Dynamic Chiropractic

The 2003 Meeting of the American Back Society, Part 1

Robert Cooperstein, MA, DC

The American Back Society (ABS) met Nov. 13-15 in Las Vegas. The ABS is the largest interdisciplinary back organization there is, and from its inception, chiropractors have played an important role in its meetings, both as presenters and as attendees. I have been attending since 1985, and have been writing symposia reports for *Dynamic Chiropractic* for more than a decade.

When I cast a look back at the panorama of past meetings, I see lots of people, from several professions, and hear lots of remarks - some that were prophetic, and others that did not stand the test of time. A long time ago, an eminent surgeon from Boston declared that the sacroiliac joints were not movable, and Robin McKenzie once said that only 2 percent of his patients would benefit from manipulation (a statement he later recanted). More recently, Nikolai Bogduk declared that manipulation would disappear during the 21st century. It will not.

Apart from the people and the remarks, I have also seen sweeping changes in how the professions represented at the ABS relate to and influence each other. In the early years, chiropractors acted as if they were privileged to have been invited to play a role in an organization whose members were mostly medical doctors. It was not uncommon to hear putdowns of chiropractic and its methods - some perhaps intentional, but usually more like innocent remarks gone wrong: "Not only doctors, but also chiropractors find this condition very difficult to treat." The ABS leadership, for its part, has always treated all participating professions equally and fairly, to its credit.

As the years went by, there was obvious erosion in the medical doctors' self-confidence,[1] their sense of having a handle on the diagnosis and conservative treatment of common spinal conditions.

Commensurate with that, as the Rand Reports[2] and AHCPR Guidelines[3] came down supporting manipulation, the chiropractors picked up lots of prestige. As incredible as it may seem these days, chiropractors virtually dominate ABS meetings; not in their numbers, since they do not appear more represented numerically compared with past meetings, but in their influence. This is not always a favorable development, in my view. Today's ABS meetings frequently feature osteopaths, physical therapists, medical nutritionists, and technique vendors who have the look and feel, unfortunately, of eccentric chiropractors. You know this has happened when you can make more sense of the surgical presentations than those of these medical "CAMoids," whereas the invited chiropractors (mercifully) appear simply mainstream by comparison. Who's kidding whom?

Jacob Rosenberg, MD, on Pain Management

Usually, the ABS conducts morning general sessions and afternoon workshops, but this meeting featured four sets of concurrent workshops on Thursday and a daylong general session on Friday (with more workshops on Saturday). It is reasonable to ask why, with 13 concurrent workshops to choose among on Thursday morning, I chose one on pain management, which predictably emphasized a pharmacological approach. Although I see no rationale for chiropractors acquiring a practice scope that includes prescribing drugs, we must develop a working knowledge of pharmacological approaches, since some of our patients are under concurrent care.

Rosenberg emphasized the biopsychosocial model of pain - the modern alternative to the traditional biomedical model, which is still held by many, if not most, medical doctors, and certainly the majority of chronic pain patients. In the biomedical model, pain may be adequately explained in biological or medical terms. Mental or emotional problems may result from chronic pain, but the pain itself is entirely biological, and the treatment approach involves physical and pharmacological intervention.

By comparison, the biopsycho-social model of pain takes into account not only biological, but also psychological and social factors. Psychological factors include the mental, emotional and behavioral aspects of pain; social factors govern how pain is modulated by interactions with other people. The standard biomedical model separates mind and body, whereas the biopsychosocial model finds them intrinsically commingled, and fosters treatment approaches that acknowledge (as D.D. Palmer did) the value of biological, psychological and social interventions.

The presenters of this workshop, knowing that other presentations would cover the gamut of surgical, physiotherapeutic and manual interventions, stressed the psychosocial context in which drugs are prescribed, used and abused. A lot of it had to do with opiates, which have experienced increased popularity in the past decade or more. Exaggerated fears of addiction formerly led many medical physicians to underprescribe and underdose, tragically consigning many patients to avoidable pain. Pseudoaddiction is described as aberrant behavior driven by underpre-scription, and disappears with proper dosing.

Granted the vast difference between pharmacological and manual treatment, the medical pain specialist has to solve at least one problem that is also very familiar to chiropractors: the potential for the abuse of passive care. From a formal point of view, addictive behavior in relation to drugs is similar to dependence on manual passive care. All of us are familiar with patients who have become dependent on chiropractic ministrations essentially unrelated to any biological necessity. Doctors of all professions must watch for signs of patient dependence and shift their patients from passive to active care as best they can.

