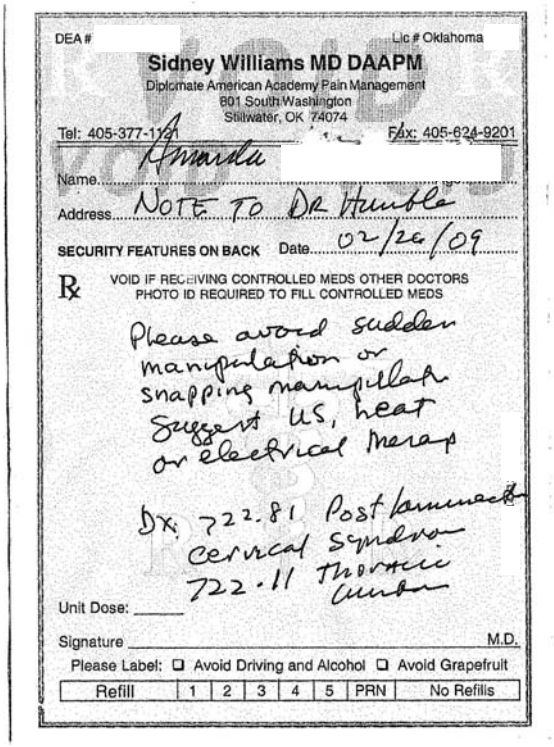
CHRONIC INTRACTABLE PAIN RELIEVED BY COX® TECHNIC

presented by
Chris A Humble DC CCSP CSCS
Certified Cox® Technic chiropractic physician
Humble Chiropractic PC
Ponca City OK
(580)762-1122
August 24, 2009

HISTORY:

A twenty five year old, white, married mother of two presented to my office on March 2, 2009, upon referral from her pain management physician Dr. Sidney Williams, MD, DAAPM. Her diagnosis was chronic intractable pain due to post laminectomy cervical syndrome (722.81) and thoracic IVD displacement (722.11). Dr. Williams provided a copy of his February 26, 2009, examination findings in which he states that the etiology of the pain involved post surgical pain, and failed back/neck surgical factors. (See Addendum 1.) Dr. Williams included a handwritten note dated February 26, 2009, stating he preferred that no "sudden manipulation or snapping manipulation" be given to his patient.



DEA # Lic # Oklahoma

Sidney Williams MD DAAPM
Diplomate American Academy Pain Management
801 South Washington
Stillwater, OK 74074

Tel: 405-377-1121 Fax: 405-624-9201

Name Amanda

Address NOTE TO DR Humble

SECURITY FEATURES ON BACK Date 02/26/09

Rx VOID IF RECEIVING CONTROLLED MEDS OTHER DOCTORS
PHOTO ID REQUIRED TO FILL CONTROLLED MEDS

Please avoid sudden manipulation or snapping manipulation
Suggest US, heat or electrical therapy

Dx: 722.81 Post laminectomy cervical syndrome
722.11 Thoracic

Unit Dose: ____

Signature _____ M.D.

Please Label: ☐ Avoid Driving and Alcohol ☐ Avoid Grapefruit

Refill	1	2	3	4	5	PRN	No Refills

This patient was well aware of her medical situation. At age nineteen, she had lifted something overhead and experienced left shoulder pain. When she went to the local emergency room the examining doctor told her she had pulled a muscle in her shoulder and would be fine. She experienced neck and shoulder pain off and on for three or four years. The pain would switch from her left to her right shoulder depending on her activity level. She was working as a medical transcriptionist at the time. In January 2008 she sought treatment at a local chiropractic office. The doctor treated her with HVLA manipulation and EMS and heat. The patient states that the first treatment made her feel better but on subsequent visits she would feel worse after the treatment. After a series of treatments the DC referred her for an MRI which showed a bulging disc at C5/C6. He then referred her to a spinal surgeon. An orthopedist performed the C5/C6 fusion in May 2008. The surgeon advised her to seek additional treatment for the pain when he dismissed her. She sought care from a pain management physician and physical therapist.

An examination and X-Rays were done at the author's office on March 2, 2009. On our intake form of March 2, 2009, her chief complaint was "fibromyalgia; retroverted spondylolisthesis of L4 on L5, post cervical discectomy and fusion and chronic pain". Her pain drawing covered the spine, her left leg to her foot and both shoulders. She stated that her main complaint was constant back pain with occasional left leg pain. At that time she rated her pain an eight on a VAS from one to ten. Within the past twenty four hours she had taken morphine, hydrocodone, Cymbalta and Lyrica. She had a lumbar MRI done on February 25, 2009, which revealed a T11-12 disc bulge mildly effacing the thecal sac.

