

MONTREAL

Radiculopathy 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.

Radiculopathy is involvement of a nerve root in the spine. Depending on the region affected, it may cause symptoms in an arm or leg, with pain, sensory disturbances and sometimes weakness or changes in reflexes. [1]

A root is a nerve segment near the spine. Compression or irritation of it may disrupt the area it supplies. The term does not specify the cause: herniation, foraminal narrowing and other conditions must be distinguished. Isolated radiating pain does not confirm radiculopathy. The examination looks for findings consistent with the level and side involved. [1]

The cervical region

In the neck, symptoms mainly involve the shoulder, arm and hand. The assessment compares upper limb function and also looks for signs that may involve the spinal cord, such as hand clumsiness associated with difficulty walking. This latter pattern requires a different priority. [2] [8]

The lumbar region

In the lower back, symptoms may extend into the buttock, thigh, leg or foot. The area depends on the root and is not always limited to typical sciatica. Walking, sensation and lower limb strength are used in the assessment. [7]

The connection with symptoms

Peripheral nerves arise from several roots. A problem near the spine may be felt at a distance, while peripheral compression may cause similar symptoms. The examination locates the problem: root, nerve in the limb, spinal cord or another structure. This distinction guides precautions and the choice of treatment. [1]

Numbered references and clickable links on page 18.

02 / THE STRUCTURES INVOLVED

Understanding the structures.

The roots travel through the spinal canal and then join the nerves of the limbs. The disc and bony structures border their path. A narrowed exit space can irritate a cervical or lumbar root. [1]

What matters in this region

The region influences tests and decisions. A neck MRI and a lumbar MRI do not answer the same questions. In the neck, the spinal cord lies within the canal and must be considered when coordination or walking signs are present. In the lumbar region, some patterns affecting several roots, particularly with bladder or bowel disturbances, also require urgent assessment. The words 'pinched nerve' do not describe all these differences. [8] [6]

Disc herniation or protrusion

A disc protrusion may contribute to root irritation. The region, level and side are checked for agreement with symptoms and examination findings, rather than treating every visible abnormality. [1]

A narrowed foramen

Disc or bone changes can reduce the opening through which a root exits. This stenosis may occur in the neck or lower back, but its presence on imaging alone does not indicate functional severity. [1]

Several associated mechanisms

A disc, osteoarthritis and other tissues may contribute together to narrowing along the path. The history, neurological findings and relevant imaging help define the most coherent explanation and care options. [1]

Another nerve problem

Compression of a nerve in a limb or peripheral neuropathy may cause pain, tingling and weakness. Findings that do not agree or an unusual course lead to a broader assessment and sometimes additional investigations. [1]

Numbered references and clickable links on page 18.

03 / SIGNS AND SYMPTOMS

Symptom distribution and activities. Changes to observe over time.

Distinguish what you feel from what you can no longer do. Pain, numbness and reduced strength are three different pieces of information, and their onset dates may also differ. [1]

Two patterns to distinguish

Arm or hand

Describe the side, the fingers affected and limited movements: grasping, writing, carrying or working. New clumsiness or a progressive deficit must be reported promptly. [2]

Leg or foot

Specify the path, walking time and difficulties such as a foot catching. New weakness must not simply be attributed to ordinary pain. [7]

What changes over time tell us

The course depends on the cause, duration, region and extent of neurological signs. Symptoms may improve with non-surgical care, but progressive weakness requires a new assessment. Follow-up must therefore distinguish pain relief from recovery of nerve function. Decisions are not based solely on a lower pain score after a session. [1] [6]

Numbered references and clickable links on page 18.

04 / THE ASSESSMENT

Connecting your history, the examination and the images.

The assessment first clarifies the cervical or lumbar location and the area involved. Prepare the course of sensations, strength and activities, as well as results of MRI or neurological investigations already performed. [1]

1 Describe each change

The professional distinguishes radiating pain, loss of sensation, weakness and limitations caused by pain. The date of each change and its progression help determine the level of priority and establish a baseline for comparison. [6]

2 Look for agreement in neurological findings

Strength, sensation and reflexes are compared in the relevant region. Walking and coordination may also be assessed. Together, these findings help identify root involvement and other explanations for symptoms in the limb. [1]

3 Arrange investigations if necessary

Depending on the clinical question, MRI or electrodiagnostic testing may help clarify the source and location of the problem. An investigation is not automatically required for every visit; medical referral takes priority when signs require it. [2]

An image of a herniation or stenosis must be matched with the correct limb, side and tests. The number of abnormalities described does not directly measure nerve function. Available results are useful but do not replace looking for a consistent clinical course. [1]

In a report: 'Radicular' involves a root. 'Peripheral neuropathy' involves a nerve beyond the spine. 'Myelopathy' involves the spinal cord. 'EMG' refers to an electrical test sometimes used to clarify certain problems. These terms guide the assessment and do not describe identical situations. [1]

05 / SEEKING HELP

When to seek care.

The affected region determines which signs to recognize. Rapidly progressive deficits, spinal cord signs in the neck or bladder or bowel disturbances in a lumbar presentation require urgent medical assessment. [6] [8]

GO TO THE EMERGENCY DEPARTMENT IMMEDIATELY

- Severe or rapidly progressive weakness in one or more limbs, or a sudden deficit with speech, facial or vision changes. [6]
- With cervical involvement: significant new difficulty walking, loss of balance or coordination, particularly with hand clumsiness or a change in bladder or bowel control. [8]
- With lumbar involvement: new difficulty urinating, loss of bladder or bowel control, or loss of sensation in the perineum, with or without worsening leg symptoms. [6]

Call 911 if you need immediate assistance.

