Dynamic Chiropractic

BACK PAIN

The ABS Meets in Orlando, Part I of II

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The American Back Society (ABS) conference, "Advanced Diagnosis and Treatment for Neck and Back Pain 2001," was jointly sponsored by the American Back Society and Allegheny General Hospital, and held at the Hilton Walt Disney World in Orlando, Florida, December 5-8, 2001. The ABS board of directors, conference faculty and attendees included a wide variety of professionals: medical doctors specializing in orthopedic surgery, neurology, occupational medicine, anesthesiology; chiropractors, some with specialties in radiology, nutrition, neurology; osteopathic physicians; and physical therapists.

The ABS and its conference are truly interdisciplinary in nature, and chiropractic and its educators would do well to seek exposure to the broad array of viewpoints and information provided in upcoming conferences. No doubt many chiropractors find the interdisciplinary atmosphere reflects their own experience, given that they frequently co-manage patients with allied health care providers, unlike the stereotypically antagonistic environment more common in days gone by, as in the "us-versus-them" myth still perpetuated in some quarters. Continuing education hours were available for almost all states.

From the conference *Zeitgeist* department: Over the years, attending meetings of the ABS, we have been struck by how frequently the various speakers hit upon themes that permeate and reoccur in talk after talk. We are reminded of the German term *Zeitgeist:* the "spirit of the age," or the general intellectual, moral, and cultural climate of an era or situation. Let's just say this meeting of the ABS was particularly strong in the *Zeitgeist* department; call the following "conference themes."

Theme 1: Patient selection. The best two examples of this were David Sudderth's talk on cervicogenic headaches, and Ronald Donelson's talk on validated subgroups of low back pain. (See below.)

Theme 2: Various experimental surgeries and other procedures. We learned about the use of Botox (botulinum toxin) for the treatment of spasm, the advent of IDET (intradiscal electrothermal annuloplasty), the X-stop device for spinal stenosis, and the Prodisc device for total intervertebral disk replacement. The latter two surgical procedures are described below, in the section covering Dr. Zucherman's talks.

Theme 3: Surgical mayhem. Drs. Cahill, Foster, and Rosomoff (see below) all participated in the fun.

Theme 4: Evidenced-based health care. The best examples were the talks by Dr. DeFoyd on chiropractic rehabilitation for the postoperative lumbar spine patient, Dr. Dreisinger in his two talks (one on a new spinal function survey instrument, and the other on a spine center that uses touch-screen technology for data input), and Dr. Donelson, on how determining directional preference enhances patient outcomes (see below).

Theme 5: Making fun of patients. Modesty precludes giving examples, but few doctors are above it.

Compassion for the human condition often incites black humor from the nicest of doctors - a Freudian sort of thing.

Theme 6: Superficial comments and workshop advertising. We have not seen much of this before at the ABS. Several speakers gave teaser talks, essentially promising to deliver the real thing at their workshops later in the day. We also witnessed an unusual number of superficial comments. For example, during grand rounds, one participant deduced from the patient's fingers hanging slightly lower on one side, that there was some sort of sacral dysfunction. As another example, a presenter on acupuncture indicated in his opening remarks that there would be no evidence to present, since we all treat the way we like to be treated, and he did not disappoint - none was presented.

Chronic Post-Whiplash Pain: Organic Versus Psychosocial Models (Dr. Croft)

At the ABS meeting in 2000, Dr. Anton, challenging the concept of a chronic whiplash syndrome. He stated: "In the end, there are irreconcilable conflicts between the biomedical, medicolegal/insurance and psychosocial models of the problem." He called for a comprehensive model that acknowledged all three. At the 2001 meeting, Dr. Arthur Croft was invited to present the opposing view.

We have seen several articles during the last few years debating the significance, even the very existence of, a chronic whiplash syndrome, invoking litigation-based or biopsychosocial models as an alternative to an organic explanation of the patient's chronic complaints. Although skepticism regarding whiplash is hardly new, the debate really accelerated with the release of the Quebec Task Force (QTF) report in 1995,[1] which found that 97 percent of whiplash victims had "recovered" at the end of one year, an argument against compensation for continuing chiropractic care. In addition to a refutation in *Spine,*[2] Dr. Croft, et al., have published several other responses[3,4] and most recently an article in *Dynamic Chiropractic,*[5] which states, "There is currently no strong evidence to support the notion that litigation significantly affects outcome in whiplash," and "psychological profiles of whiplash patients do not differ fundamentally from those of control groups, beyond the influences from concomitant neurological or musculoskeletal complaints."

After discussing some of the tissue-based and clinical support for an organic model for late whiplash, Dr. Croft discussed two other intriguing approaches he has followed. First, he is conducting an internet survey of whiplash sufferers to compare U.S. and Canadian patients with others worldwide. The initial results show no significant differences, arguing against the notion that "persons from westernized countries such as the U.S. and Canada have different outcomes than those of other nations, as a result of different claiming behavior; tort systems; media; or expectations based on cultural variances."[5] (During a Q & A session, one skeptic questioned the validity of an internet survey.)

