Dynamic Chiropractic

BACK PAIN

American Back Society: The Industrial Back

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In December, the American Back Society mounted its 10th year anniversary multidisciplinary symposium, "The Industrial Back," in San Francisco, California. Allied health professionals spent four days sharing experiences in diagnosing, treating, and rehabilitating back patients, especially the injured worker. Although I couldn't attend all four days, I was able to attend the scientific programs and workshops on Thursday and Friday.

Among the wide variety of personalities and perspectives that were represented, several distinct themes emerged, reflecting the faculty's considerable common ground. Course Chairman Rene Cailliet, M.D. perhaps struck the keynote of the symposium when he spoke the simple words, "I don't care to treat a patient until I know what I am treating." He went on to add that history is often neglected, not only due to lack of time, but because there is a lack of astuteness. Speaker after speaker advocated a "let's get back to basics" approach to diagnosis and treatment. The old saw that taking a good history is the most important element of arriving at the diagnosis was vindicated over and over.

This ode to the history was no half-hearted attempt to sound "politically correct," say, given the dazzling technical excellence of modern imaging, electrodiagnostics, and functional capacity assessment. On the contrary, the faculty stressed repeatedly that the history and the nature of the clinical problem should determine the treatment, not the MR scan, thermography, etc. Dr. Light recommended "review of the MRI scan only after the clinical examination," lest one get into trouble, while Dr. Cailliet added that "overdedication to MR can deceive." Scott Haldeman, D.C., Ph.D., M.D., and Dr. Light were both critical of thermography (Dr. Haldeman: "If you want to make pretty pictures in front of juries and in court. ...") It would seem that some of the glitter has worn off advanced imaging, now that enough experience has been compiled to appreciate the lack of a one-to-one correspondence between structural aberration and clinical function.

Even as the history was being upheld, many speakers urged us to take it with a grain of salt. Dr. George E. Becker, M.D. who commonly speaks on the subject of somatization, the expression of emotional problems through physical complaints, spoke this time on the companion subject of malingering. He began with an historical overview, recounting the interesting case of Ulysses, a well-known draft dodger at the time of the Trojan War. He tried to evade serving in Agamemnon's attempt to retrieve Helen by feigning madness, going so far as to sow salt instead of seed. However, a contemporaneous IME exposed his chicanery by placing his child in front of the plow, whereupon Ulysses was forced to reveal his sanity by not plowing over his own child. Malingering, just like somatization, should be considered whenever the patient fails to recover at the expected rate. Dr. Becker reminded us that workers' compensation fraud is a felony, and concluded his presentation with what has become his trademark proviso: "Watch out for red herrings," complete with a slide of a you-know-what.

If Dr. Becker decried the occasional unreliability of the patient's account, Dr. Haldeman addressed the chaos and lack of interexaminer reliability among disability evaluators. He reported on several studies in which many evaluators, presented with identical information on the physical exam and history findings, came up with wildly differing disability ratings. He described an alternative approach to disability evaluation awarded for specific history and exam findings. This improves the interexaminer reliability of disability ratings, but they still remain very variable. It was found that an additional effort to better educate the evaluators as to the criteria for determining the diagnostic entities further improves the result.

Having spoken to the importance and difficulty of obtaining a good history, and the ever-present danger of overinterpreting imaging and thermographic studies, the faculty warned against another common error: mistaking the presence of pain for that of the disease itself. H. Duane Sanders, M.S., P.T. emphasized that when an injured worker recovers from back pain, he hasn't necessarily recovered from his back problem. Long before the first occurrence of back pain, there is a gradual loss of strength and flexibility. Unfortunately doctors tend to see the reduction or elimination of pain as the complete solution to the back problem. They return the asymptomatic, but still deconditioned worker back to the job in a position to be reinjured. Mr. Saunders stressed the role of rehabilitation in industrial injuries, a sports medicine approach to the injured worker, the "industrial athlete." He also attacked the old adage that 90 percent of back patients recover spontaneously; again the pain resolves, but not the real back problem.

