

I. Musculoskeletal Problems ■

ACUTE LOW BACK PAIN

Patient management with these cases is critical. The patient must be made to understand exactly what the problem is and what to expect in the course of treatment.

Tell the patient that the pain may leave his back and travel into his leg. If you don't explain this initially, he may think you are paralyzing his leg. Make sure the patient understands that the vertebra needs to be set even after the pain is gone. If the patient quits when the pain does, the pain will return again in a few weeks.

Go over the x-rays with the patient and show how subluxations and compensations might react relative to a lower lumbar adjustment for low back pain. Inform the patient that he might develop pain elsewhere due to structural reorientation and weightbearing shifts.

Let the patient know it takes about 1 week after reduction for the ligaments to really start healing. Advise the patient against bending, etc., during that time. The patient should not go to work for about 5 days.

Advise the patient that it takes about 6 weeks before he can return to his normal activity schedule. Make sure he understands that from now on he must keep his back flat for all activities that place stress on the lower lumbar, such as driving, shoveling or lifting.

Tell the patient to avoid long, hot baths and to avoid heating the area in general because this will increase the swelling and aggravate the condition.

Orthopedic support belts may be used to support the area, but warn the patient against too much use as it allows the back muscles to atrophy. Make sure the patient knows the belt doesn't cure the problem even though it may help alleviate the pain. The belt may be useful when riding long distances in an automobile or in certain work conditions.

The patient can help relieve his own pain by using an ice pack on his back for about 20 minutes every hour. If the patient drives a long distance to his office, have him ice the area while driving. Also advise the patient to stop and walk for 10 minutes for every hour of driving time. This allows you to get a better set because of reduced pain and edema.

When you have located the patient's problem, stick with it during the correction period—don't jump around to other segments. However, if after three adjustments there is no positive response, re-evaluate. A spinous contact is best because it usually allows a deeper set.

If the condition is very acute with great pain and swelling, you probably won't be able to adjust the patient on the first try. You may need to see these patients up to 3 times/day in a 12-hour day, although twice is usually enough.

ADJUSTING THE ACUTE LOW BACK

Allow these patients to get themselves onto the side posture table with the involved side up. Don't attempt to help them onto the table because you will only make them hurt more. Don't use a knee-chest or hi-lo table with these acute cases. Set up gently on the involved segment in the push position and pump it 20 or 30 times. This accomplishes two things: (1) it gets the patient relaxed because he knows you aren't going to hurt him, and (2) it provides some relief to the nerve by working some of the edema out of the area. You may want to use this several times before you decide to do your first thrust. When you decide to adjust, handle the patient with care as you position his legs. Have the patient roll into you as if he were rolling off the table. Normally, the patient will stop at the point of pain. Tell the patient to go a little further and it will stop hurting. Find and make your contact without digging around and causing more pain. You'll probably need to tell the patient to let you push his shoulder up and back to extend him.

Make your first thrust count because the patient may not be able to take another. After the thrust, maintain your position for several moments; do not come right off the adjustment. Help the patient move his legs; he may receive a jolt of pain and have to stop for a second. Allow the patient to get up by himself to avoid any unnecessary pain. If you don't get a good adjustment, have him lay on his back and try it again later.

After a successful adjustment, have the patient walk as long as he can for up to an hour, but for at least 5 minutes. The walking will cause a pumping action on the disc and reduce the swelling. (In the rare instance when walking increases the pain, don't allow the patient to walk.) After walking, have the patient lie down. Allow at least 6 hours before the second adjustment. The pain should reduce greatly even before you have made a total reduction.

Don't allow the patient to sit after an adjustment because it will increase the pain; plus, he may throw it out again when he stands up. Therefore, with these cases, when you decide to start adjusting in the cervicals, adjust them first. It is best to remember to adjust the "major" initially because the fewer adjustments given the quicker the healing.

Before adjusting the patient, x-ray him in the position that he can best tolerate. For listing purposes, if you can't tell the side of spinous laterality, consider the lumbar above the involved segment and assume it is rotated the same way. This prevents an increase in the compensation.

Remember also that in these cases the lumbar are the major involvement. Only rarely will an ilium create this acute type of symptomatology.

As stated before, it is best to adjust these people twice daily—morning and evening. It takes at least 6 hours between adjustments for the instrumentation to reveal any results from the previous adjustment.

Once the patient starts to feel better, you should adjust less often and allow time for healing. Don't adjust the patient if you can't justify it with your instrument.

If you overadjust, you may reverse what you have accomplished, and the second hurt will take much longer to correct.

You may have the patient soak a pad with apple cider vinegar and apply it to the sore area. Potassium ions soak in and often relieve the pain.

Instruct the patient not to sleep on his stomach. It is best to sleep on a firm bed in any other position that is comfortable. Often it's most comfortable for the patient to lie on the concave side of a scoliosis, if present, or the side he was on during the adjustment.

If the patient asks you about surgery, tell him it is an alternative but it could mean 3 months of hospitalization. Point out that it is only successful over a prolonged period of time in 3 percent of the cases. Point out that often the wrong vertebra is fused—which doesn't diminish the pain at all and only decreases mobility until it breaks up.

In cases where the patient has undergone fusion, move him as a block but not individually. If the fusion has already broken up, adjust individual segments but verify this to the patient on his x-ray so you don't get accused of breaking it. Use a gentle thrust on these cases.

Initially, walking is the best exercise for these patients. Small movements in an acute case do the most good because large movements strain splinted muscles and ligaments.

Later on you may want the patient to swim and bicycle (British racing models).

Remind the patient when he lifts anything out of a car or truck to brace himself with a hand.

If a patient has a chronic low back, suggest he buy a car with 6-way power seats or at least an adjustable back. Sitting close to the steering wheel also aids the low back.