The trick in prescribing pain medicines is to decrease pain and return people to work and normal activities without decreasing cognitive function. Rosenberg felt that correct diagnosis is imperative and that incomplete diagnosis leads to mediocre results. One of the most critical diagnoses is the distinction of pain from suffering. Pain is the perception of an unpleasant sensation, whereas suffering is the psychosocial synthesis of pain, conditioned behavior, past experience, and current social situations that result from the pain: loss of dignity, unemployment, depression, marital and sexual problems, other family problems, and economic problems. It is imperative that medications be prescribed for pain, not for suffering. That is where the abuse comes in.

I was intrigued to learn how important it is that the pain specialist know what is happening "on the street," and the degree to which he or she must "walk a mile in the shoes" of the patient to do a good job as a physician. Pain specialists go where many doctors no doubt prefer not to be. Because of the ongoing and ever-present likelihood of substance abuse, the doctor must immerse him- or herself in the intimate details of the daily life of the patient. The doctor has to invent games to monitor patients, and the games must change all the time. Rosenberg described a patient who was selling some of her drugs for extra income; he reduced her prescribed dosage until she felt her low back pain return, so she would have nothing available to sell. The pain specialist must also deal with patients who experience multiple episodes of "losing" drugs or "running out" early, others who inject oral meds, some who call in their own prescriptions, and still others who surreptitiously obtain drugs from other physicians.

I don't know why this should be the case, but nutrition workshops often have a stream-of-consciousness character, where the speaker pulls facts and factoids, speculation and spectacle, and occasional abject absurdity out of a hat, like words in a Dada sound poem. The speaker in the workshop I attended, a medical doctor, reminded me of Kurt Schwitters, a 1920s collage artist who combined aesthetics and rubbish, tearing phrases and everyday objects from their mundane political and social contexts and rearranging them so they then referred only to themselves.

This speaker started out with prepared remarks on the "root cause of all chronic conditions," but before long, he was dishing out an uninterrupted stream of dubious statements. One of his patients was 37 pounds overweight, but only 3 pounds of that was fat - the rest was "toxic molecules." Prions are pieces of "RNA and DNA." (Hmm...) The body develops fever to "liberate calcium from the bones." (Oh...)

Despite the opening rhetoric about identifying and treating the root causes of chronic back pain (nutrition, genetics, toxicity, infection, etc.), the speaker eventually became quite clear about the true meaning of "foundational nutrition": For disease X, use nutritional supplement A. For disease Y, use nutritional supplement B. It always comes down to that, as well it should. We can live with a nutritional stream of consciousness if the isolated statements seem to make sense, taken individually.

On the other hand, patience wears thin under a merciless barrage of warmed-over factoids spiced with obvious biological mistakes: a torrent of "neutribabble." It got scary, not funny, when the doctor asked: "Can a healthy person ever become infected?" He then said that infection might be a mechanism by which the body regulates itself, rather than a root cause of disease. (Uh oh!) I almost left at that point, but was riveted to my seat by a sense of wonderment, of history being made. After all, I once found a way to repeatedly listen to the Rolling Stones' "Get Off My Cloud," as performed by teen wonders Dino, Desi and Billy.

Michael L. Kuchera, DO: Model Builder Par Excellence

Dr. Michael Kuchera is a professor at the Philadelphia College of Osteopathic Medicine. Having previously read some of his articles and book chapters, it was a great pleasure for me to attend his workshop and experience his approach to manual care. His emphases on technology assessment (testing the reliability and validity of patient assessment procedures) and the importance of the postural substrate are very resonant with my own primary interests as a chiropractor.

After confessing that the three models he was about to present were not mutually exclusive, and freely admitting that insufficiencies would be obvious, Kuchera conducted a most interesting workshop on osteopathic theories and their translation into hands-on treatment. Indeed, it was totally unnecessary that he try so hard to lower our expectations. I provide short descriptions of his three models as follows.

1. The Respiratory-Circulatory Model

The influential osteopath J. Gordon Zink developed a model emphasizing the diaphragm as the major muscle of the body, contributing to the interactive flow of the entire musculoskeletal system and visceral functions. He recognized the movement of the whole axial skeleton in synchrony with breathing, describing how torsional patterns could lead to congestion in venous and lymphatic vessels, due to compression as they pass through the diaphragm. Zink also developed a related postural distortion model[4] whose method, if not its main findings, very much resembled Logan's formulation of the Basic Distortion.[5] Kuchera, acknowledging the esoteric nature of Zink's model,

endorsed his warmth provocative test, but added, "I have no idea if it is true." (Nice...) After all, Kuchera continued, the body doesn't read our textbooks. So, when a model is applied that predicts something, and that inspires an intervention, after which the patient improves, the model has at least induced an effective intervention, even if it has no explanatory power. (Sort of nice...)

