Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

The Art of Day-to-Day Assessment and Treatment: Clinical Pearls

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Let's focus on the day-to-day process of assessing and treating the patient. I am proposing a particular attitude; a way of looking at the patient. This often evolves over a few treatments and then changes as you figure out what is significant. We can maximize the effectiveness of this process using the SOAP format as our guide.

Subjective: The History

Do we really listen? The trend toward EHR has dumbed down history-taking, leading us toward just getting numerical levels of pain, disability indexes and percentage of time the patient is in pain. I appreciate that this has helped me stop fooling myself on the patients who continually say they are better, but don't improve on their disability scores, and are stuck in a 4/10 level of pain.

Significant clinical information is often found in the history-taking process. Any statement the patient makes instantly becomes the 800-pound gorilla – so pay attention! Listen intently, ask the right questions and the patient will tell you what is wrong.

At a recent seminar, Stuart McGill, PhD, reminded us that if the patient has good days and bad days, it means they are hurting themselves and creating the bad days. McGill emphasized that our first job is to stop the patient from continually getting reinjured. This means training them to stop moving poorly. (This could go under the title of using the doctor's common sense.)

What is the patient doing that is stupid or at least thoughtless, and is continually irritating or injuring them? Old-school crunches and sit-ups are obvious things here. All kinds of bending activities come into play as well, whether sitting at the laptop, computer station or tablet; sitting on the toilet in the early morning; or bending to pick up things.

Another major confounder is morning stretching, especially into flexion or rotation. This can feel good in the moment due to the effect on sensors and spindles; but is more likely to have a negative effect by stretching sensitized nerves or overstretching joints.

What about exercise history? We all know that the sedentary patient, the one who ignores the need to move, is going to have poor tissue quality that makes it harder for them to heal. But exercise is not all good. I have a simple algorithm: The exercise or activity should not hurt during, after or the next morning.

It is OK to have muscle soreness in muscles you have challenged; it is *not* OK for the back or neck, the chief complaint, to hurt after exercise. I tend to learn this one the hard way. My body will only tolerate one hour on a bike. If I do more, my flexion-intolerant lower back aches for three days.

What was the mechanism of injury? If the patient hurt themselves weight-lifting with a deadlift or just bending over to pick some little thing up, you can expect a flexion-intolerant pain with some kind of disc injury. If they broke a rib, whether the current complaint is in the neck, thoracic or lower back, palpate the rib cage, intercostal muscles and fascia.

Were they struck at an angle in an MVA? Look for twists in the body; the soft tissues can get "glued" in place. Ask and ask again for old injury or old pain issues. Bones heal, but the fascia and muscles remember. The fascia, muscles and joints are rarely treated properly when the injury was serious enough to require surgery or orthopedic management. Even if the patient had previous PT, chiropractic or massage, it is rare for the old area to completely heal. From the injury forward, they are going to have some kind of compensatory movement that will disturb normal body mechanics.

Wherever they have been injured, there is usually some degree of a weak link. Any stress, physical or emotional, will reawaken this. So, dig for the hidden parts of old injury histories in your chronic pain patients; they can prove significant.

Objective: The Exam

The standard orthopedic exam, testing reflexes, sensation, muscle strength and ROM, is required and useful, but does not tell the whole story. I suspect we all palpate the joints for lack of motion and tenderness. Do you do some kind of functional exam? Whether it is the FMS, the SFMA or your own series of tests for the individual patient, do you have a way to figure out what is not working?

Can you identify what motion is provocative of the patient's pain? It may be an oblique motion that is not linear. Can you figure out a load and direction that makes them begin to break down? In acute pain cases, you have to be careful not to put them into severe pain and spasm. In chronic pain, this diagnostic process can be even more challenging. You need to train your eyes and hands to figure out what is not working.

If you treat the soft tissue and fascia, do you assess just in the local area, or do you search both regionally and beyond? Remember the history, especially the history of old trauma or pain; where are the weak links? On the palpation exam, is the fascia restricted above and below, or on the opposite side of the complaint area?

The entry-level approach to soft tissue is to treat the tissues that hurt. The basics are important; you need to know how to assess and treat the local area. But to quote Lewit, "He who treats the site of pain is lost." Look above, look below, assess both sides, review the trauma history. Follow the fascial chains. Both the Stecco fascial manipulation model and Tom Myers' anatomy trains emphasize lines within the fascia.

Do you routinely assess for hypermobility in the joints? Assessing hypermobility is a challenging skill, and identifies joints that are more difficult to treat. You cannot successfully adjust a hypermobile area. I cringe at the patient who gets repeated side-posture manipulation that gives short-term relief for a chronic sacroiliac. The chronic SI joint is almost always hypermobile.

To address hypermobility, you need to do at least two things. One, adjust above and below. Do you recognize that the tight upper thoracics are affecting the neck? Do you think about the effect of stiff hips and stiff lower thoracics on the unstable lower back? The second strategy: identify excessive movement and train for stability via specific targeted rehab.

