Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Iatrogenic Effects of Inappropriate Adjusting

Joseph D. Kurnik, DC

There are studies and data published intermittently, indicating that adjusting the spine is statistically safe. I have heard by way of postgraduate seminar that problems associated with cervical adjusting (i.e., resultant from adjusting) statistically correspond to the patients being in the "wrong place at the wrong time." Based upon my observations and experiences, in private practice and with instructor/consultant responsibilities in chiropractic college positions, I am not agreement with statistics I have come across. I have seen enough cases to conclude that too many mistakes are being made in patient assessment and treatment.

Often, mistakes do not result in long-standing patient complaints, but intermittently, significant adverse effects result from adjusting. I have witnessed many occasions where adjusting has created iatrogenic effects in the neck, midback, and the low back. I include my own mistakes, unfortunately, in my observations. I have seen many cases of iatrogenic back pain, neck pain, and associated consequences created, yet not reported, never reaching the statisticians' calculations. Conversely, more benefit has been derived from adjusting, even with error. Similarly, much of the good is not recognized. However, to further benefit adjustive procedures, it is important to go beyond rationalizations and admit or eradicate our errors. It is my intention to illustrate a few significant errors I have made, and those that other adjusters have made and continue to make. I confess that what I say is based upon my experiences and those of other practitioners with whom I have witnessed or communicated. The iatrogenic examples are listed below:

1. Right-sided cervical rotation and/or lateral flexion adjusting. In previous articles, I have made reference to the spine having "seeking" tendencies. If you examine the cervical spine, for example, by motion palpating from the front (anterior) and from the back (posterior), these statements would seem clearer. If, while supine, motion analysis were done from the front and back, it would be a simple matter to illustrate this anterior affinity of the right side of the spine. In so palpating, the atlas most commonly becomes fixated in relation to C-2 or the occiput on the right side in the anterior position. This may result in a muscular reaction on the right side, which is mistaken for a subluxation or fixation. This observation is quickly demonstrated if the proper supine motion analysis procedures are utilized, demonstrating a right C-1 anterior fixation. If the atlas is adjusted on the right side for a "posterior fixation" or "posterior subluxation," some of the following effects may be seen.

1. disorientation
2. vertigo
3. right-sided headache.
4. vertebral artery damage
5. neck pain
6. right SCM disorders:

1. swelling
2. muscular tension
3. soreness
4. associated swallowing discomfort

1. right eye pain or disorder

If irreversible damage is not done, this problem can be eliminated by adjusting C-1/C-2 on the left side, correcting a left-sided C-1 or C-2 restriction in rotation to the right, simultaneously taking a soft tissue contact posterior to C-1 on the right side, pulling C-1 to the posterior while adjusting the C-1 or C-2 left posterior fixation. (A left lateral flexion component may be present also.)

Not all of these types of cases are iatrogenically induced. Do not get me wrong. I see these same cases induced by conditions of daily living, such as sleeping incorrectly; whiplash; football; wrestling; etc. I get cases like this where neurologists have done brain MRIs, usually not finding the tumors they suspect, yet being corrected with an appropriate adjustment.

Final suggestion: Try to develop anterior and posterior assessment palpation procedures to add to your present assessment procedures. Be cautious about adjusting C-1 on the right side!

2. Adjusting hypermobile upper cervical articulations. This is dangerous, as you will either overstrain the supporting ligaments or injure or insult the vertebral arteries. The remedy is to add anterior or posterior cervical joint assessments to your evaluations, utilizing motion analysis. Instead of just thinking about an x-ray or leg-length-finding, add the 'feeling" assessment to a joint challenge. We do have feelings and should use them.

3. Adjusting the ilium as a PI or AS based upon leg length. The criteria for adjusting an ilium too often is based upon leg length or leg length changes. In my opinion, this is a dangerous procedure, and is most unprofessional in relation to other procedures, which can be added to such assessments. For example, one may have an anatomical short leg; based upon this, it would be adjusted as a PI ilium. Believe it or not, this practice is still going on in chiropractic colleges and doctors' offices. In reality, a short leg can manifest as a result of anatomical differences, scoliosis with imbalanced bilateral muscular tone, disc problems, or subluxation/fixation complexes anywhere in the spine. How about your stroke of upper motor neuron lesion patients, with spastic contraction on one side, pulling up the leg?

I have seen numerous examples of patients with right-sided lumbo-sacral pain, induced by adjusting the right ilium upward as a PI subluxation, based upon a short leg being present on the right side. In some cases, the problem was chronic for years because the adjuster kept adjusting the ilium as a PI due to a short leg being present. There might be temporary relief from the effects of the adjustment because motion was established; but the problem would return. The right ilium, in these cases, was an AS-locked ilium with a simultaneous right short leg due to muscle imbalance. The AS ilium was forced into more AS direction and further subluxated.

If such cases had assessments that included direct assessment of the SI joints, instead of indirect assessments, such as leg lengths and x-ray markings; then the conclusions regarding what and how to adjust often would be different. Years ago, I worked with two extremely competent and exacting practitioners, Dr. Bertrand Faucret, and Dr. Takeo Nakagawa. Both doctors utilized motion analysis procedures directly applied to the SI joints, rather than using indirect measure. They would utilize their tactile and visual senses, directly perceiving motion and function at the SI joints. This is not to say that they were not intelligent. Once they perceived the type of motion occurring,

they would intelligently make a clinical decision. This could include leg length checks, x-ray/MRI analysis, applied kinesiology, or other finding such as orthopedic/neurologic outcomes.

What I have suggested in previous articles for *DC* and in the manual *The Connection,* is the utilization of direct motion and static palpation assessments of the SI joints in the prone, sitting and standing positions. It sounds like a lot, but it can be done in 60 seconds. Of course, not all of this can be done in the acute or antalgic patient. I advocate doing as much as possible to enable you to assess as accurately as you can. Other professions do this, so why can't we do the same, instead of reducing assessment and treatment to inadequate short-cut procedures? Many doctors or students that I have observed perform more detailed orthopedic and neurological exams, but then degenerate to less detailed pre-adjustment functional assessment exams, making adjustments based upon inadequate information, such as short leg finding, x-ray marking, or instrument findings. Try to add a more detailed direct functional motion assessment to these finding; then make your decisions.

Doctors, I am sure you have noticed that physical therapists are adjusting clients with more frequency. This is because adjusting articulations is a powerful procedure. If you ever look at a PT seminar-adjusting curriculum, you will notice an increasing sophistication in assessment and procedure. The gap of sophistication will be filled by the first profession to get there.

Joseph Kurnik,DC
Torrance, California

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