Dynamic Chiropractic

PAIN RELIEF / PREVENTION

# Postradiation Lumbago in HIV/AIDS

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The tragic events of September 11 and the mailing of anthrax spores in letters have increased the our awareness of the threat of bioterrorism. The media's coverage of the anthrax letters (18 infections and five fatal cases) has made many fearful of contracting this seemingly uncontrollable infectious disease, even more so than the fears of the more familiar and controllable risks of AIDS, which kills more than 40,000 Americans each year. People with minimal flu-like symptoms have flooded doctors' offices demanding antibiotics, while our nation's antibiotic supplies become alarmingly low.

It is not my intention to understate our recent tragedies, but to place things in perspective, and to remind us that the true weight of the future AIDS epidemic may fall upon the shoulders of chiropractors. Patients see our country as immensely wealthy, and feel that medicine will save us from AIDS. "When will it come? When will there be a cure?" many ask.

As we educate our patients about the basic principles of chiropractic wellness, we are in a unique position to also educate patients about the risky behaviors that put them in danger of contracting AIDS. It is more humane and certainly more cost-effective to prevent disease than to treat it. It should be our New Year's resolution to make a combined, principled, chiropractic effort to educate ourselves and our patients about AIDS; to contact our local AIDS organizations and to be more involved with the AIDS community to aid us in better serving our patients.

Case History

The patient, 46, is a disabled white male with a history of a two-month onset of "back pain on left side with right leg pain." The patient reported radiation therapy on the right inner thigh for malignant skin neoplasm with lymphectomy. He has not had any metastatic disease diagnosed. He has since had an acute onset of the previously described symptomatology that has been sharply progressive, originating with left posterior thigh-buttock pain followed by right inner thigh pain. He commented that the radiation therapy table positioning itself might have led to his current pain levels.

The patient has undergone evaluation for physical therapy referral, which reportedly "was not working and too far to travel." Prior to his self-referral to my center, the patient underwent further work-up and evaluation with radiographs of the right hip.

Together we succeeded in gaining a specialty referral from his medical primary care provider that ultimately led to this chiropractor's medical group network affiliation for provider reimbursement. A patient with back pain deserves the attention of a back pain specialist: a chiropractor.

The patient was diagnosed with AIDS eight years ago. He has been undergoing medication treatment with protease inhibitors.

On historical examination he presents with a complaint of nausea; generally run-down feeling; severe lumbar pain; pain in the left buttock; and right anterior thigh/groin pain. Provocative features include sitting or standing longer than 10 minutes. Palliative features include Vicodin for

pain control.

On clinical examination, he has lost greater than 15 percent of his body weight. Pulse is 86. He presents to my office assisted by a loved one. Skin vital signs are moist and warm with a tendency toward profuse sweating (opposed to diaphoresis; cool and profuse sweating). He displays a small, raised, suspicious irregular facial papule. He displayed some slight dyspnea (respiratory rate 22 per minute) without chest pain or fever. The patient's gait and balance testing demonstrates severe gait abnormality. He is able to balance without assistance. He has a knocked-knee, small-spaced gait.

Motor demonstrates diffuse weakness in the lower extremities bilaterally. He demonstrates no loss of proprioception. Straight-leg-raising to 80 degrees is negative. Atrophy is absent. Bilateral leg lowering yields painful grimace. Tripod sign is present. Lumbar range of motion is severely limited. Range of motion of his hips and joints in the lower extremities does not reproduce his pain. The distal vascular exam is normal. There is a well-healed scar, with firm keloid consistency in the right axilla region.

Chiropractic assessment yields marked joint fixation of the lumbar and pelvic region with pelvic unleveling with right convex curve of the lumbar spine. Provocation of pain is demonstrated on palpation of the dorsolumbar spine and sacral region. There is paraspinous spasm in the lumbar region.

Radiographic imaging studies of the lumbar and pelvic region revealed a loss in lumbar curvature consistent to myospasm. The facets demonstrated hypertrophy and sclerosis consistent to facetal arthrosis. The pelvis demonstrated torsion and ileum rotation. There is no evidence of bony destructive lytic or blastic disease. The right-hip outside study of the previous month was made available and proved unremarkable.