Remember and review the Janda model. Janda identified the muscles that tend to get tight and short, as well as the muscles that tend to get inhibited. Assess these; they tell you a lot and can be used as a guide to your rehab and soft tissue. Watch the patient's movements; they are telling.

Assessment: What's Wrong?

When it comes to diagnosis, the ICD codes are just a starting point. Your diagnosis suffers from being required to fulfill insurance requirements. Your treatment suffers similarly. As chiropractors, we are paid to manipulate the spine, whether that is the most important thing we are doing or not.

Think of diagnosis as a bigger picture of what is wrong. Whether you write it down as an ICD code or not, have a bigger picture. The myofascial component does not have adequate ICD codes. Is the patient fit? Are they overweight? Even if you are not a big nutrition doc, do you have any idea of what the patient eats and drinks? Do they drink water, or strictly coffee and Coke? Are they getting enough sleep? Are they under enormous stress in their life; this both causes pain and slows healing.

These issues are all comorbidities. Our wellness model should address these to some degree; our diagnostic picture needs to take these things into account. A diagnostic impression needs to be a work in progress.

Your clinical impression needs to be revisited if the patient is not responding. I like to add a comment after the formal diagnosis in which I discuss my overall impression and the prognosis. This tries to take into account the big picture.

When I first see a new patient, even after 34 years as a chiropractor, I am hard-pressed to predict their response. If the patient has seen me several times over the years, I can better predict their responses. I get to know who is movement averse and who is going to overdo. I start to know who will inflame too easily and who has great tissue-healing ability. I know who always presents in severe pain, but will respond quickly nonetheless. I get to know who is going to follow my instructions, and who I need to pester, coach and watch over if I want them to do any rehab.

The patient will get better faster if they are willing to do the work and do the rehab they need. There are fit-looking patients who have one or two weaker links you need to identify and help them focus on. If you can get these folks beyond denial, they can be easier to help, as they already have the fitness ethic.

Patients who are sedentary and out of shape can make huge changes quickly, but require more motivation. Don't give up on these folks; remind them that little changes in their lifestyle can create big changes in their ongoing symptoms.

I have been in practice so long that I no longer have the illusion I can fix or cure everyone. Sit down with your patient and set realistic goals. Frame them in terms of what they want to do. The goal can be to change the quality, frequency and intensity of their pain. I tell the chronic pain patient that we want to move the pain out to the edge of their life, rather than having pain be at the center.

The Plan: Treatment

You have been given a special gift as a chiropractor: You are trained to be both a diagnostician and a treating doctor. You get to tweak your diagnostic impression as you treat – you can change treatment

to fit the actual response of the patient.

The real question, dear colleague, is can you switch gears rapidly? In my view, the master develops mastery of multiple methods and knows when to use which one. Many doctors are masters of one technique; if they get the right patients, they do well. But we see a variety of patients. We need to be able to modify our methods when the patient is not responding. Remember the definition of insanity.

What is your favorite tool? Is it your adjusting tool? I suggest you make the tool that works on your current patient your favorite tool of the moment. Appreciate all your tools and use them at the right moment on the right patient.

Intuition, or perhaps experience and the tincture of time, help you do a better job. Do you have at least 10,000 hours of experience? Have you been paying attention and learning every minute on the job? If so, your intuition, your decision-making, will improve. Your hands will seem to know where to go. You will start to know what to say to the individual patient. This is very hard to measure, but easy for you and your patient to experience.

One of most important questions: Is the patient significantly improved during the session? It is not enough to assess whether they have met your "technique"-based indicators. The muscles may test stronger, the pelvis could be better lined up; but have they really changed?

I am not trying to discount these findings, but I want to assess outside of my own favorite technique world as well. What hurt before? What motions were limited? What points were tender? Do a mini exam; take 30-60 seconds to reassess via these reality checks.

Is this approach satisfying? You bet. You are going to help patients no one else has helped. It is a challenge as a business model. You will have shorter treatment programs *because the patient is actually getting well*. The length of time they need treatment is still going to vary, depending on multiple factors, but the trend is to get them better quickly. I think this model fits the primary spine practitioner model quite well.

In a best-practices type of chiropractic practice, the exam, the diagnosis and the treatment plan become an integrated whole. Find the problems on the exam, figure out what you think you need to treat and then treat it. If the patient is responding, great! If they hit a plateau or do not respond, revisit the problem.

A re-exam does not mean you need to repeat all the orthopedic tests. A re-exam could take two minutes; consider all that you have learned and search again, looking for what you have missed. If you find the right lesion and correct it with mobilization, with soft tissue, and/or with exercise or movement, you will usually get an immediate change. This is actually exciting. I love my failures, as I have the opportunity to turn the problem into a success.

SEPTEMBER 2014