Dynamic Chiropractic

HEALTH & WELLNESS / LIFESTYLE

We Get Letters & E-Mail

The Real Wellness Paradigm

Dear Editor:

What an interesting read: "Real Wellness Means Caring - A True Story" by Dr. G. Douglas Andersen [www.chiroweb.com/archives/24/08/02.html]. It was surprising to see Dr. Andersen's paradigm of what wellness is, and I'm sure his idea of wellness is not uncommon to many of our colleagues.

But, for the sake of argument, let's look at this paradigm for a moment. His patient, "Camille," whom he uses as an example of his wellness model, is seen only when she is in crisis three to five times per year, and care is directed at treating symptoms so Camille feels better. Then she is off again until the next crisis. (Forgive me if this observation is inaccurate, but I believe this is the correct interpretation.)

Sorry, but I don't believe this constitutes any form of chiropractic wellness care. This is a medical model of sick or symptom-oriented care. I think this is pretty evident just in Dr. Andersen's terminology: "intern," "treatment" and "manipulation," rather than adjustment, which is his word choice for what I, at least, would hope is his primary form of patient care.

So, Camille comes in after a couple of years because she's hurt herself again, and she looks great because she lost weight, took some of Dr. Andersen's advice about nutrition, and so on hey, terrific. I think part of a true wellness practice is to show patients a better way of doing things. She's then asked about her children. I found it unfortunate that Camille wasn't asked to bring her children in to be checked. I think in a true wellness practice, "care" is given to optimize health rather than simply "treat" someone's symptoms.

If Camille understood that a chiropractic adjustment improved the body's ability to heal and regulate better, she would have at her first opportunity had this child, her "preemie" and her other children, checked and adjusted if necessary by Dr. Andersen. If Dr. Andersen were uncomfortable checking and adjusting children, he could choose to refer to a pediatrics diplomat for care. I think one of the great things we have in chiropractic is dedicated doctors who have special training in specific areas. Just as Dr. Andersen has chosen to specialize in sports injuries, he has the choice of referring kids like this to a diplomat of pediatrics. Unfortunately, many of our colleagues don't use these resources as much as they should.

Who knows, if Camille had been adjusted more regularly and had brought her children in to get adjusted, maybe, just maybe, this parent would have saved thousands of dollars instead of having to deal with 11 surgeries.

I take issue with Dr. Andersen's statement that most doctors of chiropractic think all medical care is bad. It certainly excels at crisis care, such as treating this woman's premature child, who was in crisis. But let's be real for a moment. Medical care is not health care and it sure isn't "wellness" care. It's crisis care or sick care, and when a population uses a sick care system for its health care, it becomes a gross contradiction. Contradictions lead to destruction and the greater the contradiction, the greater the destruction. When you apply this reasoning to the statement that

medical care is health care, it's pretty evident to me why the practice of medicine is the leading cause of death in the United States.

In closing, I certainly believe a chiropractic adjustment has the ability to affect our view of ourselves and our environment more clearly, so when our nervous system is functioning with less interference, the choices we make as individuals are better for us overall. That's my wellness paradigm.

David L. Pergamum, DC
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Whom Does the NBCE Answer To?

Dear Editor:

I have been reading *Dynamic Chiropractic* for as long as I can remember and have kept up on all the latest topics in chiropractic for the past decade. Even back then, there were many articles that I reviewed and discussed with other doctors and future doctors regarding the ridiculous fees that are charged by the National Board of Chiropractic Examiners for what little it does.

I went out and visited its headquarters in Colorado in 1993, and was able to see the $16,000 table the board members occasionally sit at a few times a year, as well as the expensive new building in the middle of nowhere. I have heard about the ridiculous amount of money they are allowed to spend on their country club memberships near their headquarters. Some of them do not even use the membership, I have been told.

The first time I really became upset is when I found out the NBCE was donating huge amounts of money to different causes. The only donation it should be giving is money back to all those who took the ridiculously high-priced examinations. That is our money. That is the student doctor's money; each person who took those examinations. Now, I am finding out that 11 people have to go to 22 places a year, maximum, to oversee some examinations, and they get $2,500 for each trip they make, for each individual, as you explained in your May 8, 2006 article. [See "NBCE Control Group: Actions Reveal Attitudes" by Donald Petersen Jr., available online at www.chiroweb.com/archives/24/10/16.html.] I am sure the average plane fare, bought in advance, is not more than $400 and average hotel stay should not be over $200. The average daily expense for food should not exceed $200, and the average cost of transportation and miscellaneous for that trip should not cost more than $100 a day. This totals out to only $1,900 for what appears to be a three-day vacation/trip that they are charging $2,500 for each time. I can see that kind of money being spent on a vacation for one person for a couple of days, but I cannot see it on a business trip, and I do not think anyone else can, either.