Discussion

This case is interesting, complex and challenging. I did not feel that the patient's symptomatology involving his right anterior groin pain was in any way related to his hip. I have told him and his family that his diagnosis is multiple. I am particularly concerned with the radiation therapy for the skin neoplasm and his compromised immune system. MRI sections and bone scans may give rise to further neuroradiological consideration. There is clinical suspicion of an opportunistic pulmonary infection.

The patient has the possibility of a bone metabolism related to his skin cancer, and a recurrent suspicious facial lesion. However, it was the patient's specific desire to seek an alternative opinion and not undergo any further medical procedures. He had in fact stopped his medication treatment with protease inhibitors (before I began treating) because they made his sick. I do not believe that the patient should undergo any further invasive medical testing, although other opinions may vary. I explained my reasoning to him with respect to his immune system, and asked that he first question whether the testing would change the method of treatment and would it place him in a more severely weakened state.

I discussed that chiropractors practice a drug-free and surgery-free foundation; that we do not treat sickness, but that chiropractic adjustments would support the immune and neuromusculoskeletal system. Yet, I still felt it was my legal and moral duty to explain the biomechanical relationship with his musculoskeletal pain and various differential diagnoses, including sacroiliac dysfunction, myofascial pain syndrome, and AIDS-related complex (ARC) with opportunistic infections (pneumonia). I explained the holistic approach of mind-body relationship

and the importance of spirituality. I explained the principle and power of the chiropractic adjustment, and the differences in the various models of health care. As I do with so many of my patients, I explained the history of chiropractic and our historical "angel symbol" as the true "guardians of health."

Based upon my reports to his primarycare provider, he underwent an oncology referral that advised him not to have chiropractic manipulation "because a metastasis may occur." My patient replied that I did more than adjustments.

He was referred to a dermatologist for a further skin lesion biopsy, but declined. He underwent pain management consultation at a time I had him in fairly good pain control, so no intervention was recommended until it was required, and it was suggested he continue with chiropractic care. He underwent infectious control referral for his pneumonia, and was treated with inhalers and the antibiotic Ciprol. In the interim, the patient agreed to allow 12 conservative chiropractic management sessions.

The physician's affiliated group and nurse casemanager were provided narrative visit reports. They agreed with my opinion, and provided authorization for subsequent care. The nurse casemanager contacted me by telephone and asked about the training of a doctor of chiropractic and my professional opinion on the patient's complaints.

I continued giving chiropractic care until the patient's death. I provided opportunities to discuss chiropractic; fears; theology; spirituality; anger; frustration; and, most importantly, to try to assist him with this process called dying. I spoke to him of my own dear mother's passing in my arms from cancer. I told her it was OK to let go; that it was time to go home (heaven).

My patient passed away at home surrounded by his family and friends. His friend later said, "He kept saying he wanted to go home. I picked him up, carried him about the house and placed him back in his bed and said, 'There, you see, you are home.'"

To which he replied, "I know I am home in San Juan Capistrano, I mean I want to go home."

I recall my patient's last visit. I asked him what activity he missed most.

"I miss my volunteer activities," he said.

I discovered that he was very active in AIDS awareness. I discovered just how active, as he spoke of his involvement in various groups or activities. I told him he should introduce me to people who could assist me in getting involved also, because with the administration and clinical activity of running a busy practice, I didn't have the opportunity to make these contacts. He promised me the next time we saw one another he would.

My next opportunity came in a rather unusual way. I honored him in his passing on the eve of AIDS Awareness Day and attended his memorial service just seven short weeks after we'd met. The memorial speakers were various representatives from the American Red Cross; AIDS Service Foundation; AIDS Care Team Network; AIDS Walk Orange County; AIDS Watch, HIV Advisory Committee; and other speakers.

I never knew he was an artist until I took home with me his rendition of the two symbolic cherub "angel symbols" on the front of his memorial service card.

Editor's note: For more information on AIDS and AIDS' organizations, go to: http://health.yahoo.com/health/Diseases_and_Conditions/Disease_ Feed_ Data/AIDS/

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