

Highlights from the Spring Symposium on Back Pain

Robert Anderson, DC,MD,PhD

The American Back Society was established in 1982 as a not-for-profit association to serve as a forum for health care professionals and scientists interested in relieving the pain and diminishing the impairment of patients suffering from spinal pathology. With keen foresight, the founder and Executive Director, Aubrey A. Swartz, M.D., an orthopedic surgeon, insisted that the society could only achieve its purpose if it brought chiropractors in as equal participants with medical doctors, fully qualified to become Fellows of the American Back Society.

The past meeting in Toronto was an enormous success, in part because it was held jointly with the World Federation of Chiropractic. The combined efforts of the two organizations provided hundreds of medical and surgical specialists in back and neck pain, with an opportunity to experience presentations by the best scientists and clinicians chiropractic has to offer. In return, chiropractors attended medical and surgical presentations by world famous physicians, surgeons, physical therapists, and scientists whom they otherwise might never have met.

From this open forum, let me share a few quotations:

Gail Donner, R.N., Ph.D.

My policy for enhancing collaborative care in practice is really quite simple. It begins with the will to work together and to respect each other's competence. Education, at the basic level, both clinical and theoretical, should provide opportunities for joint participation.

Scott Haldeman, M.D., Ph.D., D.C., F.R.C.P.(C)

I have reviewed thousands of orthopedic, neurosurgical, and neurological consultations, and only occasionally do I see a description of the evaluation of the pelvic area from a neurologic point of view. It is no wonder that we miss a substantial amount of cauda equina syndrome.

George E. Becker, M.D.

The psychomechanics of somatization are being shortchanged in the formative years plus stressed as an adult, and they equal somatization. That is the formula that I hope you will remember. The adult who is shortchanged in childhood carries around a rain check saying I need some care or attention that I didn't get when I was growing up and, given the right moment, I'm going to get my due. Adults who somatize commonly place an employer or an insurance company in loco parentis (in the place of the parent). They unconsciously seek recompense for losses in the past. They don't do this consciously; they're not aware of it, but they are looking for something that they really can't get and it isn't just money.

William H. Kirkaldy-Willis, M.A., M.D., F.R.C.S. (C&E)

Within us, as we all know, (are) our many abilities of mind, spirit, and body for healing. For

instance, you cut your finger and it heals itself. You break a bone, and it has the ability to heal, which is a God-given ability. Then we have the immune system that our creator has put within us, that is mind and body working together; mind controlling what happens in the physical and chemical parts of the immune system, and this immune system that protects us so well against infections and foreign invaders and against cancer. This is something very important that the Lord has given us and that we are becoming increasingly conscious of today. These are obvious things, but it is the obvious things that we all forget.

John J. Triano, D.C., Ph.D.

Let's take a look at the rotation effects of the capsular ligaments in lateral bending, of the intertransverse ligament, and the supraspinatus ligament we talked about earlier. We see that the changes in geometry do affect the stretching and loading of the posterior ligaments proportionately. Combined motions increase the ligament stretches of the intertransverse ligaments and capsular ligaments significantly, and extreme physiologic motions which we have not yet looked at but are feasible and are likely to cause even more stretches and represent some of the future studies. We ultimately have to experimentally verify these kinds of observations in the computer model, and this represents the work that we expect to carry out in the future.

Thomas N. Bernard Jr., M.D.

In the SI joints, it is very common to frequently overlook pain that can refer into the lower extremities, frequently mimicking a disc herniation. Within this mobile joint, it is subjected to the same infectious, inflammatory or functional states that affect other joints. It is very difficult with any of the diagnostic tests to say you have an SI joint problem or whether or not that's the source of pain. I think that at this particular stage, it is a clinical diagnosis made upon a good clinical examination, ruling out other sources of pain and noting the patient's response to treatment, which may include medication, mobilization, exercise or injection.

Gunnar B.J. Anderson, M.D., Ph.D.

With respect to testing, I think it depends on what your goals are. In general, I think that most people who buy these machines are expecting too much. The machine does not solve your problems. Furthermore, if you don't know what you're looking for, there is no purpose in having such a machine. And if you know what you're looking for, you can select among the machines, and can probably satisfy yourself with one or two. Now that's very ambiguous but, in general, I think that the machines today are overused and their usefulness is primarily in the treatment of patients and much less in the assessment of them. I think that if you use them for treatment purposes -- I'm talking about primarily gauging the effects of your treatment or tailoring your treatment to specific deficits -- they are very useful.

Stanley V. Paris, P.T., Ph.D.

We talked about manipulation and, no matter what group, everyone has a different definition of the term. So I think it's important from the outset that I define how I use it. To me it is a skilled passive movement to a joint. Now that may include a thrust or it may not. It could be an oscillation or a stretch. Anything that is passive to the joint and has an element of skill is, to my mind, a manipulation.