My questions to you and everyone else out there in the chiropractic world are: 1. Whom do they answer to? 2. Why are we not given a refund of our money, instead of our money being donated without our permission? 3. Don't we have the right to see their salaries and expenses? All chiropractors have the right to know, because they only exist because we exist!

Isn't it about time we had a full-fledged, 100 percent guaranteed evaluation by a higher authority in regards to the NBCE, its members and their practices?

Michael L. Brown, AS, RT, DC, ACRB (level 3)
Nelsonville, Ohio

George's Test: Clinically Dubious?

Dear Editor:

I am writing concerning the article by Douglas R. Briggs, DC, titled "Things I Have Learned: Don't Adjust My Neck!" which appeared in *Dynamic Chiropractic,* July 16, 2006 [www.chiroweb.com/archives/24/15/14.html]. This article, which is otherwise informative and helpful, contains information which is now out of date concerning George's test for cerebrovascular insufficiency. Based on the research conducted for the development of the Canadian clinical practice guideline, "Evidence-Based Treatment of Adult Neck Pain Not Due to Whiplash," a pre-manipulative provocative flow test is of dubious value.

This guideline, led by a partnership between the Canadian Chiropractic Association and the Canadian Federation of Chiropractic Regulatory Boards, is based on the work of three literature search teams, an evidence extraction team, and the contribution of individuals with specialties or expert knowledge in chiropractic, medicine, research processes, literature analysis, guidelines development, regulatory affairs, and the public interest. A 10-person guidelines development committee authored the guideline, with input from a five-person review panel, and a six-person task force. The draft guideline underwent two national, professional critiques and a formal peer-review prior to being finalized. It states the following with regard to provocative testing:

> "*Provocative identification of impaired vertebral artery flow.* Pre-manipulative vertebral artery function tests to identify patients with impaired flow have been part of practice knowledge since Smith and Eldridge introduced a test in 1962. Since then, several tests have been developed, and the vertebral artery flow effects of these are moderately well understood: Barré-Leiou's sign test, George's cerebrovascular craniocervical functional test, Maigne's test, Hautant's test, Underberg's test, Dix-Hallpike maneuver (also known as Nylen's or Barany's maneuver), and deKleyn's test. The most common is deKleyn's test.
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> "The evidence suggests that a positive (impaired) provocative"'flow test' rarely indicates changes in vertebral artery blood flow and, consequently, deKleyn's test is neither sensitive nor specific. Thus a positive test should not be an absolute contraindication to manipulation. Other results have also suggested pre-manipulative flow testing is unlikely to identify patients with flow impedances" (p191).

To access the complete guideline, please see the September 2005 supplement to the *Journal of the Canadian Chiropractic Association*, titled "Canadian Chiropractic Clinical Practice Guideline: Evidence-Based Treatment of Adult Neck Pain Not Due to Whiplash." A summary of recommendations and the complete guideline are also available at the Canadian Chiropractic Association Web site.

Grayden Bridge, DC
Chair, CPG Task Force

A Better Way to Screen for Vertebrobasilar Insufficiency

Dear Editor:

Regarding "Things I Have Learned: Don't Adjust the Neck!"

Dr. Briggs recommended the use of George's test. Like many of us, I was taught in chiropractic school to use this test to screen patients prior to adjusting the cervical spine. This test may be a "classic," but it has since been demonstrated that George's test is neither sensitive nor specific for detection of vertebrobasilar ischemia or risk of vascular complications. George's test is invalid and its utilization by chiropractors as a pre-manipulative screening procedure should be discontinued.[1] Much less can George's test be construed to be a measure of a patient's risk of stroke. There are established risk factors for stroke (atrial fibrillation, hypertension, family history, etc.), but a positive George's test is not one of them.

