

## Adult Torticollis

John Cerf, DC

Pain medications and muscle relaxants have limited effects in certain individuals. One such man presented to the Emergency Department (ED) complaining of having awoken with severe neck pain and immobility. The attending ED physician diagnosed the patient as suffering from acute torticollis. The patient was medicated first with an intramuscular injection of Toradol and oral Flexeril, which proved ineffective. Injection of the narcotic Demarol followed. Reporting minor relief, the patient was discharged with prescriptions for both a nonsteroidal anti-inflammatory analgesic and a muscle relaxant.

The patient returned to the ED later that evening. He complained that neither his pain nor his mobility had improved, in spite of all the medication. The evening ED shift decided to obtain a chiropractic consultation, hoping to increase the patient's mobility and decrease pain and the need for additional narcotic analgesia.

History and examination revealed findings consistent with a diagnosis of acute spasmodic torticollis. The patient exhibited severely restricted cervical ranges of motion, antalgia, muscle spasm and vertebral joint fixation. Radiographic examination revealed signs of degenerative joint disease, but was negative for fracture or pathology.

I applied electrical muscle stimulation and moist heat to the patient's neck in preparation for spinal manipulation. The purpose of the adjunctive therapy was to help relax muscle and ease pain to facilitate the manual procedures and spinal adjustment. As the patient relaxed with the adjunctive therapy, we discussed the severity of his pain and immobility in contrast to the lack of significant examination and radiographic findings. The patient appeared to understand that the torticollis was a protective splinting caused by the brain's perception of bodily injury. As with many torticollis patients presenting to our ED, there was no history of trauma or illness to explain the severity of the patient's symptoms. Patient history included frequently sleeping near an open window or in front of an air conditioner.

After removing the adjunctive therapy modalities, I performed manual therapy to further increase the patient's mobility before performing cervical adjustments. With the patient seated, I asked him to turn his head as far as possible to the painful side. I held his head still and asked him to try to turn further. I instructed him to push hard, but not enough to move my hands. After a few seconds, I told him to relax. As he relaxed, I also relaxed my grip on his head, allowing his head to move slightly toward the painful side. I had the patient repeat this several times, and then several times to the other side, until he appeared unable to achieve increased range of motion.

For the second part of the manual therapy, I stood behind the patient, held his mastoid and parietal areas between my hands, and lifted gently. I held my forearms against his shoulders and asked him to push up against my resistance. As he pushed, I instructed him to take a deep breath and hold it. The patient's physical and emotion tension increased as he simultaneously contracted his upper trapezius muscles and held his breath. I asked him to concentrate on the feeling of relaxation as he lowered his shoulders and exhaled. As he released the tension on his upper trapezius muscles, I added additional traction force. The patient repeated this procedure several times until less muscle

spasm was palpable.

With the patient more relaxed and in less pain, I proceeded to have him lie supine for cervical adjustments. I attempted to put the patient at ease by explaining that we would approach adjustment of his neck in a slow, progressive, "step-wise" fashion. I explained that he might hear a popping sound as the joints moved, which could be loud, as it involved the inner ear, separated from the cervical spine by little more than an inch. I assured him that if at any time during the procedure, he had a sense that the adjustment would hurt, he could let me know and I would defer the adjustment for another day. I also demonstrated the amount of force I would use by making a sample adjusting thrust to his arm. Cervical adjustments were performed bilaterally, with increased mobility noted.

The patient tolerated the entire procedure well and without complications. His range of motion was approximately 90 percent of normal upon discharge from the ED. He did not require any additional prescriptions for medication. Upon leaving, he stopped at the nurse's station to thank the staff for its help and to demonstrate his increased range of motion.

*John Cerf, DC*  
*Jersey City, New Jersey*

JANUARY 2003