

**DIFFERENTIAL DIAGNOSIS
AND MANAGEMENT
FOR THE CHIROPRACTOR
PROTOCOLS AND ALGORITHMS**

FOURTH EDITION

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*I wish to dedicate this text to my wife Francie,
and sons, Aaron and Wesley
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Introduction

There are new and exciting examples of the impact that chiropractors have on a healthcare system that recognizes our portal-of-entry role. Two examples worth mentioning are taken from the managed-care environment. One illustrates the effectiveness of patient management when chiropractors are used as “gate-keepers” in a managed-care system.¹ This four-year study demonstrated dramatic decreases in the use of hospitalization, surgery, and medication use when chiropractors were utilized by patients as the initial contact of care compared to medical physician-managed patients. The second, also a four-year study, demonstrated similar results for the treatment of low back and neck pain.²

Guidelines and recommendations for evaluation and management of spinal pain have proliferated over the past two years. Manipulation has weathered these highly stringent processes and is recommended as a viable approach for spine pain and spine-related pain conditions. A discussion of these guidelines/recommendations is included in the *Fourth Edition*. Some examples include:

- The North American Spine Society Evidence-Informed Management for Chronic Low Back Pain³
- The European Guidelines for the Management of Acute Non-Specific Low Back Pain in Primary Care⁴
- Clinical Practice Guidelines for the Diagnosis and Treatment of Low Back Pain by the American College of Physicians and the American Pain Society⁵
- The Bone and Joint Decade 2000–2010 Task Force on Neck Pain and Its Associated Disorders Recommendations⁶
- The Council on Chiropractic Guidelines and Practice Parameters Best-Practices Documents (on-line at www.ccgpp.org)
- Radiographic guidelines for the spine and extremities⁷

Also added to this new edition are:

- Over 500 new references
- Updated algorithms
- Updated ICD Codes
- Over 50 new medications (medications appendix)

The focus of this text has always been an evidence-based approach even before it became the adopted standard by healthcare decision makers. Over recent years many efforts have been put forth in an attempt to find out “what really works” in patient evaluation and management. What has been primarily gained is a greater appreciation for what is not known and the complexity of finding out the answers to what constitutes, produces, and sustains better health care. Conclusions reached by systematic reviews and guideline development groups are often that the quality of the literature is poor and that there is not enough quality literature to allow a recommendation for or against a given approach for either diagnosis or management. It has become apparent that the requirement for evidence supported by a randomized controlled trial (RCT) is not a practical solution to many pressing healthcare questions. In other words, RCTs are expensive and require years to conduct in an attempt to answer a very specific question with a specific group of patients. And although they reflect a very controlled study of a sample group they may not represent the individual patient sitting in front of the doctor who must make a clinical decision.

What will serve as a guide for practice decisions while waiting for RCT evidence or in lieu of an RCT and what will drive decisions in the absence of high quality literature? I contend that it is the individual practitioner and his/her colleagues that hold the key. Certainly, from a quality perspective, consistent approaches to evaluation and management are a starting point. This is a goal of this text. Having consistency for a provider and within a provider network minimally assures that a standard is

held and, hopefully, missed opportunities due to inadvertent exclusion of relevant possibilities are prevented. The standard for such a “performance” approach is certainly one of a combination of tradition and the available literature. Yet, this approach is still focused more on provider performance and less on successful strategies to patient care and management. This approach can also stifle innovation for a “positive deviant” who does not follow the standard approach but actually has a better outcome with his/her patients.

The next step is measurement through outcomes assessment that can inform the practitioner about his/her practice and as an aggregate, groups of doctors can pool information to produce representative data of their practices including the types of patients seen, responses to care in general, and responses to care based on specific approaches. Then and only then can a “best-practices” approach occur where the most successful practitioners can be modeled and used as mentors for those who seek a direction and template for improvement. Although not an RCT, comparative outcomes assessment can provide a feedback loop for continual improvement that not only informs the individual practitioner on where his/her successes are but provide a mechanism by which these areas of success can be communicated to patients, payers, and other providers.

Since the publication of the *Third Edition* (four years ago), healthcare trends that I referred to in that edition continue to dominate the healthcare agenda.

- Chronic disease is now the focus of concern for the World Health Organization and other healthcare consortiums.
- The understanding that many diseases thought to be unrelated have a common underlying inflammatory process and a likely relationship with diet and lifestyle.
- The alarming rate of increase for obesity in the U.S.

