Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

What is a Subluxation?

What is a subluxation? Wouldn't that be a great question for John Stossel (of "20/20" fame) to ask 10 chiropractors at random? The answers could range from the most scientific to the most unusual. Could it be that in our attempt to overcome a professional inferiority complex, we've overcompensated by reaching for the "golden definition" that shields us from the inevitable criticisms? Could it be that in an attempt to "try harder because we're #2," that we have lost sight of the common sense approach to explaining chiropractic?

Let's take a scenario where a "typical" chiropractic low back and leg pain patient is examined by an orthopedic surgeon. When Dr. Orthopod examines our patient, he often will find evidence of restricted motion. He will make a note of restricted range of motion and may place significance on it. He may find weakness of the extensor hallicus and/or loss of sensation to pinprick. He also will usually make note of muscle spasm, which is typically interpreted as an indication for the prescription of muscle relaxers. On x-ray the orthopod may observe disc degeneration and spurring which his literature will tell him is normal aging. And when the patient mentions concurrent constipation, it my be interpreted as a mere coincidence with no connection to the chief complaint of back and leg pain.

This scenario is not presented to pass judgment, but simply to recount what most chiropractors hear from patients on a weekly, if not a daily basis.

Can we blame third-party payers and employers for being confused when the very same patient gets examined by a chiropractor and the exam yields a different diagnosis, treatment plan, and prognosis? And then the 10 chiropractors don't agree on what a subluxation is, or what technique is best.

So much for identifying the problem. What can we do to solve it? Actually I think the answer is closer than we think and simply requires the application of that good old common sense.

First let me suggest that we adopt a model of the subluxation that acts as an "umbrella" or "syndrome" which consists of five individual components. Those components have already been identified by our orthopedist. When he found decreased range of motion he was identifying the first component of the subluxation complex: spinal kinesiopathology. Of course a chiropractor could document this even better with static and motion palpation and stress x-rays. When he determined that there was weakness of the extensor hallicus, he was documenting the second component of the subluxation complex: neuropathophysiology. The finding of muscle spasm was the documenting of myopathology and would be recognized by a chiropractor as the body's natural protective mechanism: in other words an effect of the problem, not the problem itself. The degeneration on x-ray was evidence of histopathology and would be interpreted by chiropractors (as well as researchers like Kirkaldy-Willis) to be the result of prolonged dysfunction (spinal kinesiopathology), not normal aging. Chiropractors would place significance on the constipation because of the relationship of the lumbosacral spine to the colon. This is the fifth component of the subluxation complex: pathophysiology.

So what we have is a syndrome that both professions recognize by individual components. One

profession sees only the individual components, the other sees the components as part of a bigger picture. Chiropractors have the subluxation as part of their heritage. Attempts at defining a subluxation by individual "technique gurus" have been less than successful, and we have as many definitions as we have techniques. The solution has to be a broader definition to include all techniques and all variations of subluxations.

Using the subluxation complex as a syndrome of component parts will facilitate this goal. Our Dr. Orthopod found all the components of the subluxation syndrome. Only because of our chiropractic heritage can we as chiropractors recognize, interpret, and appreciate the significance of the presence of all the components in the patient.

Additionally, the chosen technique is a matter of preference. After all, dentists don't argue over what a cavity is, and they don't argue over the best type of drill to use. As long as the lesion (cavity or subluxation complex) is corrected, the use of a given technique is not important. Research within this model would allow evaluation of techniques and procedures as well. If Gonstead doctors enter the model by emphasizing the kinesiopathology component and successfully reduce the subluxation complex, the technique is valid. If an activator or applied kinesiology doctor enters the model through the neuropathophysiology or myopathology components and reduce the subluxation complex, their technique is valid. If the latest "whop 'em on the head" technique doesn't affect the components of the subluxation complex, then it should not be considered mainstream chiropractic and should be investigated further before it is promoted to the profession.

If would be wonderful to have a common terminology to use even among doctors from different schools and different techniques. We could describe patients such as: "I have a patient with a subluxation complex. There is a major kinesiopathological component at C7, with a weakness of the finger extensors indicating neuropathophysiology, a trigger point in the right trapezius representing a myopathology, and disc degeneration at C6-C7 representing histopathology." That would leave room for the individual doctors to determine their technique of choice, yet vividly communicate the condition.

The subluxation does exist. No, you won't see it on an x-ray. You find the subluxation complex on a patient. The only difference between the exam by the orthopod and the chiropractic exam is that the chiropractor recognized the individual isolated findings as part of a larger syndrome which our profession has chosen to call the subluxation.

If we define the subluxation this way, and if we explain the semantic use of our word "subluxation" to the medical profession and insurance industry, communication will have to improve. I encourage you to examine for the components, x-ray for the components, diagnose by the components, and adjust to reduce the components. In other words, manage your patients based on the components. Notice I didn't mention only adjusting patients who are in pain.

I ask you to review your practice paradigm and either present a better model that will be as inclusive as the one I've presented, or join the movement to present a rational unified voice that still respects your individual practice style.

Adopt the component model into your practice. There are hundreds of literature citations that support this concept. Practicing this way, and educating my patients this way has been the best thing I ever did for my personal practice and, I believe, the best thing I could do to promote chiropractic health care to the people who don't understand the value of a chiropractic adjustment.

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