Dynamic Chiropractic

REHAB / RECOVERY / PHYSIOTHERAPY

When the Adjustment Won't Hold: Taking an Integrative Approach

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Many of us focus primarily on adjustments, others are primarily soft-tissue chiropractors, and still others focus on rehab. What gets the best results? Since this is my soapbox, here is my answer: Use the right combination of all of your tools for the specific patient and their specific problem.

I really hate to say this, but ... since we basically get paid almost decently for manipulation, and minimally for rehab and soft tissue, the insurance companies inherently push us toward adjusting. Doctor, if you let the insurance companies decide what you are going to do, you are not using optimal clinical judgment. Let's look at a patient who has neck or upper back pain, and has not responded to your first couple of treatments. What else can you look for when you are finding the same joint fixation patterns over and over?

When the Adjustment Won't Hold

Look at common upper-body problems: one, when the neck locks up, over and over; two, when the upper back seems to need ongoing adjustments to the vertebrae or posterior ribs. What else can you correct that may help the pattern really shift? My attitude is if I am adjusting the same thing over and over for more than two or three visits, I am missing something.

We know the whole body, including the spine, functions as a single synchronous functional unit. The neck is strongly influenced by posture and movement of the chest and upper back. Upper back pain is often referred pain coming from the neck. If the adjustment won't hold, what else should you look at? How can you decide what other issues are significant?

Once you decide to look more broadly, the challenge becomes how to hone it down; how can you find what really matters, what is really profound? This is where prioritization comes in.

What Other Problems Should I Look for in the Upper Quarter?

Other joints: If the adjustment isn't holding, some other joint is usually locked up and needs to be checked and corrected. Here are the common patterns: 1) the anterior lower cervical spine. Learn to use low-force or traditional adjusting to the front of the neck. 2) Check the ribs, all the way around to the front; the sternochondral joints and the functional joints between the ribs all the way around the intercostals. 3) Get global. Are they stiff or rigid throughout the whole of the rib cage and thoracics? General mobilization in the office and self-mobilization are often key here. (I usually attempt to be as specific in my adjustments as possible, but when a whole area of the thoracic spine is rigid, first reduce the "noise" and focus on getting the whole area a bit looser before focusing on one joint.)

Soft-tissue problems: For the upper body, Janda described the Upper Crossed Syndrome. The patient usually will have a forward head posture, excessive rigidity in the upper thoracics, possibly with excessive thoracic kyphosis, forcing the head and neck forward. In any chronic upper-body problem, look at these tissues as contributors:

- Pectorals, especially pec minor
- Scalenes and SCM
- Small muscles, tendons, and ligaments of the anterior and lateral neck; these tend to have more of a tendonosis quality, the ligaments and tendons are not stabilizing the area and need instrument-assisted soft-tissue mobilization (IASTM) to wake them up and start up first-stage healing
- Subscap and lats (the muscles and fascia that internally rotate the shoulders tend to get too short and tight)
- Intercostals; think of these both as a soft-tissue and as a joint problem
- Pericardium; when the deep structures under the chest wall are restricted from trauma or any cause, a tight pericardium can contribute to the anterior postural pull, reinforcing the same postural and same subluxation patterns

Rehab: Upper-body rehab issues are fairly straightforward: Too tight and short – the scalenes, levator scapula, pecs, SCM, subscap and lats. Inhibited, need activation – the middle and low trapezius, the serratus, the deep neck flexors, and the upper trapezius. (The upper trap is the sleeper, the lesser-known one. Think of the lev scap as the elevator of the shoulders that gets too tight, and the upper trap as a horizontal muscle that works in concert with the serratus and middle and lower traps to position the scapula properly.)

Integration: Using All of Your Tools Effectively

So, you may be asking yourself two questions by now: 1) That is a pretty long list. How can I "keep it simple?" 2) How can I integrate all of this? How can I find what is most significant? Here is a dirty little secret. You deserve to know it; after all, you've read this far. Learning to adjust, learning to work on soft tissue, learning some basic rehab – it's all just the starting point. The real challenge, especially with your more challenging patients, is figuring out *when* to do *what.* How do you truly individualize care for that specific patient at that specific moment in time? Here's another secret: Once you begin to learn to think this way, you are on your way to clinical mastery and will never be bored in practice again.

How can you know what button to push? How can you know what is going to work? To quote Craig Liebenson from a recent seminar, "assess, correct, reassess." Start by noting the relevant findings on ROM, on palpation, on whatever functional tests you use.

Assess: For soft tissue, for adjusting, for rehab, start with postural evaluation, palpation or whatever tools you are comfortable with. Palpate, move, test; find something from the list above that is not working right. Choose a spot, something to further evaluate. You are not wedded to this part of the diagnosis, it is just the next thing to test.

Correct: Do a simple correction. Keep it simple, a basic adjustment, a few reps of an exercise, a brief soft-tissue release. Keep this quick; it is a "test" treatment.

Reassess: Go back to your original findings. Are they better? They don't have to be completely better. Just be honest with yourself and observe for changes. If the tissues are softer, if the locked-up thoracic or cervical segment is less restricted, if the tenderness has diminished, if the ROM has improved – you are on the right track.

An example: For rehab, have the patient perform a simple exercise, help them fine tune the motion, and then recheck your original findings. If they are better, you know it is a good exercise for that patient. For upper back pain, I often show the patient a simple way to pull their shoulder blades back against a wall or with band resistance. If this immediately loosens up their thoracic spine, then this is a great exercise for that patient. The advantage of starting with the rehab is the

profound motivating effect it has on the patient. They know they can help fix themselves.

Complete the correction: Next, completely release that target area; whatever you found. Release the soft tissue; check to see if the area is completely clear of fixations (if you released the 5th sternochondral, check the 4th and 6th sternochondral on both sides, and work around the whole of the intercostals). Clear the area. I am always looking for something the patient can do to facilitate motor control for that area, to self-mobilize the stuck area. If an exercise helped, then help the patient groove it; help them do it really well. Whatever area you are clearing is probably your main treatment for the day.

Reassess again: If the original problem is not any better – if the neck is just as locked, if the ribs are still stuck – then try something else. This can get challenging. I sometimes try three or four different strategies within a single 15-minute office visit.

At the end, go back and recheck the symptomatic segment, whatever you started with. If it is not completely released, it is fine to adjust it. You are attempting to completely clear the area, and the local problem may need work also.

This model implies that each patient has their own individual pattern of dysfunction. It implies that there are layers of problems to be addressed. It assumes that you are not going to do the same thing on each visit; that you are part of a dynamic process with the individual patient. Get good at this and you will become the "go to" doctor in your community, and you will also become an awesome clinician. Our chiropractic art is not just about left-brain knowledge or technique; it is about really seeing the patient and their patterns. This approach goes beyond an evidence-based model toward a patient-centered approach.

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