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8. Schroeder SA. Shattuck Lecture. We can do better—improving the health of the American people. *N Engl J Med.* Sep 20, 2007;357(12):1221-1228.

- An increase in diabetes and hypertension resulting in pre-diabetes and pre-hypertension threshold levels being developed and used as initiating points for management.

Chiropractors are well-positioned to act not only as safety-nets for serious conditions in need of referral, but also as a starting point for conservative management for many of the preceding trends. Much has to do with the core concept of wellness which is to provide a path for healthy living and by doing so, provide the stimulation and encouragement for a pattern of living that is also preventive.

In a recent article in the *New England Journal of Medicine*, Schroeder⁸ presented the shocking truth of what actually contributes the most to early death in a graphic representation. Although 30 percent of premature death is attributable to genetic factors, 40 percent is due to behavioral causes. The two prominent factors are obesity/inactivity and smoking. Although chiropractors may not feel that their role is to save lives, a change in attitude and commitment should be made to do so albeit in slow motion. Behavioral change takes time and is the most complex and difficult patient management issue to initiate and monitor, yet, we are positioned in a unique interaction frequency, especially with early care, to remind and support patients to change. Let us take on this new challenge regardless of any reimbursement issues.

I am proud to have survived another edition and hope to continue on to more. In the meantime, consult the numerous Web-based opportunities to learn and keep abreast of change. Following the introduction are some general Websites related to chiropractic, for general searches, and for evidence-based/guideline resources. These are essential for filling the gap between editions of any text.

Thomas Souza, DC, DACBSP

WEBSITES

Chiropractic Websites

American Chiropractic Association
<http://www.amerchiro.org/>

International Chiropractic Association
<http://www.chiropractic.org/>

Evidence-Based Sites

Agency for Healthcare Research and Quality
<http://www.ahrq.gov/>

Cochrane Collaboration
<http://www.cochrane.org/>

Center for Evidence-Based Medicine
<http://www.cebm.net/>

Evidence-Based Medicine
<http://ebm.bmjournals.com/>

Practice Guideline Sites

American Chiropractic College of Radiology Guidelines
<http://www.accr.org/ACCRfullspineradiology.pdf>

Canadian Medical Association Clinical Practice Guidelines (CPG) Infobase
<http://mdm.ca/cpgsnew/cpgs/index.asp>

Canadian Task Force Preventive Health Care, Canadian Guide to Clinical Preventive Health Care: Full text of the Task Force guidelines on screening and other preventive health measures
<http://www.ctfphc.org>

CCGPP—Council on Chiropractic Guidelines and Practice Parameters
<http://www.ccgpp.org/>

National Guidelines Clearinghouse: Guidelines from the U.S. Agency for Health Care Policy & Research, the U.S Preventive Services Task Force, and other agencies
<http://www.guidelines.gov>

National electronic Library for Health (NeLH) Guidelines Finder: A database contains over 600 UK national guidelines with links to Internet downloadable versions

<http://www.library.nhs.uk/GuidelinesFinder/>

New Zealand Guidelines Group
<http://www.nzgg.org.nz>

Prodigy (Practical Support for Clinical Governance): Clinical guidance products from UK NHS
<http://www.prodigy.nhs.uk/clinicalguidance>

Rehabilitation Guidelines: Evidence-based rehabilitation guidelines from University of Ottawa
<http://cks.library.nhs.uk/home>

Scottish Intercollegiate Guidelines Network (SIGN): How the literature is rated.
<http://www.sign.ac.uk/>

Databases Search Sources

Pubmed
[www.ncbi.nlm.gov/Pub Med/](http://www.ncbi.nlm.gov/PubMed/)

CINAHL (Cumulative Index to Nursing and Allied Health Literature)
<http://www.ebscohost.com/cinahl/>

MANTIS (Chiropractic literature not on PubMed)
<http://www.healthindex.com/>

Cochrane Library
<http://www3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME?CRETRY=1&SRETRY=0>

Clinical Evidence
www.clinicalevidence.com

PEDro (Physiotherapy Evidence Database)
<http://www.pedro.fhs.usyd.edu.au/>

HSTAT (Health Services/Technology Assessment Text)
<http://hstat.nlm.nih.gov/>

