

When NOT to Adjust

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Soon after entering chiropractic college, I watched a debate on the "David Susskind Show." Mr. Susskind, a TV talk-show maverick, was pitting a medical doctor against a chiropractor; he turned to the DC and asked him if chiropractic could help patients suffering from lower back pain. The DC answered, "Yes." The host then turned to the medical doctor and asked if it could be dangerous for a chiropractor to perform manipulation on a patient with lower back pain. The MD listed a number of bone-weakening pathologies he claimed would make spinal manipulation hazardous. The physician's answer raised his own credibility, while making chiropractic appear dangerous. It was unfortunate that Mr. Susskind did not give the chiropractor the opportunity to answer the question about contraindications; the chiropractor could have listed the same spine-weakening disorders. He could have explained how DCs examine patients and order tests to avoid adjusting when contraindications are present. The viewers would have had a much better understanding of our expertise.

Recently, I met an orthopedic surgeon who wanted to learn about the chiro-practor's role in the emergency department (ED). When I described our results in treating young children suffering from severe neck spasm without having to resort to narcotic analgesia, he appeared upset. He warned me of the dangers of treating children, and related some tragic stories. With the Susskind show in mind, I rattled off the list of contraindications I had memorized from *Principles of Chiropractic* by Scott Haldeman. I followed up with information from an article concerning the need for an exhaustive diagnostic workup of childhood lower back pain. I believe I accomplished my goal of listing more contraindications than the orthopedist.

We have to expect medical and administrative staffs to be wary of permitting the practice of chiropractic in the hospital. Until they become familiar with our skill and knowledge, it is their duty to be skeptical. In more than two years of treating patients in the ED, our chiropractors have had neither patient complaints nor bad outcomes. The following case history demonstrates the type of chiropractic decision-making we follow when treating an acute-trauma patient.

A 29-year-old female presented to the ED complaining of neck pain following a motor-vehicle collision. She reported to have been the restrained driver of a car struck on the left rear door by another car; her car spun and came to rest as her rear tire struck the curb. She complained of an abrasion on her left shoulder from the seat belt and of neck pain without upper-limb pain or paresthesia. She denied contributory past medical or family history. Review of organ systems indicated complaints of fatigue, but no other problems related to any other organ system. A review of the chart yielded vital signs within normal limits.

Examination of cervical radiographs revealed abnormal findings restricted to hypolordosis. Examination also revealed guarded cervical movements, and palpation revealed a cervical paraspinal muscle spasm. The patient verbalized tenderness during palpation of the cervical paraspinal muscles and the right upper trapezius muscle. She denied point tenderness of the spinous processes or interspinous regions, and motion palpation revealed severe cervical vertebral joint fixation. Cervical compression and distraction both were positive, with verbalization of increased paraspinal pain, and bilateral maximum cervical compression was positive, with

complaints of increased ipsilateral cervical pain; George's test provided negative results; bruit was absent on auscultation of the carotid and subclavian arteries; Adson's test was negative bilaterally; and there was no difficulty with swallowing. The patient was intact neurologically, with +2/2 bilateral upper-limb, deep-tendon reflexes; equal bilateral upper-limb sensation; and +5/5 bilateral upper-limb strength. The working diagnosis was acute traumatic cervical strain/sprain, complicated by muscle spasm, hypolordosis and vertebral subluxation complex.

I applied electrical muscle stimulation to relax the hypertonic muscles and ease pain. As the patient relaxed with muscle stimulation, I explained the mechanism and nature of the injury; I told her how pain comes not just from the injury, but also from the body's attempt to protect itself; and how the body uses pain, muscle spasm, anxiety, and vertebral joint fixation to splint a damaged area. I also described how I would attempt to gently increase the mobility of her neck to reduce the body's overreaction to the injury, and told her I would describe each step of the adjustment. She was advised to warn me at any time if she became fearful the treatment would cause her increased pain.

After removing the electrical therapy device, I moved the patient to a supine position on the bed. While describing each movement, I moved the patient's head into position for the adjustment. After ascertaining patient tolerance, I moved her neck to end range and instructed her to relax it against the table. I applied a sample thrust to her uninjured arm, so she would know what to expect. I advised her of the popping sound that could occur. I told her that the loud volume was due to the spine being little more than an inch from the inner ear. I assured her that the sound did not mean her neck was broken. As she had tolerated everything up to this point, I returned her neck to end range and applied a gentle sample thrust, just forceful enough to push into the muscle but not move the articulation. The patient reported increased neck pain and appeared apprehensive. I deferred adjustment of the related side and instructed the patient to turn her head to the other side. She told me the movement increased her neck pain; I again deferred adjustment.

I informed the patient that her injury would not permit me to adjust her neck so soon after the accident. I assured her that after a couple of days of rest, it would be both possible and necessary to re-establish mobility in her neck. I applied additional electrical muscle stimulation for pain relief until the patient was discharged. If she had been able to tolerate the sample thrust, an extremely light, quick adjustment would have been made to her cervical spine.

While this patient was unable to tolerate an adjustment during the acute phase of her injury, hundreds of patients with similar injury have tolerated treatment with the above-described approach, facilitating increased mobility and decreased pain, with no observed or reported complications.

A thorough history and physical examination is obviously the first step for choosing patients who will be offered chiropractic care. A cautious, stepwise approach to spinal manipulation helps the chiropractor avoid adjusting a patient not yet ready to tolerate the treatment. After treating hundreds of acute-trauma patients in the ED, it has become obvious to me that careful and gentle adjusting of select acute-trauma patients results in an earlier return to normal mobility and more rapid pain reduction. Likewise, this careful approach will help to rule out those patients who should not undergo spinal manipulation during the acute phase of a traumatic injury.

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