

MONTREAL

Cervical Disc Herniation Treatment in Montreal.

The condition explained.
Spinal decompression.
Your care journey.

Practical guidance to prepare for your visit and track what matters in everyday life.

[Prepare for my consultation](#) →



Your situation comes first.

Assessment · options · follow-up

Illustrative image from the TAGMED website.

COMPLETE GUIDE / MONTREAL

- Understand
- Prepare
- Move forward

Your path through this guide

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01 / THE CONDITION

Understanding the terms. Relating them to your situation.

A cervical disc herniation is a protrusion of the disc between two vertebrae in the neck. Depending on its location, it may contribute to local pain, irritate a nerve root or, more rarely, affect the spinal cord. [1]

The disc has a fibrous outer layer and a softer centre. When disc material extends beyond its usual boundary, the report may refer to a protrusion or herniation. However, this imaging finding is not enough to explain every pain. The level, side, symptoms and examination findings are checked for agreement. Making these connections helps distinguish an imaging finding from a problem that is actually causing symptoms. [1]

Neck pain

A herniation may coexist with neck pain, but the disc is not the only structure that may contribute to local pain. The joints, muscles and demands of activities can also play a role. The assessment looks at what actually limits movement and daily life. [6]

Arm pain

Irritation of a root can cause pain radiating towards the shoulder, arm or fingers. Changes in sensation, strength or reflexes support further investigation of nerve root involvement. However, a wrist, elbow or shoulder problem may cause similar symptoms. [1]

The connection with symptoms

The cervical roots contribute to the nerves that supply the upper limb. Irritation near the neck can therefore be felt far from the disc, all the way into the hand. The examination goes beyond identifying the path of pain: it compares sensation, strength and reflexes, and checks whether the signs correspond to the same area. Several symptoms may overlap. [8]

Numbered references and clickable links on page 18.

02 / THE STRUCTURES INVOLVED

Understanding the structures.

The cervical vertebrae surround a canal containing the spinal cord. The roots leave this canal through side openings called foramina. The location of a disc protrusion influences which structures may be irritated. [1]

What matters in this region

A protrusion directed towards a root may contribute to radicular pain. A large central protrusion may involve the spinal cord and require a different approach. The distinction is essential: pain in one arm does not represent the same pattern as difficulty walking or loss of hand coordination. The record must specify the location and effects, without inferring severity from the word 'herniation' alone. [3]

Disc changes

Over time, a disc may lose height and flexibility. A tear in its outer layer may accompany the protrusion. These changes are not always painful, and their interpretation depends on the clinical picture. [1]

Irritation near a root

Contact and inflammation around a root may contribute to arm symptoms. Pain is therefore not simply a matter of dimensions on an image: the side, course and neurological signs provide additional information. [1]

Other associated changes

Loss of disc height or bone spurs can also narrow a foramen. A herniation and osteoarthritis may therefore coexist. Treatment is discussed on the basis of the identified mechanism and observed functional limitations. [8]

Symptoms from another source

Shoulder pain or compression of a nerve at the elbow or wrist may resemble pain coming from the neck. Describing the movements that trigger symptoms and the fingers affected helps guide the examination, without replacing clinical tests. [1]

03 / SIGNS AND SYMPTOMS

Symptom distribution and activities. Changes to observe over time.

Describe neck pain and arm symptoms separately. Note the side, the fingers affected, the onset of tingling and changes in how you use your hand, including writing, buttoning clothes or grasping. [1]

Two patterns to distinguish

Possible radicular pattern

Pain from the neck into the arm, burning or electric shock sensations, numbness and sometimes reduced strength. The path of symptoms and test findings must be considered together. [1]

A pattern requiring a different priority

New hand clumsiness, loss of balance, heavy legs or difficulty walking may suggest more central involvement. These changes require prompt medical assessment. [3]

What changes over time tell us

Cervical nerve root irritation may improve with non-surgical care and a gradual return to activities. Timelines vary, and symptoms may fluctuate. Follow-up also compares hand function and strength, rather than pain alone. Neurological deterioration changes the priority and warrants medical advice, even if a care appointment is already scheduled. [2]

Numbered references and clickable links on page 18.

04 / THE ASSESSMENT

Connecting your history, the examination and the images.

