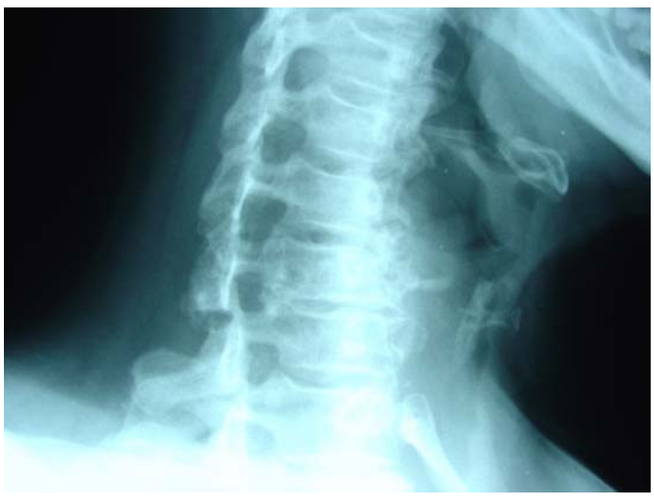
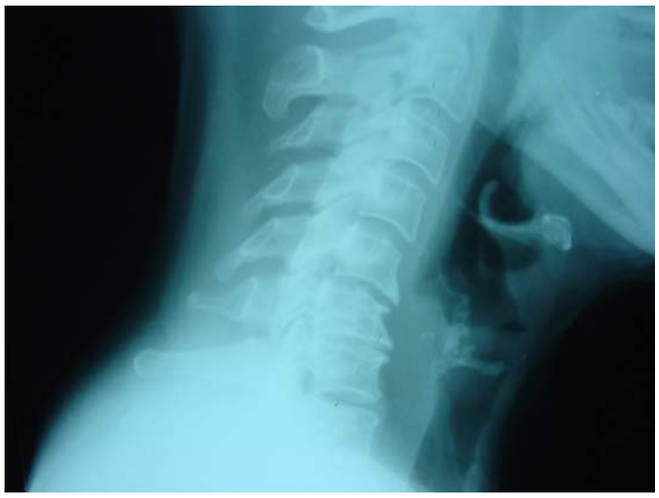
A “Common” Case Handled Well With Chiropractic Cox® Distraction Decompression Adjusting Protocols





Background Comment: Let's look at the history and findings of the case. A 72 year old white married female, accompanied by her husband, is seen at referral of her orthopedic surgeon for the chief complaint of left neck pain extending into the left shoulder with occasional numbness of the four fingers of the left hand. History shows that 4 years previously she was taken to the hospital ER with a similar pain, given morphine and x-rays were taken and she was sent home. Other pertinent history was a pilonidal cyst removed, hysterectomy for fibroid tumor, and a rotator cuff tear repair of the right shoulder. She is also presently on methotrexate for psoriasis (Yes, this is correct: it is not for rheumatoid arthritis.) and muscle relaxants for her neck pain. She smokes a pack of cigarettes a day and is a care giver for her husband.

Exam: Vital signs are BP 140/90, normal heart and lung sounds, oriented times 3, very cooperative, pleasant, and ambulates well. Range of motion of the cervical spine was impossible to ascertain on first visit due to pain. The left C2 and C5-7 levels were very painful to palpation with pain extending into the left rotator cuff muscles and down the left arm. The deep tendon reflexes of the upper extremities were plus 2 bilaterally and sensory examination was normal. Due to pain, muscle strength examination of the upper extremities was not possible. Compression did exacerbate cervical spine pain at C2 through C7 on the left side.

Imaging: Figure 1 is a left anterior oblique view showing foraminal narrowing due to posterior endplate hypertrophy at the C6-7 level. Figure 2 is a lateral view of the c/spine showing anterior head carriage, flexion subluxation and anterolisthesis of C5 with degenerative disc disease of C5-6 and extensive C6-7 disc space narrowing with endplate hypertrophy responsible for the foraminal stenotic changes seen in Figure 1.

Treatment: The orthopedic surgeon was appraised of our findings and a treatment regime and goals was established as follows. Proprioceptive neurofacilitation of the cervical spine muscles was given followed by decompression long y axis adjusting of the cervical spine with protocol I. Ultrasound followed the adjustment to the cervical spine. The treatments are given three times weekly until 50% subjective relief is attained and then the frequency of adjustments is reduced by 50%. Home therapy of alternating hot/cold/hot to the cervical spine and left shoulder girdle is given. She attended back wellness school to study ergonomics of spine function. She is given calcium citrate for osteoporosis of bone. Failure of 50% relief of the pain in 4-6 weeks of care would precipitate reexamination and reevaluation.

Clinical Outcome: In 10 days / 4 visits, the arm pain was absent, return of range of motion of the cervical spine to 70% of normal, and negative compression test.

Comment: Yes, this is a common case but that makes it very important. We see these cases routinely and sometimes forget how beneficial our form of care is to these type patients. Perhaps you may consider the use of decompression adjusting in your practice, especially since this is a case of a woman who could not tolerate high velocity adjustment. She is frail, concerned about being hurt by a chiropractor. (Do you get these patients as I do?) She is very happy with our care. Since this episode, I have also treated, successfully, left hip and lower extremity pain from spinal stenosis and am presently treating the failed surgery for a right supraspinatous tendon partial tear of the rotator cuff. In 10 visits, it is also 80-90% relieved of pain with return of range of motion. Good treatment begets happy patients who respect and use our talents.

Respectfully submitted,
James M. Cox, D.C., D.A.C.B.R.