Dynamic Chiropractic

YOUR PRACTICE / BUSINESS

Emergency-Room Chiropractor

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It is unlikely that you became a chiropractor to work in an ER. Imagine my surprise when members of our hospital's chiropractic department were asked to take a call in the emergency department (ED)! We are now in our second year of providing chiropractic coverage to the ED.

In our hospital, DCs do not work as pseudo-medical physicians. Hospitals and EDs do not need "want-to-be" medical physicians. While trained in diagnosis and knowledgeable of medical procedures, chiropractors in the ED provide services as chiropractors to increase the satisfaction of the most important people in the hospital - the patients. Perhaps you should also consider taking steps to provide care for patients in your local hospital.

In November 2000, Meadowlands Hospital Medical Center in Secaucus, New Jersey began offering chiropractic care in the ED. In an effort to satisfy the Joint Commission on Hospital Accreditation's mandate to better address pain management, Meadowlands ED Director Gina Puglisi,MD, and Albert Cataffi,DC, former chiropractic department chief, developed and instituted a "chiropractor on-call" program. Dr. Puglisi readied the chiropractors with an orientation program to define the roles of the chiropractors and the rest of the ED in treating neck and back pain patients.

Patients who present to the ED with neck or back pain are screened by the attending ED physician, who is responsible for ruling out serious pathology, fracture, neurological deficit, and other findings that might contraindicate spinal manipulation. The ED physician may order x-rays, blood work or other diagnostic tests. When a severe condition presents, orthopedists, neurologists or neurosurgeons are enlisted to take over the case. Historically, all patients without serious pathology were given prescriptions and discharged from the hospital, with or without adequate relief. With our chiropractor-on-call program, the ED physician now has the option of calling for a chiropractic consultation, which gives the patient the opportunity to receive additional relief.

The typical chiropractic patient in the ED is one that would present only on occasion in a chiropractic office. One such patient was a 33-year-old man who reported injuring his lower back by lifting a heavy airplane tire at work. He found himself immobilized by pain and supine on the cement floor of the aircraft hangar. He remained on his back for four hours before he would admit that he was not going to be able to get up. His coworkers called for the ambulance and he was brought into our emergency department. Following evaluation by the ED physician and radiographic examination, the patient was given injections of Toradol for pain and Flexeril to relax muscles. Due to his persistent inability to ambulate, he was later given an injection of Demerol, a narcotic analgesic. As the patient was still unable to move about, the ED physician called for a chiropractic consultation.

Upon my arrival, the ED physician gave me a summary of the patient's history, examination findings, and treatment. I reviewed the chart and the available x-ray films and test results. Upon meeting the patient, he was still unable to get out of bed. I performed a detailed history and physical examination to clarify the nature of the patient's disorder and to further rule out contraindications and the need for additional tests. I performed an analysis to determine the most appropriate type of chiropractic care.

The patient complained of severe lower back pain and paresthesia that radiated down his posterior left lower limb to his foot. My examination revealed severe muscle spasms and vertebral joint fixation. Orthopedic testing was positive for a strain/sprain injury to the lumbar spine. The patient was neurologically intact, with normally responsive deep tendon reflexes, equal bilateral dermatome sensations, +5/5 bilateral great toe strength, and a down-going Babinski's reflex.

This patient is a good example of a minor injury, by emergency department standards, accompanied by severe incapacitating pain. The medication had not given him sufficient relief. The attending ED physician did not want to resort to stronger narcotic analgesia or hospitalization. The patient would have obviously avoided additional diagnostic testing if something were done to relieve the severity of his pain.

Having determined that chiropractic care was both warranted and safe, I began treatment with the application of electrical muscle stimulation to the lumbar paraspinal muscles. The purpose of the adjunctive therapy was provided to supplement the effects of the medication to relieve spasm and reduce pain and make it easier to perform lumbar chiropractic adjustments. The patient and I discussed his injury and how his body was overreacting with severe pain and muscle spasms. We talked about how this would be an appropriate response if a vertebra had been fractured. He appeared to understand how his body's overreaction of pain, spasm, anxiety and joint fixation would slow his healing and prevent the quick resolution of his pain. I advised the patient of what I was going to do and what he could expect. I told him to alert me if he felt he would not be able to tolerate continuing the treatment.

The patient moved slowly to a lateral recumbent position in preparation for a side-posture adjustment. As he moved into position, I checked to see that he was not in additional pain. I performed a stretch in the side-posture position to check for patient tolerance. I demonstrated an adjusting thrust to his shoulder so he would know what to expect. As he exhaled, I performed a quick, light, lumbar adjustment to the fixated segments, and noticed a modest release. The patient did not report relief, but he was able to tolerate the procedure without complication. I performed the same procedure on the other side, with a good release noted. Returning to the first side, I repeated the procedure - this time with a good release.

Following the treatment, the patient appeared surprised, noting that his pain had lessened significantly, and that he no longer felt an abnormal sensation in his left lower limb. He was able to get out of bed, dress himself and be discharged from the hospital. On his way out, he stopped at the nurse's station. The nurses were equally surprised to see that the patient was able to leave the ED under his own power. Not only had the patient improved, but the improvement was witnessed by our medical counterparts.

In the past, it was rare for me to see a patient in this much pain in my office. The ambulance doesn't bring acute agonizing patients to the chiropractor's office. I would have likely suggested that the patient be seen first in the ED. Now, as part of that department's team, I can participate in the early treatment of the severe patient with the backup of a well-staffed and equipped hospital.

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