

American Back Society Meets in Orlando, Part II

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26 Years of Managing Chronic Back Pain without Surgery

According to Dr. Hubert Rosomoff, the Comprehensive Pain and Rehabilitation Center (CPRC) was established in 1974, and dedicated to the evaluation and nonsurgical treatment of persons seeking pain relief from acute or chronic conditions. He discussed the outcome of more than 2,000 patients treated there, claiming the avoidance of disability and a return to the previous lifestyle and work in 86 percent of those treated.

Dr. Rosomoff, as a spinal surgeon, hardly ever saw a need for surgery, and said he was "grateful for the opportunity to express my heresy to you." He is totally unimpressed with the Mixter-Barr herniated disk model;¹ he believes that even when surgery "works," the reason is not so much that something is structurally improved, as much as foreign matter to which there is an inflammatory response has been removed. In other words, control the inflammation, with or without back surgery, and the symptoms will ameliorate. Moreover, 75 percent of herniated disks are resorbed or appreciably smaller in one year with alternative, conservative treatments. Much of what is thought to be radicular pain turns out to be myofascial on closer scrutiny, once again arguing against surgical solutions.²

"So fellows," Dr. Rosomoff, warned, "you'd better get used to this idea because you're committing mayhem almost every day," as only 0.5 percent of low back patients have any indications for surgery.

From the "Interesting Surgeries" Department:

Spinal surgeon James Zucherman described two interesting surgical procedures, neither seeming to produce much mayhem: (1) an artificial disk spacer and (2) a prosthetic (artificial) disk.

The X-Stop is a titanium implant used to create interspinous process distraction to maintain spinal flexion. Insertion of the spacer is an outpatient surgery, using local anesthesia and requiring less than one hour. It is not approved at this time for multilevel application. It is a minimally invasive treatment for spinal stenosis, which is a narrowing of the spinal canal, lateral recess or neural foramen, resulting in neural compression. This is a problem very much associated with life extension, since in previous centuries people almost never lived long enough to acquire the degenerative changes associated with it. Dr. Zucherman finds that individuals who have had to relieve their symptoms by flexing much of their trunk forward, say by leaning on a shopping cart or using a walker, can assume a more natural posture or gait if the device is used to produce flexion in the most extended segments.

Since February 2000, the safety and efficacy of the X-Stop have been evaluated in a prospective, randomized multi-center study that will eventually involve 200 patients: 100 who get the X-Stop,

and another 100 who receive epidural blocks. To be included in the study, in addition to various symptoms, the patient's spinal canal or neuroforamen must be reduced by 50 percent or more when compared to the segments above and below. At the six-month follow-up, 82 patients suffering from neurogenic claudication at the L3-4 and/or L4-5 levels have been enrolled, of whom 47 received the device. The Zurich Claudication Questionnaire scores showed 73 percent of these patients were significantly improved, compared with only 14 percent of the patients who received an epidural block.

Treatment failures among those receiving the device resulted from misdiagnosed comorbidities, rather than failure of the device itself. Inserting the device at the wrong level - the symptoms must correspond to the level seen to be stenosed in the imaging procedure - will probably be the most common problem with the procedure. These results are also very favorable when compared to decompressive surgery, with equivalent or better results, less complications, shorter recoveries, and almost no risk of significant complications. Although it has not been tested yet, Dr. Zucherman believes the titanium implant may also help in discogenic cases.

Should chiropractors worry about losing business to the X-Stop? Maybe, but the device itself is so tightly inserted that it does not contraindicate spinal manipulation. It limits extension by design, but not other spinal movements. One does wonder about a thrust that would increase spinal extension.

In another talk, Dr. Zucherman discussed his results using a prosthetic (artificial) intervertebral disk. He believes the Prodisc device³ he is using for total disk replacement offers significant advantages over the original Charite device.⁴

Donelson on Directing Effective Care

For all the attention we chiropractors give to obtaining subluxation listings, there is precious little evidence that knowing the listing improves the outcome of care. That is, we really don't know if thrusting in a direction to correct the putative listing gets a result any better than thrusting so as to worsen it. The situation is far better in the McKenzie "world," where there are studies showing that knowing the low back pain subgroup does direct effective care, as Dr. Donelson, whose stunning work has been frequently addressed in these Chiropraxis columns, went on to explain.