Although the chiropractors present presumably agree that pain reduction should not be the sole outcome assessment criterion, they probably felt less comfortable with the generally negative judgment cast by the presenters on the value of "passive therapy," -- things that therapists "do to" patients. When Dr. Cailliet asked the panel if there was "any role for passive therapy," they answered that its only place was in the short-run following an acute injury. Even in that scenario, the passive treatment would be best administered when self-applied at home, in the form of ice, heat, etc. Mr. Saunders added that treatment of the patient is just a small part of the big picture." Education, ergonomics, and case management will have a bigger ultimate payoff, both economically and in terms of workers' welfare. Indeed, education and exercise are the only things that matter in the long run. Early return to work is part of the treatment, and not just a cost-cutting ideal. There was general agreement on the importance of rehabilitation in industrial injuries, and many espouse a "sports medicine" approach to the injured worker, the "industrial athlete."

Dr. Simmons spoke on the indications and success of salvage surgery in workers' compensation cases. One of his more startling conclusions was that the single most important predictor of failure in salvage surgery is that the doctor is treating a workers' compensation case. The most important predictors for success include the worker liking his job and knowing that the employer will take him back. The technical success of the procedure is less important. The ultimate criterion for predicting a successful surgery is that when the injured worker is asked what they would do if the pain was gone, replies: "I would go back to work."

One of the afternoon workshops I attended was conducted by my own Palmer West colleagues, William Meeker, D.C., MPH, Robert Mootz, D.C., and Dr. Walford, along with their associate, Dr. Bonni. They had intended to describe in a general way the delivery of chiropractic care in the industrial injury setting, but the workshop audience participants manifested an overwhelming curiosity in a well-known FCER-funded clinical trial that these individuals are administering at the Advantage Clinic in San Leandro, California. In this long-term study, injured workers are being randomly assigned to

chiropractic treatment (emphasizing HVLA thrusting), medical treatment (emphasizing modalities and education), and combined medical and chiropractic treatment. The presenters described their algorithms for what amounts to triage for injured workers, and for what defines appropriate treatment regimens as a function of the type of injury, stage of healing, and time frame.

If I may judge from my own experience, electrodiagnosis is not a strong component of chiropractic education. Therefore, I decided to attend Dr. Nudleman's workshop on the subject. He spoke on the different methods in common use, emphasizing EMG, SEP, and infrared thermography. I learned with great interest that there is a window in time, more than two to three weeks, but less than three to four weeks subsequent to an injury in which EMG can determine whether neurological abnormality may be ascribed to the current injury or a previous one. Dr. Nudleman also explained how thermographic diagnosis can detect reflex sympathetic dystrophy (RSD) before other evidence has manifested, thus allowing preventative care.

Dr. Michael Martin conducted a workshop in myofascial trigger point therapy. After elaborating in some detail the hypothesized anatomical basis for the trigger point phenomenon, he finally concluded that we just don't understand the syndrome, nor do we understand how Travell's "spray and stretch" treatment works. Dr. Martin took us on a whirlwind tour of selected clinical problems, providing us the relevant muscle anatomy, Travell's moniker (e.g., the scalenes: "The Entrapper,") the muscles' pain map, and finally how to spray and stretch the tissues. He suggested that plain ice be used in place of ethyl chloride or methylfluorine, both of which are ecologically unsound, claiming there is no loss of clinical efficacy.

I was especially taken with Dr. April's workshop on spinal imaging. He is not shy about the art of disabusing us of our misconceptions. "Bulging disks? The normal disk is larger than the end-plates, so that everyone has "bulging disks"; the straight edge of the CSF column that is seen in myelograms is inherently deceptive. On whether there's a place for myelography today: the standing myelograph is more diagnostic than MR for dynamic phenomena. On the quality of contemporary MRI: Most facilities render poor images, whether out of ignorance or the economic imperative to save time. Poor studies do not begin and end with slices lateral to the root canal; they do not obtain enough sequences; they omit coronal (yes, coronal) views; they fail to control for CSF pulsation through the use of ERG gating. His "white dot sign": A high intensity zone amidst the annular fibers indicates fissuring, which strongly predicts pain on discographic injection. On discography: If you want a "positive" discogram just inject the contrast material outside the nucleus. Various external phenomena seemed to conspire to shut Dr. April down, including an out-of-control slide projector that changed slides whenever it saw fit, and a participant snoring like a cordless chain saw on a low battery. Nonetheless, the more attentive participants would not allow Dr. April to leave, so that the workshop ran through intermission time right into its next incarnation.

I must admit to some disappointment with Grand Rounds. The cases were not especially dramatic, nor did anything controversial come up. We were not presented with any follow-up, as had been the custom in previous symposia. It was like having a film projector fail near the end of a movie that, anyway, had not been of compelling interest -- where's your reward for getting through it?

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