you specifically traction L5-S1?

Answer: To specifically traction the **L5-S1** segment using the Back On Trac (BOT), it's important to understand the mechanism of axial traction provided by the device. Unlike many traditional decompression/traction systems that stabilize the upper torso with a strap while the lower unit creates the pull, the BOT delivers a controlled, straight axial traction that effectively isolates the lumbar spine, including the **L5-S1** region.

While the thoracolumbar area may experience some degree of traction due to the nature of the pull, the design of the BOT ensures that the majority of the traction force is applied to the lumbar spine. This is particularly effective for **L5-S1** because the straight axial pull focuses on elongating the lumbar spine without excessive movement in the upper torso or other segments.

The result is a targeted, gentle traction that decompresses the **L5-S1** area while minimizing strain on surrounding structures. This unique approach distinguishes the BOT from traditional systems and enhances its efficacy for patients needing decompression at this specific level.

Back On Trac Clinical Question

Types of spondylolisthesis

Question:

What are the specific protocols for anterolisthesis and retrolisthesis?

Answer:

Anterolisthesis and retrolisthesis are both types of spondylolisthesis, which is a spinal condition that occurs when a vertebra slips out of place.

I am not aware of any protocols for antero or retrolisthesis. However, the Back on Trac will help strengthen the soft tissue around the area with any of the protocols.

If the movement is minimal (in regards to anterolisthesis anything a grade 2 and under), it should not be a problem or contraindication. I would approach a Grade 3 cautiously and avoid anything higher.

Unless there is some type of neurological compromise, like a cord compression, the BOT should be helpful for someone with a listhesis.

General Lumbar Conditions and Protocols

Lumbar Segmental Dysfunction

Pain ranging from

8-10 Protocol B

5-7 Protocol U

1-4 Protocol M

Therapeutic Exercise

Pain ranging from

8-10 Protocol B

5-7 Protocol U

1-4 Protocol U

Neuromuscular Re-education

Pain ranging from

8-10 Protocol B

5-7 Protocol U with Vibration

1-4 Protocol U with Vibration

General Lumbar Conditions and Protocols

Low Back Pain

Location

Right, Left, or Midline

Pain ranging from

8-10

Right Protocol **J**

Left Protocol **H**

Midline Protocol **B**

5-7

Right Protocol **U**

Left Protocol **U**

Midline Protocol **U**

1-4

Right Protocol **M**

Left Protocol **M**

Midline Protocol **M**

General Lumbar Conditions and Protocols

Lumbar Spain/Strain

Location

Right, Left, or Midline

Pain ranging from

8-10

Right Protocol **H**

Left Protocol **J**

Midline Protocol **B**

5-7

Right Protocol **C**

Left Protocol **C**

Midline Protocol **C**

1-4

Right Protocol **U**

Left Protocol **U**

Midline Protocol **U**

General Lumbar Conditions and Protocols

Lumbar Disc Bulge

Location

Right, Left, or Center

Hip Pain

Yes/no

Right or Left ?

Pain ranging from 8-10

If Right, Yes, Right Protocol H

If Right, Yes, Left Protocol J

If Right, No, Protocol H

If Left, Yes, Right, Protocol H

If Left, Yes, Left, Protocol J

If Left, No, Protocol J

If Central, Yes, Right Protocol H

If Central, Yes, Left Protocol J

If Central, No, Protocol B

Pain ranging from 5-7

If Right, Yes, Right Protocol Q

If Right, Yes, Left, Protocol S

If Right, No, Protocol Q

If Left, Yes, Right, Protocol Q

If Left, Yes, Left, Protocol S

If Left, No, Protocol S

If Central, Yes, Right Protocol Q

If Central, Yes, Left Protocol S

If Central, No, Protocol U

Pain ranging from 1-4

If Right, Yes, Right, Protocol U

If Right, Yes, Left, Protocol U

If Right, No, Protocol U

If Left, Yes, Right, Protocol U

If Left, Yes, Left, Protocol U

If Left, No, Protocol U

If Central, Yes, Right Protocol U

If Central, Yes, Left, Protocol U

If Central, No, Protocol U

General Lumbar Conditions and Protocols

Lumbar Disc Herniation

Location

Right, Left, or Center

Hip Pain

Yes/no

Right or Left ?

