Dynamic Chiropractic

PAIN RELIEF / PREVENTION

Working With Pain: Best-Practice Principles

Marc Heller, DC

What principles stand the test of time and research to provide guidance in the challenge of working with patients in pain? The following is drawn from 40 years of experience in practice, and from the evidence. Special thanks to Stuart McGill, PhD, my current favorite teacher. As usual, my examples are focused on the lower back, but can apply to any pain.

Find the Pain Generator

The goal of the history and exam is to find the pain generator and uncover ways to change the pain pattern. It is vital to listen carefully to the patient and ask questions that can elicit additional information. What are their past injuries and old pains? The patient may inadvertently give critical information. A recent example follows.

A 60-year-old standing female patient stated, "It hurts to lie flat on my back." As she said this, she bent into lumbar extension. This led to a diagnosis of L4 facet irritation with functional instability.

Can the patient touch the pain and/or trace the path of their pain? Can palpation reproduce the pain? Sounds simple enough, but pain is often vague and challenging to localize. The patient's internal image of what is wrong may be inaccurate and erroneously reinforced by what they find on the Internet.

Can the pain be provoked by a specific movement? Ask the patient to demonstrate a body motion that hurts (if they are able to do so). Employ various movements to elicit the same response using range of motion, overpressure and or neurodynamic principles.

A workable hypothesis of the origin or cause of the malady is the first step toward healing. The literature has a plethora of studies that show minimal effectiveness for any kind of treatment of nonspecific low back pain.

Pain patterns are layered. What may appear as obvious is rarely sufficient for complete treatment. Advances in fascial research demonstrate how vital the soft-tissue support systems are. Adjusting the joints is not enough.

Even if the key joints have been identified, the various factors that reinforce or further contribute to the pain must be addressed. These may or may not be directly in the pain area.

For example, head and neck posture can strongly influence lower back pain. Information can also be gleaned from examining multiple distant areas, including the upper cervical spine, and the hips, feet and ankles. This is where experience, intuition and creativity come into play. The practitioner ideally is an artist, not solely a technician.

Relevant considerations include the breadth of your mindset, the size of your clinical toolbox, and the

ability to use your skills effectively. Do you love the difficult cases that challenge you to dig deep and learn?

Focus on Function

Once the source of pain is identified, what comes next? Our job is to improve function, rather than anatomy. Degenerative arthritis is often a useless diagnosis. The wear and tear shown on X-rays may or may not be a significant guide to the source of the pain.

How do you know if you are on the right track and have found a significant source of the pain? One of the best guides to effective care is immediate, in-session changes in the pain pattern. You can measure this via reduced tenderness and patient's ability to move with less pain.

Are you overly enamored with your technique system's indicators? Step outside that mindset; utilize more objective indicators and reality checks. Are the hot spots less tender? Can the patient move with more ease? The patient is rarely going to get well in one visit, but that first visit does set the tone.

Engage the Patient in Their Own Care

Once the pain generators and pain relievers have been identified, convert that knowledge into simple homework / rehab. Liebensen advocates having the patient do a corrective exercise *before* passive treatment, whether adjustment or soft tissue. I love this simple idea. Doing the rehab first empowers the patient and enhances compliance.

Why is this critical? Muscles in an area of pain are inhibited and begin to atrophy within 48 hours of pain. Home exercise is a vital aspect of continued healing. The patient will comply more readily if demonstrations and supportive materials are clear.

Rehab includes some basic principles. McGill describes the first step as getting rid of the cause of the pain. He means that the patient needs to stop doing the movements and activities that aggravate their pain. For your flexion-intolerant (disc) patients, teach them to stop moving the lumbar spine into flexion. Instead,show them how to hinge at the hips, how to get out of a chair, how to turn over safely, and the best way to get out of bed. Simple, profound and powerful.

From a plethora of choices, first find and share a movement that relieves pain. Test the exercise in the office to make sure it works and that it is understood. Reinforce with a handout, or make a short video on the patient's smartphone for them to take home for reference. This is incredibly empowering to the patient.

Use your rehab toolbox to find exercises that feel good and relieve the pain. Ask your new patients what they do, other than pharmaceuticals, to relieve their pain. So few of your patients have and use this simple tool.

It is crucial to find ways that build endurance and tone in the muscles that have lost function. Pacing is critical. Success can be attained by beginning slowly. As Craig Liebenson says, "Find the most difficult exercise that they can do with perfect form." If you are not able or willing to be the coach, suggest a good trainer.

We can help so many people, no matter how severe or chronic their pain. Start with these simple steps and enroll your patient in the exploration of their pain and healing.

MARCH 2020