

American Back Society

DR. SCOTT HALDEMAN ON BACK PAIN IN THE NEXT DECADE

Robert Anderson, DC,MD,PhD

In his theme address to the fall meeting of the American Back Society (ABS), Dr. Scott Haldeman succeeded in what would have seemed nearly impossible 20 years ago. He addressed an audience of 750 specialists on spinal disorders in which 50 percent were physicians and surgeons and 33 percent were chiropractors. (Many of the rest were physical therapists.)

To one who knows the history of chiropractic, it is a cause for quiet celebration to take part in a five-day symposium of that size in which clinicians and researchers came from all over North America and beyond solely on the basis of their shared commitment and expertise. Doctors participated without discrimination on the basis of what kind of doctor each was. It is also worthy of note that a mere eight years earlier, the first meeting of the American Back Society gathered fewer than two score hardy pioneers who were allured by the interprofessional vision of Ardrey Swartz, M.D., the founder and executive director of the American Back Society.

Dr. Haldeman was the clear choice for setting the tone of the conference and for serving as co-chair (with William H. Kirkaldy-Willis, M.D., professor emeritus of orthopedic surgery). Scott Haldeman, D.C., Ph.D., M.D. is the son, grandson, and brother-in-law of chiropractors in South Africa, where he was born and raised and where he began his own distinguished career as a chiropractor. His influential book, *Modern Developments in the Principles and Practice of Chiropractic* is scheduled to appear in an updated and elaborated second edition next January.

Dr. Haldeman's personal skills in chiropractic, neurophysiology (the specialty of his Ph.D.) and neurology (his specialty in medicine) have been shared over the years with many ABS audiences and workshop participants. His address this year drew attention to a key concept that lies behind the purpose and program of the ABS. "No single discipline has all the answers and no single profession can learn and practice all procedures which may benefit the patient with back pain." He went on to point out how important collaboration has become. "The blending of medical, chiropractic, and osteopathic theories with research in biomechanics, physiology, biochemistry, and anatomy is leading to a more uniform and informed theoretical basis for the understanding of back pain."

Let me illustrate how we learned from one another in that meeting. J. David Cassidy, D.C., M.Sc. (Ortho), F.C.C.S. (C) and a candidate for the Ph.D. in pathology, gave a talk listened to intently by all, including many orthopedic surgeons who do not believe that the sacroiliac joint ever causes pain, but rather, serves as the final common pathway for referred pain that deceives some clinicians, including most chiropractors and osteopathic physicians.

In recent ABS symposia Dr. Cassidy has earned respect from all, including the large medical contingent. He has worked as a colleague and co-researcher with ABS President Dr. Kirkaldy-Willis for years in the orthopedics department of the medical school at the University of Saskatchewan in Canada. An important contributor to Dr. Kirkaldy-Willis' text, *Managing Back Pain* (2nd edition, 1988), he is medically and scientifically trained in pathology. Most importantly, his obvious command of facts, figures, and hypotheses has never failed to impress his ABS audiences.

According to Dr. Cassidy, the sacroiliac joint is an atypical synovial joint with unique developmental features. The sacral side develops in a manner similar to the other synovial joints, while the iliac side lacks an epiphysis and develops in a manner similar to pseudoarthrosis. The result is a joint with hyaline cartilage on the sacral side and fibrocartilage on the iliac side.

Dr. Cassidy reports that by the third decade, the iliac side is undergoing degenerative arthrosis. By the fifth and sixth decades, some joints have undergone severe degeneration and fibrous fusion. He further notes that the main function of the joint is probably shock absorption, since motion is not under voluntary control. He concludes that the role of this joint in the pathogenesis of low back pain is open to speculation, especially since the diagnosis of sacroiliac syndrome is based on subjective clinical findings.

More research is needed, but this much is clear: the sacroiliac syndrome responds to manipulation and to local injection. Both Drs. Cassidy and Kirkaldy-Willis, identify the sacroiliac syndrome as a diagnostic entity, and they have demonstrated in excellent observational studies that it responds well to manipulation and to local injection.

