

BACK PROBLEMS: THE DIFFICULTY IN DIAGNOSIS. THIS IS WHAT SOME OF THE SCIENTIFIC ARTICLES HAVE TO SAY ABOUT THIS ISSUE.

The articles below are describing the uncertainty of laying our clinical hats on the table to describe, "why" you have pain. There are several areas of questions we can glean here:

1. Over reliance by clinicians on imaging studies to make a diagnosis. This often translates into treatments, medication or surgery which may be not targeting the pain generator or the "cause"!
2. The absence of image findings can lead the doctor to consciously or unconsciously invalidate your very real experience of your pain. This can be problematic in the long run.

Many patients and doctors can identify with the following scenario: Mr. Jones traveling from doctor to doctor (the doctor shopper), looking for the answer as to, "what's wrong" – gathering as many opinions as there are doctor visits. What is being silently expressed here is the uncertainty of what's wrong. The revolving wheel of opinions damages patient hope in any given treatment. When I examine these types of patients, a functional testing is performed in addition to other examinations procedures. This type of test places functional demands on structural areas of the body. The results are compared to the normal values found in the scientific literature. If defaults are found, a specific exercise program is put into place and tracked over time. Remember, most individuals are experiencing pain while moving their bodies; not complaining when they are at rest. It's about function!

1. **Haldeman, DC, PhD, MD. Spine 1990:15(7):718-723.** The pathology model cannot explain back pain or disability. It is not possible to look at pathology and determine the symptoms a patient may be suffering. It also not possible to look at a patient with back pain with no neurological deficits and determine the nature of the pathology. About 30% of asymptomatic subjects show abnormalities in the lumbar spine by meylogram, CT and MRI. There is a large percent of symptomatic patients with severe complaints whom testing fails to reveal any structural lesion.

2. **Gracovetsky SA, PhD et al. Spine 1998:23(5):568-575.**
Diagnosis has been demonstrated to be nonspecific in 80-90% of low back pain cases. As many as 90% of benign low back diagnoses are classified as nonspecific low back pain.

3. **Jensen. Dept. Rehab Med, U WA. New England Journal of Medicine 1994:331(2)July14:69-73.** Found a high prevalence of abnormalities in lumbar spines in 98 people without back pain. (Average age 42.3 years), Only 36% had a normal disc at all lumbar levels. 52% without symptoms had a bulge at least one disc, 27% had protrusion, 1% had extrusion. 67% of the 27 people 50 years or older had multiple abnormalities compared with 27% of the 71 younger people. About half had a bulge and a quarter had at least one protrusion. Given the high prevalence of back pain, the discovery of a bulge or protrusion on MRI in people with lower back pain may frequently be coincidental. Abnormalities of lumbar spines are meaningless if considered in isolation.

4. **Liebenson, DC. Rehabilitation of the Spine. Williams and Wilkins, Baltimore. 1996;** Most orthopedic tests search for structural pathology although they are present in only at 20% of the cases. The remaining 80% of patients have no identifiable structural pathology and require treatment based on evaluation of functional deficits. In the majority of cases, patients have soft tissue injuries and functional changes are the only objective findings on which to base treatment and judge progress. Outcomes assessment including objective functional tests give third party payers, patients and doctors a way to measure progress over time and evaluate the prescribed treatment. Overemphasis on treatment of structural pathology results in a failure to identify or focus on functional losses and work demands. The failure to recognize the limitations of diagnosis has plagued medicine, whose overconfidence in diagnosis of disc syndromes has promoted a passive approach of rest and medications. By encouraging inactivity this results in immobilization and leads to deconditioning. Chiropractors who concentrate exclusively on passive interventions are also placing the patients at risk for deconditioning. Unless patients are educated on control environmental stressor (work demands) and trained to recondition functional deficits, pain recurrences and treatment dependency will be the rule rather than the exception.