In the second study, "experts" in the whiplash business - attorneys, medical doctors, and insurance representatives - were unable to reproduce the profile of an actual whiplash sufferer. That is, when asked to complete the survey and fake having a whiplash syndrome, they could not do so effectively, arguing against mere patients having an ability to simulate a syndrome that experts in the whiplash business cannot.

Sandeweiss on ... Functional Release?

Although this was listed in the program notes as a talk on "Functional Release," what we mostly got was a very long history of a 45-year-old woman, used as a vehicle to make several points about CAM (complementary and alternative medicine). Jay Sandeweiss,DO, definitely wins the allied-

health-practitioner-most-like-a-chiropractor (specifically, applied kinesiologist) at ABS meetings. Unfortunately, unlike some of the AK writings we have seen, this presentation was almost entirely conversational, devoid of even the hint that data (or in some cases plausibility) might interest some of the doctors and other health professionals who were present. He does deserve credit for being unabashed about describing practice patterns that are likely seen as "over the edge" by most of the symposium attendees. For example, the program notes say that in this patient's case "a petrojugular dislocation of the right temporal bone is discovered during cranial motion examination," and the doctor finds a "whiplash pattern in her cranial rhythm."

During the talk, to further illustrate his reflex technique approach, Dr. Sandeweiss connected Addison's disease to functional hypoadrenia to *sartorius,* and *gracilis* problems to a functional short leg; to a PI ilium; to a diet overly rich in coffee; and to hypoglycemia. Yes, we get it, "These people don't have the glue that holds together the structure, plus emotional components... You can fix them structurally, but the true healing begins when you address the rest" (the patients' marriages, jobs, etc.).

In this meeting, as in his most recent past presentations before the ABS, Dr. Sandeweiss pretty much laid out his "kitchen-sink" approach to treating patients, who receive lots of line items from the litany of alternative treatments out there for back pain: physiotherapy; neutraceutical and herbal therapies; nutritional changes; exercise; psychotherapy; lifestyle and ergonomic interventions; drugs; acupuncture; etc. Patients may be referred for the Alexander technique; rolfing; homeopathy; yoga; martial arts; hypnosis; injections; etc.

If Dr. Sandeweiss had a primary point to make, it was the central importance of the mind-body connection. His patients read John Sarno's work, probably *The Mind-Body Prescription: Healing the Body, Healing the Pain.* You can read at www.amazon.com that this book claims: "Backaches, slipped discs, headaches, and other chronic pains are due to suppressed anger," and that "Once the cause of the anger is addressed, the pain will vanish."

Dr. Sandeweiss presented a version of the "triad of health": an equilateral triangle with mental/emotional/spiritual, biochemical and structural sides. He also found a way to get into toilet training - that you are good if you learn to keep bowel movements inside - that we are programmed to think that a loose, relaxed butt is bad. The bioenergetic message that tightened buttocks is good creates ischemia in low back and pelvis, hemorrhoids, and pelvic pain in women.

We never did get much information about functional release, although from the program notes we may conclude it is some sort of palpating-challenging-mobilizing-something-or-other. In our opinion, while any primary care provider should be capable of providing advice on diet, exercise, smoking cessation, weight management and healthy living in general, the other components of mind-body care that Dr. Sandeweiss recommends require additional training and perhaps licensure. Psychological counseling, for example, should not be undertaken by well-meaning amateurs. It seems that the vast array of CAM care Dr. Sandeweiss proposes for pain patients should require a primary physician's connectedness with a vast array of providers in their areas. He didn't propose how to do this: whether to refer, do it all oneself (as he apparently does), or practice within a multidisciplinary clinic.

Dr. Dobbins, Comedian Extraordinaire

If Dr. Sandeweiss presented himself as the allied-health-practitioner-most-like-a-kind-of-chiropractor, Dr. Dobbins came across as the chiropractor-most-like-a-nightclub-entertainer. Perhaps half his talk, which was slated to be on nutrition and herbal remedies for managing low back pain, was a long joke that had nothing to do with back pain. Perhaps we should lighten up and

not get bent out of shape that a chiropractor would waste so much precious time addressing this august body cracking jokes, in stark contrast to data-laden presenters who must fight the clock to present the fruits of their many years of labor. Nonetheless, there was hardly any time left to discuss phytochemicals, the ostensible goal of the presentation.

Through it all we learned that willow bark is good; then we learned that ginger is good; then we learned that cayenne is good. Dr. Dobbins mentioned that the native Americans were horrified with the introduction of aspirin that patients taking it would not receive the benefit of other components of willow bark, besides the salicylates that it contains. Interesting, perhaps, but when asked why a physician should recommend an untested and unregulated phytochemical like willow bark over a tested and regulated NSAID like Vioxx, all we heard were more jokes, and an unrelated anecdote to the effect that a 1941 dog food study showed dogs given a vitamin-enhanced diet did worse than dogs eating dog junk food. Then he said (ha, ha, ha, hee, hee, hee!), "Fibromyalgia is a billing code." We guess Dr. Sudderth, who gave a talk at this same symposium on new concepts in the diagnosis and treatment of fibromyalgia, does not agree. He said, "Substance P is markedly increased in patients with fibromyalgia syndrome," but he wasn't very funny.

References

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