

## More on the Case for Full Spine Radiography

Jesse Jutkowitz

I had two very memorable cases come into my office recently both involving neck pain that had been treated with chiropractic adjustments elsewhere. The thing that made the cases memorable will be evident shortly.

The first case was a woman with long-standing severe neck pain and spasm who would no longer allow her chiropractor to adjust her neck because it led to severe pain and dizziness. The chiropractor was using hot packs and electrical stimulation, no adjustments. It gave the woman temporary relief, but her history was ongoing bouts of this same neck pain treated by her chiropractor for several years.

The second was a woman with severe neck pain and spasm after a day of moving boxes. Her history was of continuing bouts of neck pain and stiffness over the last five years treated by her chiropractor with physical therapy and light cervical adjustments because hard adjusting hurt.

Both women said they liked their chiropractors very much and continued going because it was better than medication or nothing. Both of these women had their necks x-rayed and were showed where the bones were subluxated. On both of these women's cervical films the lower cervical spine demonstrated curves going into the thoracic spine. Neither chiropractor had radiographed further to investigate.

Physical examinations in both cases demonstrated cervical ranges of motion less than 15 degrees in any direction, palpable tenderness, etc. Motion palpation indicated fixations in the upper cervicals.

Full spine films of the two women changed markedly from sitting to standing as did their pertinent physical findings such as range of motion in their neck.

### Case One

There's a significant thoracic, thoracolumbar, and lumbar scoliosis on the AP views that change markedly from standing to sitting. Standing, the curves are 11° upper thoracic, 11° thoracolumbar, and 10° lumbar. Measured at the same points on the sitting AP, the curves change to 13° upper thoracic, 6° thoracolumbar, and 4° lumbar. Obviously the upper thoracic area is a primary problem but, a closer look reveals a sacralized L5 that must also be considered primary.

Standing, the cervical kyphosis is within normal range though slightly hyperkyphotic in the upper cervicals. The thoracic curve looks almost normal except for a sharp anterior tilt at T3 (which is just below the apex of the scoliosis seen on the APs), and the lumbar curve slightly hyperlordotic, just outside normal limits.

But on the sitting lateral, underlying this entire process, is a total breakdown of the thoracic and lumbar curves. In fact, the lumbar lordosis is completely reversed. T9 to T6 is flat, and T5, T4, and T3 form a reversed kyphosis. The cervical curve is slightly hyperlordotic! No wonder cervical

adjustments hurt this woman: The cervical spine was the only thing holding this woman up. The cervicals were locked in a hyperlordosis to compensate the entire thoracic and lumbar spine.

Were you taught to x-ray only the area of pain? Were you taught that subluxation means one bone is out of place compared to the one below and the one above? The spine is a single synchronized unit. Unless chiropractors get back to that concept and away from the medical sectional -- neck, thorax, and lower back -- thinking in this profession is doomed.

Chiropractic radiologists or roentgenologists are often very nice people, and people with their function are needed, but all they look at is organic pathology, not biomechanical pathologies. What has happened is the necessity to have chiropractic experts in radiographic pathology, and these people's insistence on using radiology strictly for determination of organic pathology has led to the abandonment of the basis of chiropractic -- full spine biomechanics.

In the second patient, the standing film shows a similar scoliosis pattern: 12° upper thoracic, 10° mid-thoracic, and 11° lumbar starting at L4. L5 is tilted only 3° left while L4 is tilted 10° left. There are no visible abnormalities of L5. The standing shows 11° upper thoracic, 9° mid-thoracic, and 20° lumbar. L5 is tilted 1° left. L4 is tilted 8° left.

Note the pattern: The angle of the L4-L5 disc is 7°. In both positions there are three basis curves, the lower being most mobile. This is the same basic pattern as the first woman.

On the laterals: standing, we have a normal looking curve pattern. The lumbar spine seems to be in normal limits as does the thoracic, but from L2 to T9 is absolutely straight. It is tilted back so it seems normal but there is no curve. The entire thoracic kyphosis is from T8 up to T1 with the cervical spine in a slight hyperkyphosis.

Sitting we see a horror story. The lumbar spine is reversed into a kyphosis. From L2 to T9 is actually reversed into a lordosis. From T8 to T1 you have a hyperkyphosis and the cervical spine is in a slight kyphosis.

The second woman is a little better off. Instead of just her cervical spine locked in a hyperlordosis to compensate she had her upper thoracics and her cervical spine compensating. Since the force needed to hold her up was spread over her upper thoracic and cervical spine, she had fewer problems overall than the other woman who only had her cervical spine left to compensate.

Obviously you would treat L5-L4 in both these women, probably giving them heel lifts to take the pressure off that area between adjustments, but how would you treat the thoracic spine. Would you adjust with the patient prone P to A? A recipe for disaster.

Why are not these types of full spine patterns researched in our colleges? Such patients walk into all of our offices weekly. Do you have difficulty adjusting someone's cervicals? What else is happening in that spine? Is the area of pain just painful because it is compensating and that is where the pressure is?

Both of these women left my office with normal ranges of cervical motion from day one. They had pain on motion from the swelling of the soft tissue in the cervical spine and they will be coming back for a while to get to their best biomechanical states, but they should be cake cases for any chiropractor to relieve their pain. Let's get our schools back to full spine biomechanics and into basic chiropractic research instead of the type of studies I see in JMPT.

Remember, in 30 years of research, Alf Brieg, MD, a neurosurgeon, has demonstrated and published two books that state multiple sclerosis, ALS, and other degenerative neurological diseases are primarily mechanical in origin. And they are doing good things in some small hospitals in Scandinavia and Europe. But the medical profession in general has no concept of biomechanical pathologies causing that kind of degeneration, and the drug companies are not going to put research dollars into it because they are in business to make a profit. If chiropractors can't find the cause of neck pain with this kind of simple biomechanical pattern, how can our profession figure out the biomechanical pathology causing the spinal cord to rub against the column, killing itself with friction?

*Jesse Jutkowitz, DC*  
*Milford, Connecticut*

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