

## Severe Antalgic Low Back Pain

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Patients who present to your chiropractic office with extreme low back pain, antalgia, and immobility may have to be referred to the emergency department (ED) for treatment, as they are frequently "untouchable" in the office setting. These patients make up a large percentage of the patients seen by chiropractors in the ED. While often difficult to manage in the office, these patients almost always respond well when treated by a chiropractor who is working as part of the ED team.

In the ED, the patient is initially worked up by the attending medical physician to rule out the most severe causes of low back pain. Radiographic images are typically obtained to rule out aortic abdominal aneurysm, fracture, tumor and other underlying pathology. A physical examination is performed to rule out neurological deficit. The patient can then expect the administration of an analgesic medication.

Medication for severe lower back pain usually begins with a nonsteroidal anti-inflammatory drug (NSAID). The patient may be given oral ibuprofen or an injection of Toradol, a strong NSAID. The patient may also be given a muscle relaxant, e.g., Flexeril, Valium or Skelaxin. If the pain is not relieved, the ED physician may elect to offer the patient a narcotic medication, e.g., Demerol. The Demerol injection is typically accompanied by another medication, Visteril, which will help prevent the nausea that can accompany the administration of Demerol. In some cases of very severe, immobilizing pain, the ED physician may order the administration of morphine, a very potent and potentially addictive narcotic analgesic.

At times, analgesic medication does not offer the patient sufficient pain relief or return to ambulation without assistance. The chiropractic consultant may be called, in an attempt to provide greater relief. Sometimes, the chiropractor may be called because the ED physician does not believe the patient is a good candidate for medication; or the ED physician may feel that the condition could be better treated by the chiropractor, even if the patient is a good candidate for analgesic medication. Sometimes, a patient does not respond well to NSAID medication, but the ED physician does not believe narcotic analgesia is an acceptable treatment for the particular patient. In some cases, the patient may have received narcotic analgesia without sufficient response to be discharged from the ED.

Insurance companies typically don't want to pay for the treatment of patients who are hospitalized for lower back pain. The hospital's review nurse is likewise unlikely to allow a patient to remain hospitalized for lower back pain except under the most extreme situations. The chiropractor is frequently of value when trying to prevent inpatient hospitalization.

In the ED, the on-call chiropractor's first objective is to add to the diagnostic workup of the patient. A triage nurse and ED physician have already taken the patient's history and performed physical examinations, but the patient has not responded sufficiently. The chiropractor must go into greater detail in the history and examination to ensure that more unusual causes of pain are not present. The chiropractor also adds a biomechanical component to the evaluation and treatment. Biomechanics is an important addition to the patient's treatment, as the ED staff's approach is

almost entirely physiological.

The chiropractors in our ED have found that by taking a slow, stepwise approach, we are able to use spinal manipulation to increase mobility and decrease pain in a high percentage of patients who present with severe pain. The patient is advised that while we want to perform a procedure that is likely to help, we do not want to do anything that will add to their pain. We say that we are going to proceed step by step, while explaining each step. The patient is further advised that if they get even an "uh-oh" feeling that something is going to hurt, they should tell us so we can stop. We assure them that we are either going to help or do nothing at all.

Treatment for severe antalgic back pain may include manipulation, electrical muscle stimulation, passive MUA-type stretching, and/or active lumbar stretching using a wobble chair.

The wobble chair is an excellent addition to the ED chiropractor's toolbox. It has a triangular seat that is balanced upon a post. The seat is attached to the post so as to allow it to tilt in any direction. The patient is instructed to sit on the chair and slowly tilt the chair laterally to one side and then to the other, while feeling the stretch in the spinal muscles. The patient may then be instructed to move the seat top in a forward/backward, circular, and/or figure-eight motion, depending on the patient's tolerance and response to the initial lateral movements.

After using the wobble chair, the patient is typically less antalgic, with less pain and increased mobility. Using the chair for ED patients is particularly useful as a transition from the immobile, bedridden patient who was brought in by ambulance to the ambulatory patient who is about to walk out of the ED under their own power. It is a much better alternative than having a patient go directly from lying on their back to getting up and walking out. The wobble chair stretching helps the patient to actively increase their mobility and gain a sense of how it feels to weight-bear during different lumbar postures.

The ED chiropractor has an excellent opportunity to observe the effects of many commonly used chiropractic techniques on a large number of new and typically severe cases. Due to the lack of control subjects in the ED, the results obviously have to be considered anecdotal. It would be of great value to chiropractic practitioners if use of chiropractic techniques, e.g., the wobble chair, were to be challenged by more rigorous, double-blind scientific evaluation.

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