A Tough Cervical Spine Case-

A Comprehensive Approach

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I'd like to describe a chronic neck pain case that I was lucky enough to help. W.G. was a 52-year-old female with longstanding, right-sided, chronic neck pain. I had previously helped her four years before with a shoulder problem and with an acute discogenic lower back pain episode. At that time, the right-sided neck pain was a minimal problem. When she returned with neck pain, she noted it had gradually worsened over the last few years. She had no recollection of significant trauma. By November 2006, the pain levels averaged a 6/10 and could be as bad as a 9/10. The neck pain also was contributing to frequent headaches, difficulty sleeping and fatigue. She had seen a neurosurgeon, and tried a few courses of physical therapy, massage, acupuncture and laser treatment; all without any lasting changes. Range of motion to the right side was quite limited. Her MRI showed, at C5-6, 4 mm of degenerative retrolisthesis, a moderate annular bulge and vertebral plate osteophytes, resulting in mild cord impingement; mild to moderate central canal stenosis; and moderately severe, right foraminal stenosis. Milder degenerative changes and annular bulges were present at the levels above and below.

We noted that she appeared to have an anatomical short leg, which we corrected with a heel lift. Her right-sided lower cervical intertransverse ligaments were quite tender, so we treated these and the involved musculature with Graston technique, instrument-assisted frictional massage.[1] This immediately improved her range of motion. We taught her basic upper-body exercises aimed at improving head posture including scalene stretches and scapular stabilization exercises. We kinesiotaped her right shoulder, attempting to bring the whole shoulder girdle back and down. We used low-force adjusting to the upper cervical, lower cervical, upper thoracic and chest region.

Progress was slow at first. We had a breakthrough when we started doing the Graston technique with movement, having her actively move her neck as we treated the ligaments and muscles. If this was a usual case, the methods outlined above would probably have been enough. I would guess that 60 percent to 80 percent of chronic neck cases might respond to the combination of soft-tissue techniques, exercise and manipulation. But in this case, she got somewhat better, but seemed to plateau, and the pain would return.

I suspect that, in general, pain might be better measured as YES, the pain affects the quality of one's life or NO, the pain is minimal enough that one can ignore it. The goal is to get the pain level down to the NO level, where it is no longer the center of the person's life.

As W.G. was still not that much better, we started searching for other factors contributing to her pain. She mentioned that her pain often was the worst first thing in the morning and that there was facial pain at that time. We noted that when we had her place tongue depressors between her teeth, her range of motion increased. We started working on her jaw, which seemed to help.

We looked further regionally, noted tension in the chest and used visceral manipulation to release the pericardium and diaphragm. We noted, during one headache, that the base of her skull had abnormal tension patterns and we were able to change that with craniosacral techniques. We did a brief nutritional assessment. She was already taking fish oil and we added magnesium.

Another breakthrough occurred when, through muscle testing, we found that scar tissue might be significant. Lewit and Olsanska published an article[2] about the importance of scar tissue, but I suspect few of us regularly look for distant or regional scars in chronic pain. In this case, we scanned her various scars and found an active scar in the roof of her mouth, related to a childhood trauma that she only remembered when we started working on this, and found another active scar at the site of a breast lumpectomy on the right side. We addressed both of these areas with gentle myofascial release. These methods gave her rapid relief and immediate range of motion improvement. The work on the roof of the mouth and the jaw made a significant change, with the facial component of her pain completely gone after a few treatments focusing on this area.

By this time, six months out, we were treating her less frequently, about every three weeks. She was using a home microcurrent unit for "breakthrough" pain. At that point, I thought I had done almost everything I knew how to do and that the result would be just a lessening of her pain. I suspected that she would continue to suffer, although less than previously. Surprisingly, she came in at the end of May 2007, and described her pain as much more tolerable. Three weeks later, she described her pain as minimal, and it has not worsened since. What was the breakthrough technique? I really don't know. I suspect that we had removed or modified almost all of her pain sources and that the chronic inflammation finally settled down.

To review, our treatments in-cluded a heel lift, cervical adjusting, Graston technique and other soft-tissue methods to the ligaments and muscles of the neck and upper back, exercise instruction, craniosacral to the cranium, soft tissue to the jaw, visceral manipulation to the pericardium, myofascial release to scar tissue of the hard palate and chest, and nutritional therapy (magnesium).

I'll quote from a recent article by Donald Murphy and Eric Hurwitz. "The challenges of diagnosis in patients with spinal pain, however, are that spinal pain is often multifactorial, the factors involved are wide ranging, and for most of these factors there exists no definitive objective tests."[3] This case illustrates their point well.

This case took 26 treatments to resolve – way over my average. I'm glad she wasn't part of managed care. Her success in solving this problem was aided by her faithful follow-

through and her consistency with the exercises. Pain is a liar, the causes of spinal pain often are multifactorial, and the underlying causes can be quite difficult to diagnose. The usual, obvious lesions, with the usual treatment, are sometimes not enough. When the pain continues to recur, doing the same procedures over and over is not likely to produce different results. Instead, search for other factors that may be contributing to the pain.

In my experience, when I find a significant lesion, whether near or far, common or unusual, addressing it almost always makes an immediate difference in range of motion, tenderness, and/or pain levels. I often find in chronic pain cases that there can be 10 to 20 different identifiable lesions that may be contributing. If you limit yourself strictly to methods or diagnoses that have a strong evidence base, you may miss significant lesions. If you limit yourself to one chiropractic technique or one type of search algorithm, you may miss significant factors. The approach I describe in this case is not easy to apply, is not simple and is not perfect. I do fail to solve many chronic pain cases. More often, this type of comprehensive approach does help in chronic, difficult cases.

References

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