There are four published randomized controlled trials (RCT) showing improved patient outcomes using specific mechanical treatment vectors, emphasizing or avoiding certain directions of spinal bending, as tied to specific examination findings.⁵⁻⁸ Other studies, though not RCTs, show similar results: the outcome of care can be effectively predicted by determining directional preference, the presence or absence of centralization.^{8,9}

Usually, but not always, extension is preferred to flexion. Although most clinical guidelines have chosen to ignore the McKenzie literature, a Danish panel did award these assessment procedures recognition for a high level of scientific support.

The program notes¹⁰ make a significant point that didn't really come up during Dr. Donelson's talk, having to do with the increasing influence of the biopsychosocial model of low back pain (as exemplified by Dr. Sandeweiss's talk):

"The biopsychosocial model is very important and useful, but it must be understood and used properly . . . Our initial responsibility as clinicians is to not miss a physical cause of pain. It is understandable to focus on the prominence of psychosocial factors

in patients in whom a physical cause cannot be identified and who is exhibiting a lack of recovery. It is inappropriate, however, to use the model as a rationale for painting the black box of low back pain a new psychosocial color, to the point of influencing and closing minds to the potential to learn more about a patient's physical cause of pain."

One assumes that Dr. Croft, who strongly criticized the biopsychosocial model as an alternative to an organic explanation of patients' chronic whiplash-related complaints, would agree with Dr. Donelson's warning against "overpsychosocializing." There are many examples of this problem among chiropractic system techniques, several of which are poorly camouflaged means of sheltering lay psychotherapy under the chiropractic technique umbrella, much to our distaste.

A Tale of Two Workshops

We attended two workshops: one on diagnostic imaging; the other on electrodiagnosis, featuring Dr. Naomi Abel, MD, that provided a stark contrast between what defines good and bad workshops. The presenter in the imaging workshop put up a bunch of slides that seemed not so much selected as what he just happened to have had in front of him the day before hurriedly leaving town, slides he used for teaching purposes. His workshop consisted of throwing up an image featuring some pathology, challenging the spectators to "name that disease," then on to the next slide.

It was a form of "radiographic pathology Trivial Pursuit."

Dr. Abel, by comparison, built her electrodiagnosis workshop carefully, from the ground up: anatomy, pathophysiology, electrodiagnostic procedures, and the comparison of their results with CT/MRI (which turned out to be very favorable). It was far more satisfying to leave her workshop knowing more, as compared with the empty challenge structure of the diagnostic imaging workshop.

Grand Rounds: Still the *Cinéma Vérité* of Back Pain

In 1995¹¹ I devoted a Chiropraxis column to how grand rounds at the ABS serves as a barometer of medical self-consciousness; this year was a perfect example. This time there were three patients: a case of failed back surgery syndrome, a psychogenic case, and a deconditioned guy who didn't like his job. Not much has changed since I wrote:

"Grand rounds at the ABS has become a fairly automatic affair, mostly featuring two types of patients: the first one is mechanically boring, while the other has a history of having been surgically abused. The mechanically boring patient is deconditioned. The case history takes a surprising five minutes to present in spite of its evident banality. The patient has chronic low back pain, few significant examination findings, and has not worked for a long time. The surgically abused patient has received two or three increasingly unsuccessful procedures for what may have started out as a fairly unimpressive industrial injury some 11 years ago. The patient is still out of work, and depressed.

"The mechanically boring patient serves as a vehicle to reiterate the point that psychosocial factors represent an important, perhaps dominating, component of back pain, with the admonition that failure to identify such cases can result in expensive and totally unnecessary diagnostic and treatment procedures. The surgically abused patient is used to remind us that we should address the patient's functional status and not the CT scan or MRI; that most surgeries are unnecessary; and that the prognosis for salvage surgeries (second and third procedures) is especially grim.

"Grand rounds at the ABS has beaten a hasty retreat from the dramatic heroism of a Robin Cook medical thriller to the stark melancholy of a docudrama about ordinary people with ordinary bad

backs. The grand rounds experience has become something of the *cinéma vérité*¹² of back pain."

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12. *Webster's Universal Encyclopedic Dictionary* defines *cinéma vérité* as "the art or technique of filming a motion picture as to convey candid realism."

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