Dynamic Chiropractic

DIAGNOSIS & DIAGNOSTIC EQUIP

Trigger-Point Grading

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There is no standard or published grading system for trigger points. The only system anyone will find grades from "1" to "4" based on the severity of the subjective response from the patient. The problem with this practice is that the grade is still subjective. Even with this minimal system, who can say what the difference is between "2" and "3," or "3" and "4"? What if the patient has a high degree of tolerance for pain, and only provides minimal subjective responses? Is the trigger point there all the time? What about when patients say they have no pain without your testing? Does that mean no trigger points exist, or are they only below the noticeable pain threshold?

Regardless of how you cut it, a subjective system is generally worthless, particularly where it counts most - in a court of law. The following system takes into account objective test results that are admissible in court as true evidence of the described test results. An objective test result is one the patient is generally incapable of controlling or creating on a conscious level. A good example of this is a reflex reaction to the patellar tap (hammer strike). If the response is fast enough to be considered a reflex (instead of a patient-initiated response) by an informed and trained observer (a doctor), it can be duplicated by another trained observer, and is considered objective evidence. Another form of objective evidence is measurable changes in uncontrollable autonomic nervous system activity, such as increased respiration or heart rates.

The following system takes all the above into account. It deals with patient-noticeable and unnoticeable pain and subjective and objective evidence, and is admissible in court.

For any test results that do not have detailed and strict result criteria (as opposed to quantified and standardized tests, such as SLR or Kemp's tests), you can still use the tests, introduce their results into your SOAP notes and reports, and render them acceptable to all who may review your records - even a judge. All you have to do is have a written definition of what your results mean in specific detail, so that another reviewer (although he or she may not agree) will have to acknowledge your strictness and detail of application of the test, the specific results and their implications. When reporting objective evidence, list known and widely accepted evidence considered objective by the majority of the health care community (examples are listed above). Doing so in your reports and notes objectifies your findings.

Know these terms, and their meanings:

Trigger point found on examination: Moderate or firm pressure held for approximately one second, which would usually not cause pain in the given spot of application, may cause pain. The perception of pain must be communicated by the patient. (Ask the patient.) The ability of the examiner to feel or find trigger points on his or her own has been shown by controlled clinical research to be fallible and unreliable. For it to be classified as a trigger point, the primary criteria must be a change in the patient's perception of the pain (again, ask the patient) within approximately 10 to 45 seconds (generally reduced pain or centralization, or from sharp to dull). If patient preception doesn't change, the pressure is not directly on top of the trigger point, or it is not a trigger point at all. A secondary criterion is the referred pattern of pain. This is not always present, but the primary change is always present. The referred pain may be distal, following

specific patterns of referral, or it may be a halo pain (surrounding a one- to two-inch area) that reduces to a central point of pain.

Latent trigger points: trigger points found on examination that are generally not consciously felt or perceived by the patient as anything more than a discomfort, tension or stiffness for a majority of the time unless exacerbated (aggravated) by some physical activity, or what would be considered mild trauma (referred to as "at rest"). These trigger points are considered to be there all the time, ready to be exacerbated, but below the level of pain perception.

Active trigger points: trigger points found on examination that are consciously perceived by the patient as pain, even at rest, without activity or exacerbating trauma, during a significant percentage (generally 30 percent or more) of the time in question.

Objective signs: There are two basic perceivable signs of objective evidence to the examiner. The first is the "jump sign" - any physical response in muscle tissue that occurs at the speed of a reflex. Even the slightest delay from reflex speed negates this sign. The second objective sign is a change in autonomic nervous system activity. This is best observed as an increase in respiration or pulse rate. Both will be found to slow as the trigger point dissipates (changes).

Subjective signs: This is any physical reaction not at the speed of a reflex. This also includes the patient's description of the pain or discomfort felt upon the exerted pressure on the trigger point.

With these definitions in place, the grading system is now descriptive, precise and objective. The first question to be asked is how the patient perceives his or her condition during the majority of the time in question. This will determine a "latent" or "active" trigger point. Once that is done, the scan and examination of trigger points will define its specific grading number.

Latent trigger points are always rated "1" or "2" and active trigger points are always rated "3" or "4," regardless of the severity described by the patient upon compression of the trigger point. Therefore, a "2" rating describes trigger points not generally perceived by the patient as pain at rest, but still in existence below the conscious level of pain. A "3" rating describes trigger points that cause perceptible pain or discomfort in the patient, even at rest, during a significant (30 percent or more) amount of the time in question.

A latent trigger point that elicits an objective sign is classified as a "2" (describe it in your notes). However, on a subjective scale, a rating described by the patient as a "five or six" (or more) on a scale from zero to 10, with 10 being severe pain, can also be classified as a "2" for its severity. Any description by the patient as "4" or less should be classified as "1." This describes trigger points that are not generally perceived, but occasionally flare up and cause mild to severe pain on examination. How long these trigger points have been there is subject to patient history and determines chronicity, not grading.

An active trigger point that elicits an objective sign is classified as a "4." Any trigger point without this objective evidence is classified as a "3," regardless of the severity described by the patient. By specifying this difference on objective signs, this system renders objective evidence upon testing grading and where it counts - in court.

Some examples will be helpful:

- Example #1: The patient has felt the same pain during a particular activity every few months, but otherwise doesn't hurt. On examination, objective signs are found. This is grade 2, because these are latent trigger points not generally perceived during the time in question.

- Example #2: The patient has experienced a dull ache that has lingered for some time, and causes discomfort or pain upon activity. Upon examination, the patient states the pain is a "6" on the 0-to-10 scale, but no objective signs are found. This is grade 3, because the perception of pain or discomfort is there for a significant amount of the time in question, but objective signs are not found.
- Example #3: The patient has felt a pain or ache three or four days a week for the past few months. On examination, there is a reflex speed muscle contraction, and the patient says it hurts at a "4" on a 0 -10 scale. This is grade 4, because it is perceived during a significant amount of the time in question, and there is objective evidence present.

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