Our concern, of course, is mechanical stress to the vertebral arteries, causing intimal dissection, subsequent thromboembolism and ischemic stroke. A properly performed adjustment of the cervical spine is unlikely to cause vertebral artery dissection (VAD).[2] However, VAD is a contraindication to manipulation, because a dynamic cervical spine adjustment might accelerate the progression of an incipient VAD.[3] If, based upon the case history, VAD is suspected, George's test and other provocative testing of the cervical spine should not be performed, and the cervical spine should not be adjusted.[4]

VAD is easily missed clinically since it often presents with head or neck pain as the only symptom.[5] The most sensitive means of detection is computed tomographic angiography (CTA), not exactly a handy and convenient screening tool for a chiropractor in private practice. But if you are treating a patient who has sustained acute trauma to the head and/or neck (particularly cervical spine fracture), or if following acute trauma, the patient has neurological deficits or cranial symptoms suggestive of vertebrobasilar insufficiency, ordering a CTA of the vertebral and carotid arteries would be prudent.[6] Vertebral artery dissection also occurs spontaneously in otherwise healthy individuals, but no risk factors for this phenomenon have been identified, and no clinically appropriate screening procedure is available.

Even if you can successfully identify all patients who are at risk for or have VAD, that doesn't eliminate the possibility that a patient might have a stroke during an office visit or soon thereafter.[7] Stroke from all etiologies is, after all, one of the most common causes of disability and death.

So, how should we screen for patients at risk for cerebrovascular accidents following adjustment of the cervical spine? 1. Recognize the differences between vertebrobasilar insufficiency, VAD, and stroke. 2. Recognize the risk factors for stroke and the clinical signs and symptoms of stroke. A patient who appears to be having a stroke requires emergent medical attention. 3. Recognize the risk factors for VAD and the symptoms of vertebrobasilar insufficiency. If you suspect VAD, refer the patient for imaging or further evaluation.

If a patient not a risk for VAD or stroke has symptoms of vertebrobasilar insufficiency, be careful, as Dr. Briggs suggests. But what does "be careful" mean exactly? Adjust fewer vertebrae? Adjust with less force? Don't adjust at all? Increase the coverage on your malpractice insurance?

Although vertebrobasilar insufficiency syndrome has been identified as a contraindication to manipulation of the cervical spine, there is evidence to suggest that a chiropractic adjustment can improve vertebrobasilar blood flow.[8] To me, "being careful" means the avoidance of high velocity adjusting techniques and provocative testing, and utilization of low-force/no-force technique. Yes, Haldeman, et al., found that even non-force techniques are associated with increased incidence of

vertebrobasilar dissection and stroke,[3] but that association is temporal, not causal. It is not possible to cause trauma without a trauma mechanism, and low force/no force technique (BEST, Logan Basic, NSA) does not utilize sufficient mechanical force to traumatize anything.[9]

I don't count myself among those who insist that everything we do must be evidence-based. To do so would be to quash the spirit of innovation that continues to make chiropractic such a uniquely valuable means of caring for the spine and nervous system. But if we are going to assess a patient's level of risk for a life-threatening condition, let's not stray too far from the evidence.

References

1. Terret A. "Current Concepts in Vertebrobasilar Complications Following Spinal Manipulation." NCMIC 2001.
2. Symons BP, Leonard T, Herzog W. Internal forces sustained by the vertebral artery during spinal manipulative therapy. *J Manipulative Physiol Ther*, October 2002;25(8):504-510.
3. Haldeman S, Kohlbeck FJ, McGregor M. Stroke, cerebral artery dissection, and cervical spine manipulation therapy. *J Neurol* 2002;249(8):1098-1104.
4. Thiel H, Rix G. Is it time to stop functional pre-manipulation testing of the cervical spine? *Man Ther* 2005;10(2):154-158. Epub 2004 Oct
5. Arnol M, et al. Pain as the only symptom of cervical artery dissection. *J Neurol Neurosurg Psychciatry* 2006 Jul 4. 6. Schneidereit NP et al. Utility of screening for blunt vascular neck injuries with computed tomographic angiography. *J Trauma* 2006 Jan;60(1):209-15.
6. Kier AL, McCarthy PW. Cerebrovascular accident without chiropractic manipulation: a case report. *Journal of Manipulative and Physiological Therapeutics*, May 2006;29(4): 330-335.
7. Jensen TW. Vertebrobasilar ischemia and spinal manipulation. *J Manipulative Physiol Ther* 2003;26(7):443-447.
8. Whedon J. Reduction of tinnitus by spinal manipulation in a patient with presumptive rotational vertebral artery occlusion syndrome: a case report. *Altern Ther Health Med*, May-Jun 2006;12(3):14-7.

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