The assessment connects your history with examination findings. Bring reports you already have, details of treatments tried and an example of an activity that has become difficult, without deliberately provoking significant pain. [6]

1 Locate the symptoms

The professional clarifies the onset, side and path, as well as positions that change the pain. The effects on sleep, work and arm use help define goals suited to your needs. [6]

2 Check nerve function

Sensation, strength and reflexes are examined. The neck, shoulder and upper limb are considered together to look for a nerve root source or another explanation. Tests are interpreted as a whole. [1]

3 Determine which investigations are useful

MRI can provide more detail about the discs, roots and spinal cord when the context warrants it. Electrodiagnostic testing may sometimes help distinguish a root problem from a peripheral nerve problem. Not everyone needs all of these investigations. [1]

New imaging is not automatically required before every first consultation. The indication depends in particular on neurological signs, the context, persistence and the decision to be made. Bring existing investigations; a medical referral may be needed to complete the assessment. [6]

In a report: 'C5-C6' describes the level between two vertebrae. 'Foraminal' locates an abnormality near a root's exit. 'Spinal cord compression' involves the cord. These terms have different implications and must be explained alongside the symptoms, rather than interpreted in isolation. [1]

When to seek care.

New signs affecting walking, coordination or several limbs may signal involvement that requires urgent medical assessment. They must not wait for a scheduled non-surgical spinal decompression session. [3]

GO TO THE EMERGENCY DEPARTMENT IMMEDIATELY

- Severe or rapidly progressive weakness in one or more limbs, or significant new difficulty walking, with loss of balance or coordination.
- New bladder or bowel control problems associated with weakness, walking difficulties or other neurological symptoms.
- Severe neck pain accompanied by sudden speech or vision problems, paralysis, or neurological symptoms after significant trauma. [7]

Call 911 if you need immediate assistance.

Prompt medical advice

- New hand clumsiness, dropping objects or difficulty buttoning clothes.
- Progressive weakness, numbness or sensations in the arm.
- Persistent night pain, fever, trauma or unusual deterioration. [7]

A visit to arrange

If pain persists, worsens or interferes with sleep and your activities, seek an assessment. Describe changes since the onset, measures already tried and a specific activity that has become difficult.

Numbered references and clickable links on page 18.

06 / OUR TREATMENT

Spinal decompression at TAGMED.

DOC non-surgical spinal decompression applies controlled motorized traction with settings adapted to the region being treated. For a cervical herniation, the goal discussed is clinical and functional improvement. A reduction in pain does not, by itself, demonstrate resorption of the herniation; the response and neurological signs must be reassessed. [4]



Illustrative image of the care journey.

A non-surgical approach

Motorized traction applies controlled tension to the cervical region. Setup and settings take into account the selected clinical profile, precautions and the sensations you describe during the session. [9]

DOC equipment from Pivotal Health Solutions

The device allows adjustment of position, force and cycles. Program selection is based on assessment and tolerance; a device's capabilities alone do not predict a clinical outcome. [10]

Goals to discuss

- Reduce arm discomfort and improve tolerance for selected activities.
- Monitor changes in sensation and hand function.
- Gradually regain useful mobility and more comfortable sleep.

Controlled force. Individualized settings.

Traction and positioning aim to modify mechanical stresses. The program can vary the force, its gradual increase, its hold and the relaxation phases. [9]

1

Position

The region and position are chosen according to the clinical profile, precautions and your comfort.

2

Program

The practitioner adjusts the force, duration and pattern of the traction cycles.

3

Adjust

Tension follows the selected program, with phases of reduced tension.

4

Reassess

Your sensations and response guide whether to continue, adjust or stop treatment.

What “decompress” means

A reduction in pressure and fluid exchange within the disc are among the proposed mechanisms. They do not demonstrate disc regeneration, lasting widening of bony structures or the certain disappearance of a herniation. A useful effect is assessed in your daily life and during reassessments. [9] [11]

Numbered references and clickable links on page 18.

The right treatment begins with the right clinical profile.

A cervical herniation is not an automatic indication for non-surgical spinal decompression. Whether a trial is appropriate depends on the clinical presentation, neurological course, medical history and precautions checked before positioning. [1]

An option to discuss

In some radicular pain patterns, controlled cervical distraction may be considered among non-surgical options. It aims to improve symptoms and activities. The discussion must clarify alternatives, expectations, reassessment criteria and what would lead to changing or stopping treatment. [4]

Situations to clarify first

Suspected spinal cord involvement, progressive weakness, trauma or another condition requiring medical advice change the approach. Cervical surgeries and implants must be reported. Traction settings are not chosen simply from the level listed on an MRI. [3]

Medical history to disclose before any session

The DOC manual lists fracture, spinal instability, infection, tumour, advanced osteoporosis and certain spinal implants among the contraindications. Pregnancy and previous surgeries also require particular attention. [9]

This list is not exhaustive. Bring details of your medical conditions, procedures and treatments.