A. Hadjipavlou, M.D., F.R.C.S.(C)

Pseudarthrosis of spinal fusion remains a major issue. In recent years, experience acquired in screw and plate osteosynthesis of the extremities has been applied to the spine. Over the past four

years, we have used spinal fusion for rigidly stabilizing the spine when indicated. Instrumentation with transpedicular fixation with the goal of enhancing the rate of spinal fusion rigidly stabilizing the spine when indicated. Instrumentation of the spine is not a panacea or a means to automatically achieve spinal fusion. Nerve root injury is a major complication and meticulous attention must be paid to the technique of bone grafting. If extensive facetectomy is required, then PLIF should be considered. PLIF can also be used as an adjunct in the reduction of spondylolisthesis.

H. Duane Saunders, M.S., P.T.

Considerable change is occurring in industrial medicine today. Companies are becoming more knowledgeable about medical care and are playing a much more active role in medical management of the patient with a back injury. Awareness of potential overutilization of medical services and the increasing importance of rehabilitation/work hardening and patient education programs are issues that the health care practitioner must recognize and be prepared to deal with in the future.

Parviz Kambin, M.D.

Proper patient selection is the most important single factor which will ultimately affect the final outcome of arthroscopic microdiscectomy. Our inclusion criteria are the presence of incapacitating pain, failure to respond to conservative therapy, positive tension signs, neurological impairment or abnormal electromyographic findings, and correlative CT, MR, or myelography. Laminectomy remains the cornerstone of treatment for patients with spinal stenosis, extruded or sequestered disc, cauda equina syndrome, and severe neurological deficit.

Rene Cailliet, M.D.

The "failed patient" probably begins before the very onset of the injury. A person discontent with his occupation or with his supervisor is a "candidate" for "failure." A recent review paper has done a prospective study and found that the vast majority of industrially injured patients were "unhappy" with their jobs, their future, and bored with their work and their relationship with their supervisors. This unhappiness possibly also predisposes them to injury as they are distracted and uncoordinated in their occupation by virtue of their unhappiness.

J. David Cassidy, D.C., M.Sc., F.C.C.S.(C)

We've noticed in a small subgroup of autopsy specimens on patients who are involved in severe motor vehicle accidents or have died from other causes, that we have seen tearing of the anterior sacroiliac ligament. Here we see, this is a torn anterior ligament and there's a small hematoma underneath the anterior ligament. I've seen this in five cases now -- tearing of the anterior ligament without pelvic fracture or dislocation.

Mark Laslett, N.Z.R.P., Dip. M.T.

The McKenzie conceptual model is based on the premise that end-range, repeated movements in one direction or sustained end-range postures will cause a progressive migration of fluid or gel within the intervertebral disk towards the convexity or side of least pressure. That this movement occurs is no longer controversial: Stahl, Krag, et al., Schnebel, et al., Seroussi, et al., all report that the nucleus moves posteriorly with flexion and anteriorly with extension. The hypothesis is that when sufficient material has been displaced in one direction, the vertebral body margins are forced apart, thereby producing the deformity. This is in contrast to the prevailing view which suggests that the trunk is pulled into deformity by reflex spasm.

Acute deformities in the lumbar spine are usually rapidly reversible, and the conceptual basis of treatment is the use of repeated movements or sustained positions in such a direction as to cause a movement of the contents of the intervertebral disk opposite to the placement which causes the deformity.

M. Scott Sullivan, M.S., P.T.

We don't really know how much extensor torque is required for a patient to lift a given weight unless we go through a very complex biomechanical analysis. So when we place a patient into one of these devices that gives us the measure of torque, I have to question what its relationship is to any functional activity. To this date, there haven't been any studies that validate its relationship to functional activity. People will say that this is a measurement of muscle function. People will say it's a functional measure. I think we have to question whether or not what we're measuring can be applied in any way to the activities that patients are performing.

Thomas Dreisinger, Ph.D.

If you're going to put somebody in a rehabilitation program and evaluate them, then you ought to be able to use that information to prescribe exercise for them in some manner that will be valuable and work. Once you have a specific test in mind, then you should have some sort of specific training in mind. The idea basically is that human performance factors are basically independent. When you strengthen you get stronger. When you do endurance work, you gain more endurance.

John P. Kostuik, M.D., F.R.C.S.(C)

The fundamental hypothesis in the musculoskeletal system is that a stable mobile joint is preferable to a fused joint and loss of mobility is not compatible with normal function. Mobility decreases stress transfer to adjacent levels in the spine. In other words, if you have a fusion, there is an increased risk of problems at other levels.

John F. Barnes, P.T.

The importance of an entire physiological system -- the fascial system -- has been virtually ignored. The myofascial release approach is a safe, effective "hands-on" therapy to be integrated with your current evaluatory and treatment regimens to enhance your effectiveness and permanency of results in relieving pain and restoring motion.

If you would like more information about the American Back Society or want to see the program for the Fall Symposium on Back Pain scheduled for December 11-15, 1991 at the San Francisco Marriott, phone (415) 536-9929 or write me, American Back Society, 2647 East 14th Street, Suite 401, Oakland, California.

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