

We Get Letters & E-Mail

Big Problems With Disc Article

Editor's note: The following letter to the editor is followed by a response from the author of the article critiqued in the letter.

Dear Editor:

"Protocols for Managing Disc Injuries" in your [Feb. 1 issue](#) contains serious examples of misinformation. I am concerned that such an article might influence young chiropractic graduates, or be read by members of other professions that treat discs.

Every section of the article contains problematic clinical advice. For instance, the author states that "reducing psoas hypertonicity ... will allow disc bulging to return to normal alignment." Really? Where is the evidence to support this startling statement? Are we to tell our medical colleagues that chiropractors believe a disc bulge can be reduced by simply relieving tightness in the psoas muscles? The author writes this in the clinical section of a publication sent to every chiropractor in the world!

The author states that disc injuries are "usually easy to identify" because of antalgia, when in fact, antalgia is often the presentation of less acute disc patients, while many more severe disc patients do not go into antalgia. Disc patients, all of whom require a neurological workup, are often difficult to accurately diagnose.

Treatment? A psoas maneuver is presented as the treatment for disc conditions: "Patient mobility should increase and pain decrease immediately." Say that again? You mean that for the range of disc conditions, some with acute low back and leg pain, sometimes with neurological findings, we just need to treat the psoas? Hey, this author needs to dust off his copy of Cox's *Low Back Pain* or better still, attend a seminar.

As for rehabilitation, the author states that an inversion table provides "amazing relief" to disc-injured patients and recommends that while in inversion, they perform various lower back movements. This is perhaps the most seriously flawed, even dangerous, recommendation in the article. I strongly caution students and new practitioners who have not had experience treating discs *not* to place their patients on inversion tables, and certainly not to have them engage in low back motions while on the table. I won't even get into other recommendations, including "lunge stretches."

Chiropractic is facing a crisis: It needs to address how it will expand its scope without compromising its unique approach to patient care. We can't address this crisis if we can't follow established clinical protocols in treating spinal conditions, the core of our current acceptance in the health care arena. We can provide conservative care for most disc conditions, but the diagnosis and management of such conditions is extremely difficult and nuanced. Needless to say, treating the psoas muscle is not the central element of accepted conservative disc management.

Hopefully this article will not end up in a neurosurgeon's hands as a summary of the chiropractic

approach to disc injuries. I think most of us would be embarrassed if it did.

*Arn Strasser, DC
Portland, Ore.*

One of Many Tools for the Clinician to Use

Dear Editor:

I am grateful for the responses I have received from numerous colleagues on this article. I appreciate and welcome feedback from all practitioners, whether you agree with my protocols or not. I emphasize that no diagnosis should be made on the basis of one test alone.

Dr. Strasser repeatedly states that disc injury diagnosis is difficult. According to his website, Dr. Strasser "diagnoses disc injuries with a comprehensive evaluation including chiropractic and neurological findings." I am relatively certain he was taught these diagnostic procedures at his alma mater, Western States Chiropractic College. CCE schools are required to teach differential diagnosis including dermatome evaluation, reflex testing, muscle testing and numerous neurological tests. Every new graduate should have been trained properly in school to diagnose a disc injury. I pray that our chiropractic colleges do not fail to teach graduates how to diagnose one of the most common low back conditions in the world.

Psoas correction is another tool for the clinician to add to their technique repertoire. I do not suggest that correcting the psoas dysfunction is the only problem that needs addressed when dealing with disc conditions. In my article, I stated, "other hypertonic hip flexor muscles may continue to restrict motion and prevent patient progression."

Regarding traction therapy for disc rehabilitation, it is interesting to note how Dr. Strasser regards inversion therapy combined with movement protocols as "seriously flawed, even dangerous, recommendation(s)." He prefers to use Cox technique protocols.

"Cox Technic chiropractic protocols involve spinal flexion-distraction and decompression adjustment with an appropriate combination of ... exercise. Treating Protocol II Conditions (includes disc herniations) involves putting the spinal joints and segments through their normal ranges of motion. The caudal section of the table (on which the patient's legs lie) is maneuvered up and down (for flexion and extension), side to side (for lateral flexion), or in a circular motion (for circumduction)." (www.coxtechnic.com/patients/treatment)

In a study by A. Nachemson, et al., in 1970 ("Intravital Dynamic Pressure Measurements in Lumbar Discs"), the researchers measured internal disc pressure (in the third lumbar disc) through a range of activities, including standing, sitting, bending and vertical and supine traction. The study suggests that a traction load of 60 percent body weight is sufficient to reduce the residual pressure of 25 percent standing body weight to zero.

Even while lying down, your spine maintains 25 percent of standing pressure, especially in your lumbar. In order to decompress, the spine needs a traction force of at least 60 percent of your body weight, roughly equivalent to inverting at an angle of 60 degrees on an inversion table.

Using Cox technique, the doctor controls the movements while the patient is in traction; using an inversion table with adjustable degrees of angulation, the patient can control their own movements. I have difficulty seeing how a patient controlling their own degree of motion is dangerously harmful.

Dr. Strasser also notes that "treating the psoas muscle is not the central element of accepted conservative disc management." Not yet! It is my full intent that every disc injured patient have their psoas muscles evaluated and corrected.

I am thankful that D.D. Palmer didn't hold back because he wasn't accepted by other health care providers. So thank you, Dr. Strasser, for your valuable feedback. Since I am hosting my lumbar disc protocols seminar just a few blocks away from your office, I invite you to attend as my guest. You can experience my psoas correction firsthand and we can discuss how my protocols can be improved. Hopefully we can both continue to grow our profession as genuine colleagues.

*Todd Turnbull, DC
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