Another regular speaker and teacher at ABS symposia is an orthopedic physician, Philip E. Greenman, D.O., F.A.A.O. Dr. Greenman is a professor in the College of Osteopathic Medicine of Michigan State University and an acknowledged leader in his profession. His text, *Principles of Manual Medicine* (1989) establishes him as an authority of enormous credibility.

Dr. Greenman's talk was on an even more controversial topic than that of Dr. Cassidy. He reported on research, much of it carried out in his own university, under the title, "Craniosacral manipulation: Fact or Fancy?"

In his review of the history of craniosacral work, Dr. Greenman noted that in the past quarter of a century research supporting some of the claims of the advocates of craniosacral manipulation have been validated. Anatomical and physiological studies in animals and humans have demonstrated the patency of the sutures into the ninth decade of human life. The sutures contain blood vessels, a vasonervorum and free nerve endings in a matrix with Sharpey's fibers that have specific orientations.

Physiologic studies have demonstrated motion termed the craniorhythmical impulse, Dr. Greenman explained. This pulse is not synchronous with cardiac or respiratory rates or any other known physiological rhythm. Motion across sutures has been identified in animals to include both rotary and translatory components. X-ray studies have demonstrated an involuntary movement of the sacrum between the innominates accompanying respiration.

Dr. Greenman noted, finally, that craniosacral manipulation has been advocated for the treatment of a wide variety of conditions, including headache, cervicocranial syndrome, late effects of closed-head injury, temporomandibular joint syndrome, and others. To date, however, no controlled clinical trials of efficacy demonstrate that craniosacral manipulation actually makes any difference for patients under treatment. This leads Dr. Greenman to conclude that we cannot give final answers at this time. Does craniosacral manipulation make people well? Is it fact or fancy? In Dr. Greenman's words, "take your pick."

Of the many outstanding contributors to the success of the last symposium, I really must mention a talk given by George E. Becker, M.D. Dr. Becker is the distinguished vice president of the ABS, and unique in a room full of specialists as a board certified psychiatrist who is also board certified in orthopedic surgery. He is also a congenial participant who is easy to meet and talk with.

Speaking on the subject, "Somatization: The Great Imposter," he reminded his attentive audience that every patient must be evaluated for psychological and social (including occupational) issues. Over the years, Dr. Becker has discussed various aspects of psychiatry relating to back pain, but this fall he focused on two types of somatization. In the first, no underlying physical condition explains any of the symptoms except on a psychological basis. This type is far less common than the second, in which an underlying physical condition is present, but symptoms and incapacity are greatly out of proportion to what usually occurs in such cases.

For the doctor in daily practice who must address the realities of workmens' compensation and personal injury claims, the causation of somatization must be addressed. After a review of all the facts discussed by Dr. Becker, the physician must identify the most likely cause of somatization when it develops following physical injury. To do this, one must understand somatization and its developmental roots. Unfortunately, if somatization and its causes are not recognized and treated promptly, the injured worker may, at best, experience prolonged disability and unnecessary treatment. At worst, he or she may undergo repeated unsuccessful surgical operations and ultimately can emerge as an iatrogenic back cripple. It is therefore most important, Dr. Becker concluded, that somatization be recognized when it causes or complicates a back complaint.

Drs. Cassidy, Greenman, and Becker illustrate, as did a large roster of other presenters, the truth of Dr. Haldeman's assertion. No single discipline has all of the answers. We have a lot to learn from each other. We need to refer to one another and to collaborate in the delivery of health care. Medical and osteopathic physicians and surgeons who attended this symposium learned a lot from chiropractic physicians on the faculty, and so chiropractic physicians also learn a lot in return. Isn't that as it should be?

If you would like to participate in the fall symposium on Back Pain scheduled for December 11-15, 1991, at the San Francisco Marriott, and if you are not on our mailing list, write me: American Back Society, 2647 East 14th Street, Suite 401, Oakland, California 94601.

Robert Anderson, M.D., Ph.D., D.C.
Oakland, California

MAY 1991