Dynamic Chiropractic

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# "Old Fashioned Competency in History Taking and Physical Examination"

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The American Back Society, in association with the New York State Chiropractic Association, entered its 11th year by mounting a symposium in Buffalo, New York, May 19-22, 1993. Like the December meeting in San Francisco, the focus was on the industrial back.

Once again, the presenters advocated somewhat of a strategic retreat from technical wizardry in diagnosis (e.g., advanced imaging, electrodiagnosis) in favor of good, old-fashioned competency in history taking and physical examination. This neoclassical approach to doctoring extended to the terrain of treatment as well, where dazzling surgical technique and designer pharmaceuticals garnered less enthusiasm than preventive and conservative care, soft-tissue rehabilitation, and careful attendance to psychosocial factors.

The most forceful participant in the meeting was neither invited nor present. I refer, of course, to Hillary Clinton, whose task force on health care, although quite dormant now in July, was grabbing a lot of headlines in May. Although the details of the coming plan for national health care remain remarkably obscure, especially given all the media attention, trial balloons, and special pleading, one thing is certain: doctors are going to be mandated to render better care, more cheaply. This simple fact is not entirely unrelated to the revival of interest in neoclassical diagnosis and treatment, which in addition to everything else is cost effective.

Some of the tensions accruing to the crisis in national health care and the fear of the unknown surfaced in a panel discussion that filled the time slot usually occupied by Grand Rounds in ABS meetings. Doctors, administrators, a state assemblyman, and a workers' compensation judge all participated in a very frank discussion on the status of the New York State Workers' Compensation system. Moderator Simmons made a valiant and yet completely futile attempt to confine the panelists' remarks to "constructive criticism." The frustrations and dissatisfaction on all sides kept bursting through, although there was indeed sincere agreement on the part of the participants and the audience members that communication among the worker, employer, administrators, and physicians is of the utmost importance if the system is to improve.

Dr. Bernard, medical director of the NYS Workers' Compensation Board, eventually suggested a sort of golden rule for workers' compensation: he asked ABS members how they would like to be treated if they were to become injured workers. At one point Compensation Judge Strom sternly advised that he doesn't want doctors evaluating disability, only supplying medical information to the state by filling out forms. Panel Moderator Simmons added that doctors should not be in the litigation business. State Assemblyman and former Compensation Judge Gregory Meeks capped the discussion with a well-received declaration that in every state the workers' compensation system endangers workers, employers, and all concerned. He asked a rather obvious question: "Why don't 'independent' examining physicians and the treating doctors communicate so that the judge, who doesn't really want to practice medicine without a license, would never have to make the call?

Dr. Edward H. Simmons, after detailing the escalating cost of low back disability over the last

decade, offered up that physical therapy had sustained the largest percentage increase. He tried to dispel the image of the indolent American worker, stating that only two percent of the workers miss as much as nine days per year, compared with eight percent missing 34 days per year in Sweden. The real problem is not the worker who is out for three weeks to three months, but the one who is out for longer, often for years at a time. Dr. Gary Clark, speaking on rehabilitation, pointed out that the median cost of an injury is $400, but the mean is $6,800. A small number of cases incur by far most of the cost, those where the injured worker is out for greater than six months.

Dr. Simmons was the first of several presenters who announced the end of an era, the "Dynasty of the Disk"; Dr. Marzo added that normal disks undergo normal degeneration. By their seminal paper of 1934, Mixter and Barr had ushered in a new conventional wisdom which goes something like this: back pain + leg pain = ruptured disk. Nowadays, this is actually thought to be somewhat uncommon, as compared with conditions like pedicular kinking, spinal stenosis, spondylolisthesis, facet syndrome, etc.

Not that everybody there was thrilled with the concept of facet syndrome. This symposium, not content with debunking the "Dynasty of the Disk," went on to revoke the authority of "facet syndrome." It was left to Dr. Hadjipavlou to defend it, in one of the more contentious and provocative talks of the meeting. He attempted to refute a number of recent papers disputing the diagnostic and therapeutic value of facet injections (one titled "Goodbye Facet Syndrome?" in the Back Letter, Vol 5(11). Dr. Hadjipavlou contended that all _ previous investigators have defended the clinical entity of facet syndrome; that the recent studies may put into question the therapeutic value of injections, but not the existence of the clinical entity.

The next entrenched item to come on the chopping block was "shake'n'bake therapy." Kenneth Kurtz, PT, especially knocked the practice of "passive therapy" -- things done to the patient -- which, he said, leads toward dependence on the therapist and the machines, and even to a feeling of hopelessness. He coined the term "modality madness" to describe a situation where the therapist's attitude leads to an insidious patient attitude of "fix me!" He drew attention to the difficulty of proving the cost effectiveness and the validity of common physiotherapeutic mechanisms in an increasingly demanding medicolegal environment. Sound familiar? Mr. Kurtz indicated that treatment must be directed not so much toward pain reduction as function restoration. There would be no point in returning the injured worker back to work before healing has been adequate, in that chances for reinjury would be high, which risks putting the worker into the chronicity that really adds to the cost of job-related injuries.

