

Can We Successfully Treat Patients Who Have Had Spinal Surgery?

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Can chiropractors successfully treat patients who have undergone spinal surgery, even when they present with pain in the area of surgery or surgical fusion?

When I was going through chiropractic college in the mid-1970s, many of the doctors teaching the courses were pioneers of the profession. They taught us things that students today are told not to do. They taught us things today's students are told cannot or should not be done. These great doctors taught us safe ways to do things that are no longer taught in school.

For the past 15-20 years, I've been continually amazed when speaking to younger doctors. Most of them wouldn't consider treating or even touching a patient who has undergone spinal surgery, particularly vertebral fusion. Many doctors are actually afraid to treat these patients - they were never taught how to deal with or treat them.

In 20-plus years, I have successfully treated patients who have had various types of spinal surgery - radical discectomies, Harrington rod implantation, laminectomies and nonradical laminectomies.

To answer the question I posed at the beginning of this article, the answer is yes - you can successfully treat these patients! The manner in which a postsurgical patient is treated depends on the type of surgery he or she has undergone. Initially, you may treat these patients the same, or with similar techniques.

When treating postsurgical patients, you must realize several basic facts: These patients are usually already in a great deal of pain; and they are scared to death that you are going to undo or "break" something that was fused, causing even more pain. You have to find a way to work around the surgically affected area, whether it has been fused or not, or whether or not there is some form of prosthesis, such as a Harrington rod.

It is my sincere hope that when you went through school, you learned as many different techniques as possible. With a little bit of luck, you learned and remember how to use a few soft-tissue and reflex techniques; you will find them extremely useful, especially in the initial stages of treatment.

It is often a good idea to introduce some physiotherapy prior to working on the patient. The type and extent of surgery that the patient has undergone will help determine the type of physiotherapy you use or don't use. If there is no surgical metal left behind, such as staples, screws, rods, etc., I prefer to start with pulsed ultrasound, to help decrease deep-tissue inflammation. This will also get the patient comfortable with you touching them without causing pain. Use of electrical muscle stimulation will also help.

During the early stages of treatment, I prefer to use Logan Basic, some trigger-point therapy, and possibly Activator, along with a technique I have adapted for use on patients who are severely arthritic or postsurgical. If you start with Logan Basic, it will relax the paraspinal musculature in the affected region, which by itself will often make the patient feel better immediately. I then use

some trigger-point therapy to help break up some of the chronic spasms and adhesions that have built up since the surgery.

When treating patients who have undergone Harrington rod surgery, I have found that using some electrical muscle stimulation, followed with Logan Basic and trigger-point therapy, will often provide the patient with at least some pain relief after only a few treatments.

Prior to initiating treatment, it is important to let patients know and be certain they understand that your goal is to attempt to relieve their pain. You are not going to be able to correct the condition. Surgery has already made that impossible. Most of the time, patients are already aware of this; they just want some relief from the pain - without going through another surgery.

When treating patients who have undergone radical discectomy, as long as the region is free of any metal, I will usually start with pulsed ultrasound to help diminish the deep-tissue inflammation. If I am unable to utilize ultrasound, or decide to change my therapeutic approach, my next choice is to use cryotherapy, combined with electric muscle stimulation. Again, the goal is to help decrease any existing inflammation and to help relax the paraspinal musculature. Next, I will usually use a reflex technique - something along the lines of Logan Basic.

The reflex technique will permit you to relax the paraspinal musculature along the entire length of the spine, especially near the site of the surgical procedure. This alone often provides the patient with some measure of pain relief. By getting the paraspinal musculature to relax, you are able to treat the surrounding region using little force. When starting to adjust vertebrae in the affected region, I usually rely on a fingertip technique, adapted from a pediatric adjusting technique; or something along the lines of Activator, set on a very light setting, which gives a specific, controlled thrust.

The combination of techniques used in the order and method described above will allow for doctors to work on the affected area without having to apply anything more than light force. Adjusting the segments above and below the segments that have been operated on will impact the entire region. This will often bring the patient a significant amount of pain relief. The same technique can be used to treat surgical fusion patients.

Initially, you may find that patients respond quite a bit slower than what you are accustomed to, but as time and treatment continue, they will usually become much more relaxed and comfortable with you working on them. As the subluxations and fixations start to break up, patients will relax and you will be able to adjust them more readily. Of course, the amount of presenting symptomatology you can resolve will vary from patient to patient.

As a doctor who some of you may consider one of the "old timers," I realize that there is more to this subject, but for now, I feel you may need time to digest what I have discussed thus far.

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