If warning signs are present: appropriate medical assessment is the priority. See the emergency guidance on page 6.

09 / THE SESSION

What happens during a decompression session.

The first consultation establishes the clinical profile and the proposed plan. On the day of a session, setup and settings depend on what has been selected for you. [11]

1 Review your situation before starting

Report changes since the last visit: pain, symptom distribution, sensations, strength and reactions to care.

2 Get comfortably positioned

The support system suited to the region is positioned. The operation of the stop control is explained to you. [9]

3 Apply the selected program

The force and cycles are set. Describe your sensations; an increase in symptoms warrants stopping and checking. [9]

4 Check the response after the session

Tension is released, then you get up gradually. Instructions and what to monitor before the next visit are explained. [9]

Time to allow: the discussion, setup, treatment phase and final check. Your appointment length is confirmed when you book.

Numbered references and clickable links on page 18.

10 / THE PLAN AND REASSESSMENTS

A structured care journey. Progress to measure.

The frequency and number of sessions are individualized. Reassessments allow comparison of your response and adjustment of care, rather than automatically continuing a program. [11]

01 Establish the starting point

Describe the main problem and choose measures to track: neck or arm pain, hand use, sleep and a chosen activity.

02 Assess tolerance and response

Compare observations over the course of visits. Function, tolerance and clinical signs contribute to the decision to continue.

03 Adapt the next steps

Depending on progress, modify the parameters, frequency, advice or referral. Persistent or new symptoms may warrant another opinion.

Before agreeing on the plan, clarify together:

The goals, proposed frequency, costs, first reassessment and options if progress is insufficient.

Numbered references and clickable links on page 18.

11 / POSSIBLE BENEFITS AND EVIDENCE

What you can expect. What remains uncertain.

Studies of cervical traction mainly examine people with radicular pain. Their results must be distinguished from those for isolated neck pain and cannot predict an individual patient's outcome. [5]

SYSTEMATIC REVIEW · 2018

Potential value within some programs

Romeo and colleagues studied the addition of traction to care for cervical radiculopathy. Favourable effects on pain and disability were observed in some comparisons. The authors highlight limitations, including variation in definitions and protocols. This finding concerns an intervention added to other care. [4]

REVIEW · 2020

An effect to interpret cautiously

In the pooled studies, Colombo and colleagues find a statistical difference in pain when traction is added to other treatments. However, the difference does not reach the selected threshold for clinical importance, and the certainty of the evidence is low. The choice therefore cannot rest on a general promise of effectiveness. [5]

APPLICATION TO YOUR CASE

Monitor a concrete response

Results from a group of studies are not a success rate for TAGMED or a DOC device. The professional and patient choose useful measures: arm pain, tolerance for a task, sleep and function. Sufficient benefit, good tolerance and a reassuring neurological course must be verified. [2]

Key point: Cervical traction may be discussed for some radicular patterns, with uncertain benefit. The decision also considers adapted activity, exercises and your preferences. Continuing requires useful progress and good tolerance; any neurological deterioration requires reassessment. [4] [5]

Simple actions. A pace to adjust.

In the absence of warning signs, the goal is to continue activities you can tolerate. Advice and exercises are adapted to your symptoms and abilities; ask what is appropriate for your situation.

01

Keep moving

Break activities into periods you can tolerate. A gradual return may be preferable to prolonged immobility, taking into account the advice you have received.

02

Vary your positions

Alternate tasks and postures, particularly at work or during travel. Record how long you can tolerate them rather than seeking a perfect posture.

03

Find comfort at night

Look for a comfortable position with suitable neck support. Avoid forcing a position or stretch that increases arm symptoms.

04

Ask for advice

Discuss medications with your physician or pharmacist. Report any decline in strength, sensation or function instead of pushing through these changes.

A specific goal to choose with your practitioner

The activity I want to resume: _____

My starting measure (time, discomfort or distance): _____

Answers to help you make an informed decision.

Does a herniation visible on MRI necessarily explain my painful arm?

The level and side must be compared with the symptoms and examination. Other arm or shoulder causes may coexist. The image provides important information, but clinical agreement determines what it explains in your situation. [1]

Can non-surgical spinal decompression be chosen based only on the report?

An assessment checks symptoms, nerve function, precautions and treatments already tried. Reviewing the report is part of this process. Suspected spinal cord involvement or progressive weakness requires a different priority. [3]

Which changes should I report between sessions?

