Dynamic Chiropractic

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Justifying the Second Exam

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In this cost-cutting era of insurance protocol, the physician is often questioned about the rationale for conducting a second examination. In a normal course of chiropractic treatment, a second examination is usually performed after the 10th visit. The major textbooks regarding physical examination (Mosby and Gates) do not discuss re-examination at any length, and the American Chiropractic Association's *Basic Chiropractic Procedural Manual* does not offer any indication regarding the necessity of a re-examination.

The following case study and the information associated with the case clearly show a justifiable reason for doing a re-examination. The patient is a 68-year-old African-American female who presented with a primary complaint of right knee pain, as well as some lower back pain and a feeling of being tired. Family history was unavailable due to an adoption. The patient's case history indicated normal factors associated with her age. An extensive examination was performed on this patient, taking well over 45 minutes. Many systems were reviewed and the patient identified her right knee as her major problem.

The patient presented to the office utilizing a walker that was necessary for her gait. She was referred to my office by her primary care physician, who had previously run several blood tests and performed radiological examination of the patient's right knee. All orthopedic and neurological testing was negative to the primary care physician.

The patient had an obvious stepping gait and upon examination of the patient's right knee, only some orthopedic testing proved mildly positive. Radiological examination was performed on the lower lumbar spine, and the association with various factors produced a working diagnosis of degenerative disk disease and right knee sprain/strain. Within a course of approximately eight treatments, the patient noted a significant decrease in her lower back pain, but an increase in association with her weakness. Her right knee pain showed improvement; however, her ability to support her weight on her right knee continued to be a worsening issue.

A re-examination of the patient was scheduled. Repeating some of the same questions asked during the initial examination shed additional light on a possible new diagnosis. The original list of medications that the patient reported using included only muscle relaxers and naproxen sodium (Aleve). During the re-examination, the patient confirmed that she was also taking cholesterol medication. This information had not been provided during the initial examination, according to the patient, because she did not feel the medication had any relevance in terms of her condition. This omission came in spite of the fact that the patient had been asked originally about use of other supplements or any other medications.

A further review of the patient's true medication list indicated a possible interaction problem with glyburide and hydrochlorothiazide. Given the course of those two medications, I immediately called the patient's primary care physician and discussed the situation with the doctor, who immediately concurred that the use of statins was likely causing rhabdomyolysis [rapid breakdown of skeletal muscle tissue]. This was added to the patient's working diagnostic list. A comprehensive review of the patient's medications was initiated by the primary care physician on an office visit later that

day.

After removal from cholesterol medication, combined with physical therapy, nutritional counseling and several manipulations, the patient is now walking without assistance. All of her knee pain has subsided and she is able to do deep knee bends without pain.

After practicing for more than 20 years, my skills as a physician are not perfect, but my ability to perform differential diagnosis is one of my strongest and most successful tools available to me. I felt this situation warranted discussion with many of my colleagues to produce some simple standardization of protocol.

It is important to realize that the clinical picture of the patient often changes over the course of treatment and needs to be re-evaluated. In some cases, the lack of response to the treatment protocol often requires additional review, including a duplication of previous testing and questions asked during the initial evaluation.

It is in my nature to never assume or trust that another physician has competently reviewed or performed a medical protocol appropriately. In reflecting on my practice success over the years, I believe my "doubting Thomas" approach to previous medical care has been a cornerstone of my professional career. Being able to second-guess your decisions is a very strong asset and will not only help you avoid misdiagnoses, but also help keep your protocols more dynamic.

The patient's clinical picture can change and your treatment protocol must do the same. The importance of the second examination exists and so does the protocol for determining the medical necessity of its use.

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