2. The Autonomic (Segmental Facilitation) Model

This is well-known territory for chiropractors, directly related to our models of viscerosomatic and somatovisceral phenomena. The osteopathic term "somatic dysfunction" is their subluxation-equivalent term.[6] It can be detected through the acronym TART (Tissue texture changes, Asymmetry of structure, Restriction of motion, Tenderness to palpation), which is rendered by the closely related PARTS acronym in chiropractic.[7] This leads to a facilitated segment, as described by Denslow, Korr, and others, that is essentially a highly excitable segment of the spinal cord. Spinal pain, perhaps due to trauma, causes greater gamma efferent activity in the spinal cord, increasing spindle fiber sensitivity, leading to hypertonic muscles; then local tissue congestion; and then even more pain - perpetuation of the problem. Moreover, there would be autonomic consequences, as well, in which the related level of the sympathetic nervous system is also in a state of chronic overactivity, damaging the target organs and lowering the patient's health. The reader is urged to consult the revisionist discussion of Nansel and Szlazak,[8] or Cleveland's very comprehensive discussion.[9]

3. The Postural Gravity-Strain Model

Kuchera's model of gravitational stress very much resembles structural models in chiropractic,[10] as manifested today in the work of individuals such as Pettibon,[11] Harrison[12] and Troyanovich.[13] Departures from an ideal posture predispose toward musculoskeletal train and eventually, degenerative changes in the musculoskeletal system. As the patient is overwhelmed, we see further postural deformity, chronic or recurrent sprain/strains, myofascial pain syndromes (trigger points), ligamentous laxity, and somatic dysfunction. Somatic dysfunction, as we have already discussed, may lead to visceral dysfunction.

Kuchera was careful to state that these three models bleed into one another and are not mutually exclusive. For any given patient, one model may seem more applicable, but only as a matter of degree.

(*Author's note:* Part II will cover presentations by Hoban on thoracic spine posteriorities, O'Neill on nucleoplasty, Donelson on McKenzie patients receiving the "wrong" treatment, and Haldeman's keynote address.)

Notes

1. Cooperstein R. Grand rounds at the American Back Society: Cinema VeritŽ of back pain. *Dynamic Chiropractic* 1995(August 29):16,20.
2. Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Phillips RB, Brook RH. *The Appropriateness of Spinal Manipulation for Low Back Pain:* project overview and literature review. Santa Monica, CA: RAND; 1991.
3. AHCPR. *Acute Low Back Problems in Adults.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, AHCPR; 1994.
4. Defeo G, Hicks L. A description of the common compensatory pattern in relationship to the osteopathic postural examination. In: www.chiroweb.com/archives/11/24/15.html: *Dynamic Chiropractic*. Feb. 5, 1993.

5. Logan HB. *Textbook of Logan Basic Methods*. St. Louis, Missouri: unknown; 1950.
6. Cooperstein R, Gleberzon BJ. Toward a taxonomy of subluxation-equivalents. *Topics in Clinical Chiropractic* 2001;8(1):49-60.
7. Bergmann T. P.A.R.T.S. joint assessment procedure. *Chiropractic Technique* 1993;5(3):135-136.
8. Nansel D, Szlazak M. Somatic dysfunction and the phenomenon of visceral disease simulation: a probable explanation for the apparent effectiveness of somatic therapy in patients presumed to be suffering from true visceral disease. *Journal of Manipulative and Physiological Therapeutics* 1995;18(6):379-97.
9. Cleveland III CS. Neurobiologic relations and chiropractic applications. In: Redwood D, Cleveland III C, editors. *Fundamentals of Chiropractic*. Philadelphia PA: Elsevier Science, 2003. p. 155-186.
10. Rosenthal MJ. The structural approach to chiropractic: from Willard Carver to present practice. *Chiropractic History* 1981;1(1):25-29.
11. Pettibon BR. Pettibon chiropractic bio-mechanics procedures for detection and correction of the vertebral subluxation complex-Part I. *Chiropractic Products* 1995(October):120-122, 124-126, 128-130.
12. Harrison DD. Chiropractic: *The Physics of Spinal Correction. CBP Technique.* Evanston, Wyoming: Harrison CBP Seminars, Inc; 1994.
13. Troyanovich SJ. *Structural Rehabilitation of the Spine and Posture: A Practical Approach*. Huntington Beach, CA: MPAmedia; 2001.

Dr. Robert Cooperstein, a professor at Palmer College of Chiropractic West, can be reached at www.chiroaccess.com, or by e-mail at drrcoop@aol.com.

APRIL 2004

©2024 Dynanamic Chiropractic™ All Rights Reserved