Report increased numbness, reduced strength, dropping objects or new difficulty walking. Specify when the change appeared and how it has progressed. Deterioration must not be kept as a simple observation until the next session. [7]

Should treatment include exercises?

Exercises and adapted activity may form part of the plan, with choices that take symptoms and abilities into account. Traction studies often concern combined programs; they do not demonstrate that a table alone suits every herniation. [4]

Does improvement mean the herniation has disappeared?

Pain and function may change without a new image being needed. Clinical improvement does not directly measure the size of the herniation. Follow-up focuses first on your symptoms, activities and relevant neurological signs. [1]

How should I prepare for my first consultation?

Bring existing reports and the list of medications, care, surgeries and implants. Note the path into the arm, the fingers affected and a movement that is limited. This information makes the discussion more precise without asking you to reproduce severe pain. [6]

Numbered references and clickable links on page 18.

14 / MY PREPARATION CHECKLIST

Your first visit, with a clearer mind.

Check the items you have prepared. Bring this sheet, your symptom journal and the documents you already have.

Initials (optional): _____

Date: _____

☐ **The location and distribution of my pain**

How long? Which side? How far do the symptoms extend?

☐ **Activities that have become difficult for me**

Arm or hand use, work, sleep or driving.

☐ **Reports and images I already have**

MRI scans, X-rays, reports and previous opinions, if I have them.

☐ **Medications and care I have already tried**

Effects experienced, procedures, implants and important medical history.

☐ **My questions and goals**

What I want to understand and the activity I want to return to.

Questions to ask

- What is the most likely cause, and what supports this hypothesis?
- Which options suit my clinical profile, with their benefits and limitations?
- How should we measure progress, and when should I seek another medical opinion?

Personal sheet to keep and bring to the visit.

Observe changes, as well as pain.

Fill in one row per day. Choose an activity to compare and record your reactions to care. Function and changes in sensation are as useful as the pain score.

Pain: 0 = none; 10 = worst pain imaginable. Specify the region.

Activity: minutes tolerated or chosen measure. **Sleep:** awakenings due to pain.

Date	Neck / arm 0 to 10	Arm use minutes	Other task minutes	Sleep awakenings	Notes / care tried and effect experienced

What has improved

What remains difficult

New or progressing weakness must be reported promptly.
For emergency signs, see page 6.

16 / YOUR NEXT STEP

Review your situation in Montreal.

Sylvain Desforges, docteur en ostéopathie

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Terrebonne

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(450) 704-4447

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Choosing the right appointment portal

Montreal / Mont-Royal

Medexa displays “Le Centre Neurothérapie de Montréal”. Select the new patient osteopathy pathway and check the selected practitioner.

Terrebonne

On GOREndezvous, select the new client pathway and osteopathy treatment, then Sylvain Desforges in Terrebonne and an available appointment.

[View fees](#)

[Sylvain Desforges's profile](#)

Availability is shown in the portals. Services are not covered by RAMQ; osteopathy receipts may be issued. Check your insurance policy conditions.

17 / REFERENCES

Learn more and find the sources.

Numbers in square brackets refer to the sources below. Titles are clickable. Sources accessed on October 22, 2026.

[1] AAOS / OrthoInfo. Cervical Radiculopathy (Pinched Nerve).

Anatomy, symptoms, differential diagnoses, examination and options.

[2] NHS Inform. Cervical radiculopathy.

Course, adapted activity and functional progression.

[3] NHS Inform. Degenerative cervical myelopathy.

Spinal cord signs: hands, walking, coordination and bladder and bowel function.

[4] Romeo et al. (2018). Cervical Radiculopathy: Effectiveness of Adding Traction to Physical Therapy.

Systematic review and meta-analysis of randomized trials.

[5] Colombo et al. (2020). Traction Therapy for Cervical Radicular Syndrome.

Statistical difference without sufficient clinical importance; low-certainty evidence.

[6] Assurance Maladie. Neck pain: consultation, treatment and recovery.

Examination, imaging and care.

[7] Assurance Maladie. Neck pain: what to do and when to seek care?

Timing of consultation and urgent situations.

[8] Johns Hopkins Medicine. Radiculopathy.

Nerve roots, symptoms and distinction from myelopathy.

[9] Pivotal Health Solutions. DOC Manual, rev. E.

Device operation, settings and precautions.

[10] Pivotal Health Solutions. DOC Decompression Table.

Device features and parameters.

[11] Clinique TAGMED. Spinal decompression.

Overview of the treatment offered by the clinic.

General information document from TAGMED Clinic. It does not replace an individual assessment or medical advice. Parameters, suitability and the care plan are determined on a case-by-case basis.