Pain ranging from 8-10

If Right, Yes, Right Protocol H

If Right, Yes, Left Protocol J

If Right, No, Protocol H

If Left, Yes, Right, Protocol H

If Left, Yes, Left, Protocol J

If Left, No, Protocol J

If Central, Yes, Right Protocol H

If Central, Yes, Left Protocol J

If Central, No, Protocol B

Pain ranging from 5-7

If Right, Yes, Right Protocol Q

If Right, Yes, Left, Protocol S

If Right, No, Protocol Q

If Left, Yes, Right, Protocol Q

If Left, Yes, Left, Protocol S

If Left, No, Protocol S

If Central, Yes, Right Protocol Q

If Central, Yes, Left Protocol S

If Central, No, Protocol U

Pain ranging from

1-4

If Right, Yes, Right, Protocol U

If Right, Yes, Left, Protocol U

If Right, No, Protocol U

If Left, Yes, Right, Protocol U

If Left, Yes, Left, Protocol U

If Left, No, Protocol U

If Central, Yes, Right Protocol U

If Central, Yes, Left, Protocol U

If Central, No, Protocol U

General Lumbar Conditions and Protocols

Radiculopathy

Location

Right, Left

Leg/Hip Pain

Yes/no

Right or Left ?

Pain ranging from 8-10

If No Protocol **B**

If Yes, Right, Protocol **B**

If Yes, Left, Protocol **B**

5-7

If No Protocol **U**

If Yes, Right, Protocol **C**

If Yes, Left, Protocol **C**

1-4

If No Protocol **M**

If Yes, Right, Protocol **U**

If Yes, Left, Protocol **U**

General Lumbar Conditions and Protocols

Sciatica

Location

Right, Left

Leg/Hip Pain

Yes/no

Right or Left ?

Pain ranging from 8-10

If No, Protocol B

If Yes, Right, Protocol B

If Yes, Left, Protocol B

5-7

If No Protocol U

If Yes, Right, Protocol C

If Yes, Left, Protocol C

1-4

If No Protocol M

If Yes, Right, Protocol U

If Yes, Left, Protocol U

General Lumbar Conditions and Protocols

Spondylosis

Pain ranging from

If **8-10**, Protocol B

If **5-7**, Protocol U

If **1-4**, Protocol M

Spondylolisthesis

Grade Level

1 - proceed with normal protocols

2 - proceed with normal protocols

3 - Proceed with caution. If the patient experiences an increase in pain during the session, discontinue use immediately.

4 - Do not proceed. It is contraindicated to use the Back On Trac on a Grade 4 or 5 Spondylolisthesis.

5 - Do not proceed. It is contraindicated to use the Back On Trac on a Grade 4 or 5 Spondylolisthesis.

Location

Right, Left

Leg/Hip Pain

Yes/no

Right or Left ?

8-10

If No Protocol B

If Yes, Right Protocol B

If Yes, Left, Protocol B

5-7

If No Protocol C

If Yes, Right Protocol C

If Yes, Left, Protocol C

1-4

If No Protocol M

If Yes, Right, Protocol M

If Yes, Left, Protocol M

General Lumbar Conditions and Protocols

Degenerative Disc Disease

Location

Right, Left

Leg/Hip Pain

Yes/no

Right or Left ?

Pain ranging from

8-10

If No Protocol **B**

If Yes, Right Protocol **B**

If Yes, Left, Protocol **B**

5-7

If No Protocol **U**

If Yes, Right Protocol **C**

If Yes, Left, Protocol **C**

1-4

If No Protocol **M**

If Yes, Right, Protocol **U**

If Yes, Left, Protocol **U**

General Lumbar Conditions and Protocols

Facet Syndrome/Arthrosis

Location

Right, Left, or Midline

Pain ranging from

8-10

Right Protocol **B**

Left Protocol **B**

Midline Protocol **B**

5-7

Right Protocol **U**

Left Protocol **U**

Midline Protocol **U**

1-4

Right Protocol **O**

Left Protocol **O**

Midline Protocol **O**

General Lumbar Conditions and Protocols

Spinal Stenosis

Location

Right, Left

Leg/Hip Pain

Yes/no

Right or Left ?

Pain ranging from 8-10

If No, Protocol **B**

If Yes, Right Protocol **B**

If Yes, Left, Protocol **B**

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If No, Protocol **C**

If Yes, Right Protocol **C**

If Yes, Left, Protocol **C**

1-4

If No Protocol **U**

If Yes, Right, Protocol **U**

If Yes, Left, Protocol **U**