Prompt medical advice

- Declining strength or worsening numbness in the arm, hand, leg or foot.
- Dropping objects, a foot catching or an activity previously possible suddenly becoming difficult.
- Persistent or unusual symptoms with night pain, fever or a concerning medical context. [6] [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.

The DOC table allows controlled distraction to be applied to a defined region. For radiculopathy, a possible trial aims to improve symptoms and activities after clinical selection. The response must be measured in the relevant area; a change in strength or coordination is not treated as a simple pain fluctuation. [3] [5]



Illustrative image of the care journey.

A non-surgical approach

Motorized traction applies controlled tension to the cervical or lumbar 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

- Improve a concrete arm or leg task according to the region affected.
- Monitor pain, sensation, strength and functional ability separately.
- Quickly identify neurological changes requiring a different referral.

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.

Radiculopathy does not automatically lead to choosing non-surgical spinal decompression. The region, cause, neurological stability, precautions and other options must be established before discussing a program of motorized traction. [2] [6]

A discussion specific to the region

Studies of cervical traction and those of lumbar traction are distinct. For a possible trial, the plan must specify the limb being monitored, the priority activity, tolerance and timing of reassessment. Improvement in lumbar patients cannot automatically be applied to a cervical problem. [3] [5]

Neurological findings may change the plan

Progressive loss of strength, spinal cord signs in the neck or bladder or bowel disturbances in a lumbar presentation require a different priority. A history of surgery and implants is important. The goal is to propose an approach consistent with the case and adapt it when the situation changes. [6] [8]

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: painful region, arm or leg 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.

Research must be read according to the region and population studied. Protocols, positions and associated treatments vary. A review of radiating neck pain does not answer every question about lumbar radiculopathy. [3] [5]

CERVICAL RADICULOPATHY

Variable results

Romeo and colleagues report value in adding traction in some comparisons of cervical programs. Colombo and colleagues subsequently emphasize the low certainty of the evidence and an average difference that is not clinically important by their threshold. These results call for a nuanced discussion and assessment of the individual response. [3] [4]

LUMBAR RADICULOPATHY

A possible short-term effect

Vanti and colleagues report a possible short-term effect of mechanical traction in the supine position added to physiotherapy for lumbar radiculopathy. The results rely on low-quality evidence in this comparison. They do not establish lasting benefit for every clinical pattern. [5]

INDIVIDUAL DECISION

Function remains the measure

A research finding does not provide a success rate specific to a clinic or device. Follow-up must document the symptoms and activities that matter to you. The course of neurological deficits may warrant medical referral even when some of the pain improves. [6] [1]

Key point: The suitability of non-surgical spinal decompression depends on the region, diagnosis and neurological course. Relief does not prove nerve recovery. Available results remain uncertain; continuing requires useful functional benefit, good tolerance and appropriate 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. A support cushion may help, depending on your tolerance. Avoid maintaining a position that clearly increases 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 pain in a limb confirm radiculopathy?

It may guide the investigation, but several causes can produce radiating pain. The examination looks in particular for a consistent change in sensation, strength or reflexes and checks the area involved. The diagnosis does not rest solely on the word 'pain'. [1]

Is treatment identical for the neck and lower back?

The region, structures, precautions and scientific evidence differ. Goals and the program are adapted to the limb and identified mechanism. Results from lumbar studies cannot automatically be transferred to a cervical problem. [3] [5]

Is an EMG always necessary?

It may be useful for some questions of location or differential diagnosis, particularly between a root and a peripheral nerve. The need is determined in the context of the case. Bring existing investigations without assuming that a new investigation is mandatory for every consultation. [2]

What does it mean if pain decreases but weakness increases?

Pain and nerve function do not always progress together. New or increasing weakness must be medically assessed and may change the priority of care. It must not be overlooked because pain has become less intense. [6]

How can I compare my progress?

Choose a task related to the region: hand precision, arm work, walking or sitting. Also note changes in sensation and strength. These observations complement the examination and help decide whether the plan meets your needs. [1]

Can non-surgical spinal decompression guarantee nerve recovery?

Results depend on the mechanism and clinical condition. Traction studies cannot provide such a guarantee. The discussion covers possible benefit, limitations, alternatives and reassessment, with medical referral when a deficit requires a different approach. [4] [5]

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**

Walking, arm use, sitting, sleep or work.

☐ **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	Region / 0 to 10	Activity 1 minutes	Activity 2 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.

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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 Desforbes in Terrebonne and an available appointment.

[View fees](#)

[Sylvain Desforbes'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] Johns Hopkins Medicine. Radiculopathy.

Regions, causes, symptoms and differential diagnoses.

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

Cervical examination and electrodiagnostic testing.

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

Systematic review of cervical traction.

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

Clinical significance and low certainty of cervical evidence.

[5] Vanti et al. (2021). Effectiveness of Mechanical Traction for Lumbar Radiculopathy.

Systematic review and meta-analysis on the lumbar region.

[6] NICE. NG127: Suspected neurological conditions, recommendations for adults.

Referral, weakness, radiculopathies and signs requiring a different priority.

[7] NLM / MedlinePlus. Sciatica.

Lumbar symptoms, examination and warning signs.

[8] NHS Inform. Degenerative cervical myelopathy.

Difference between a cervical root and the spinal cord.

[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.