What had been an important theme at the SF symposium had become a virtual litany at this meeting: every presenter decried jumping from a radiological finding to the clinical diagnosis. Although it has become rare for an ABS presenter not to warn against equating a radiological defect with disability in the absence of clinical, functional corroboration, Dr. James White distinguished himself by adding a necessary corollary: disability, when present, is not necessarily due to a clear radiological defect. Images are overwhelming in their import, for patients and doctors; one must always be on guard to take them with a grain of salt. Andrew Matteliano extended the same point to electrodiagnostic testing for nerve injury in the industrial setting. The electrodiagnostic findings are significant only when they correlate with clinical examination findings.

Not that clinical examination findings are always consistent. Not having seen very many patients for whom dermatome, myotome, and DTR findings correlate, I had always supposed that "the world of Stanley Hoppenfeld" was just a utopian caricature of my own clinical practice (or else I was being karmicly paid back for doing bad ortho/neuro exams in a previous lifetime). Dr. John Marzo

explained the anatomical basis of the typical noncongruence of findings: Although clinicians generally focus on osseous anomalies, soft tissue anomalies are also very frequent. Not only may nerve roots take egress through noncustomary IVFs (e.g., C6 through the C6/7 foramen), but there may be intradural connections between adjacent nerve rootlets. This is not the exception but the rule in the cervical spine, and occurs as well, although to a lesser extent, in the lumbar spine. This is more typical in the posterior than the anterior primary ramus, which is why we find clinically more sensory level overlap than motor level overlap. In the end, symptoms do not indicate the true level of pain.

Dr. Edward D. Simmons, apart from being extraordinarily poetic ("the teleological formation of osteophytes"), pointed out that the dorsal root ganglion is more vulnerable and pressure-sensitive than the nerve root, a point that has also been made in the chiropractic milieu by our own Dr. Charles Lantz. Some 10-20 mm Hg pressure on a nerve root reduces intraneural blood flow by 45 percent and an inflamed nerve is much more sensitive to pathological processes than a normal nerve.

Dr. James White spoke on spondylolisthesis in the injured worker. According to Wiltse (acknowledged expert on spondylolisthesis, and pioneer of its surgery), they occur only in man, and are apparently related to the advent of bipedalism. Although they are not present at birth, there is a genetic predisposition toward their eventual development. Current thinking is that this results from an autosomal recessive single-gene defect with incomplete penetrance. Up to 50 percent of Eskimos are effected.

Dr. James Mathews pointed out that for some reason, physicians are more likely to look for and detect ligamentous problems in the extremities than they are in the lumbopelvic region. It is no longer possible to believe that the sacroiliac joints are immobile (even though Moderator Simmons did express some skepticism), and indeed, it is possible to become locked in an abnormal position. This, of course, was no surprise to the chiropractors in attendance.

Osteopath Philip Greenman, departing from his scheduled topic, opted to present a case history: that of an elderly patient with two blown disks and a grade II spondy, with advanced radiological degeneration. After everyone had been duly impressed by the x-ray, he asked the multitude for an orthopedic/neurological consultation. One doctor took the bait and began detailing the surgical options, whereupon Dr. Greenman knocked the socks off of everyone by divulging the identity of the patient -- himself. He also announced that he has been asymptomatic for some two years, thanks to strict adherence to an exercise regimen. It was quite amazing to see how freely the doctors offered up invasive solutions to clinically quiescent problems, in spite of all previous admonitions to the contrary. If the film is dramatic enough, interventionism becomes reckless. Dr. Greenman went on to provide an overview of the osteopathic approach to manipulative therapy, emphasizing that the ultimate and even exclusive purpose is to increase the motion available to the dysfunctional joint.

I am told there is audio equipment that can speed up a person's speech without changing its pitch. If that's true, then without question, Dr. Michael Geraci was using this equipment in an unfortunate effort to save time. This problem notwithstanding, he delivered what appeared to be a very interesting talk on low back muscle imbalance. What follows is the half of the mechanism that I was able to get down: muscle imbalance (tight hip flexors) leads to anterior pelvic tilting, which causes hyperlordosis, which makes the lumbothoracic junctional area the (hypomobile) fixed point for the movements of the lower extremities, which makes the low lumbar area hypermobile, which predisposes toward disk herniations. Iliopsoas would be the primary muscle involved in this process, producing lateral shift (curvature involving at least three segments) that is convex on the hypertonic iliopsoas muscle side; the CNS limbic system gets involved. Whew. ...

Many speakers reflected on the psychosocial parameters of work-related injuries. We don't pay nearly as much attention to this in chiropractic. Does this difference manifest possibly less comprehension of "hard" factors in medicine, or alternatively chiropractics' failure to adequately consider "soft" factors?

The only DC to give a platform presentation distinguished himself from the other presenters by not offering a single useful idea on the treatment of injured workers (or anything else). He devoted his entire time slot to an arcane rehash of some very tired platitudes, which are not worth quoting even to criticize. Near the end of his allotted time the doctor said that he didn't have time to discuss the "basic procedures of chiropractic." Too bad.

The next ABS meeting is December 8-11, in San Francisco. You may contact the American Back Society at 2647 E. 14th St., Suite 401, Oakland CA 94601, Tel (510) 536-9929, Fax (510) 536-1812.

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AUGUST 1993

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