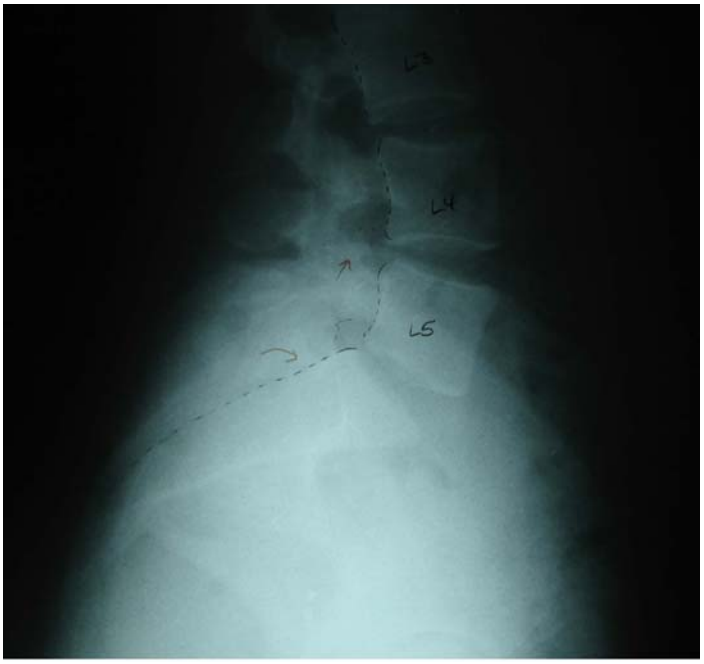
EXAMINATION:

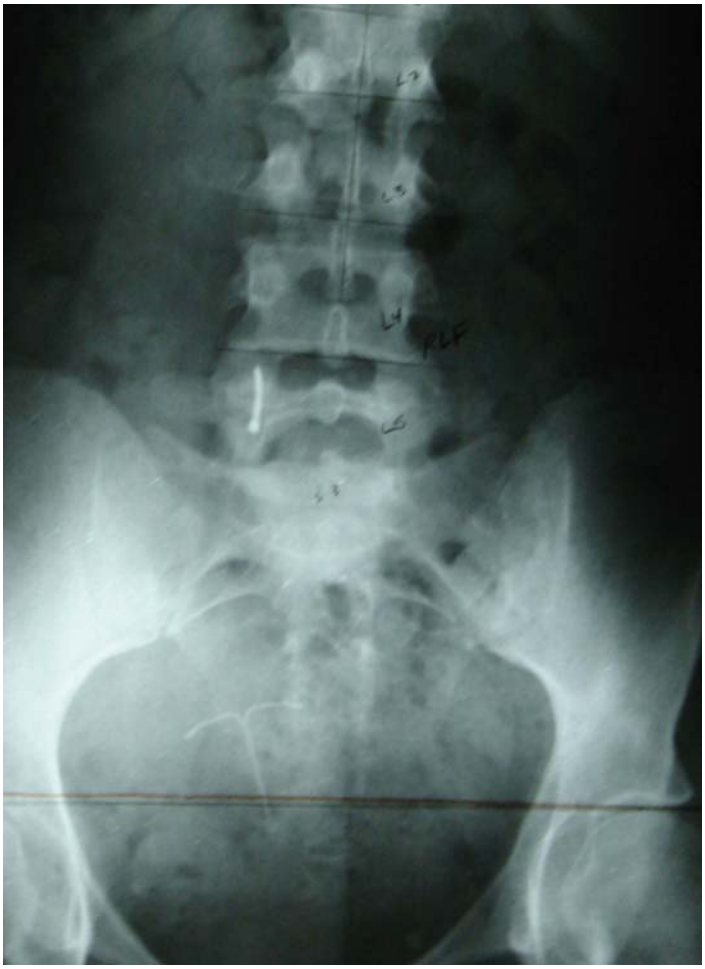
Physical:

On examination she stood 5'2" tall, weight was 150 lbs, with a resting pulse of 104 bpm and blood pressure of 113/76. Cervical range of motion in flexion was 60 d, extension 40 d, right rotation 60 d, left rotation 45 d. Pain was noted in the mid thoracic area on flexion and left rotation. Cervical compression produced pain at T6. Lumbar range of motion was 70 d on flexion, 20 d on extension, right lateral flexion was 30 d, left lateral flexion was 40 d. Low back pain was elicited on all movements at the end range. Right and left shoulder ranged of motion was within normal limits without pain. Joint dysfunction/fixation was noted at C1/C2, T3/T4/T5, T9/T10, and L3/L4/L5. Prone leg length demonstrated a right short leg of 3/8 inch. (See LETTER TO REFERRING PHYSICIAN – Addendum 2. Note: Such letters are excellent to share our care with colleagues.)

Imaging:

AP and lateral lumbar X-Rays revealed an anterior sacral base with extension subluxation of L4 on L5, a 4 mm left short leg, right lateral flexion subluxation of L4 on L5. There was no evidence of the spondylolisthesis she thought she had. The lateral cervical film demonstrated the anterior fusion of C5/C6 with mild hypo lordosis.


L3
L4
L5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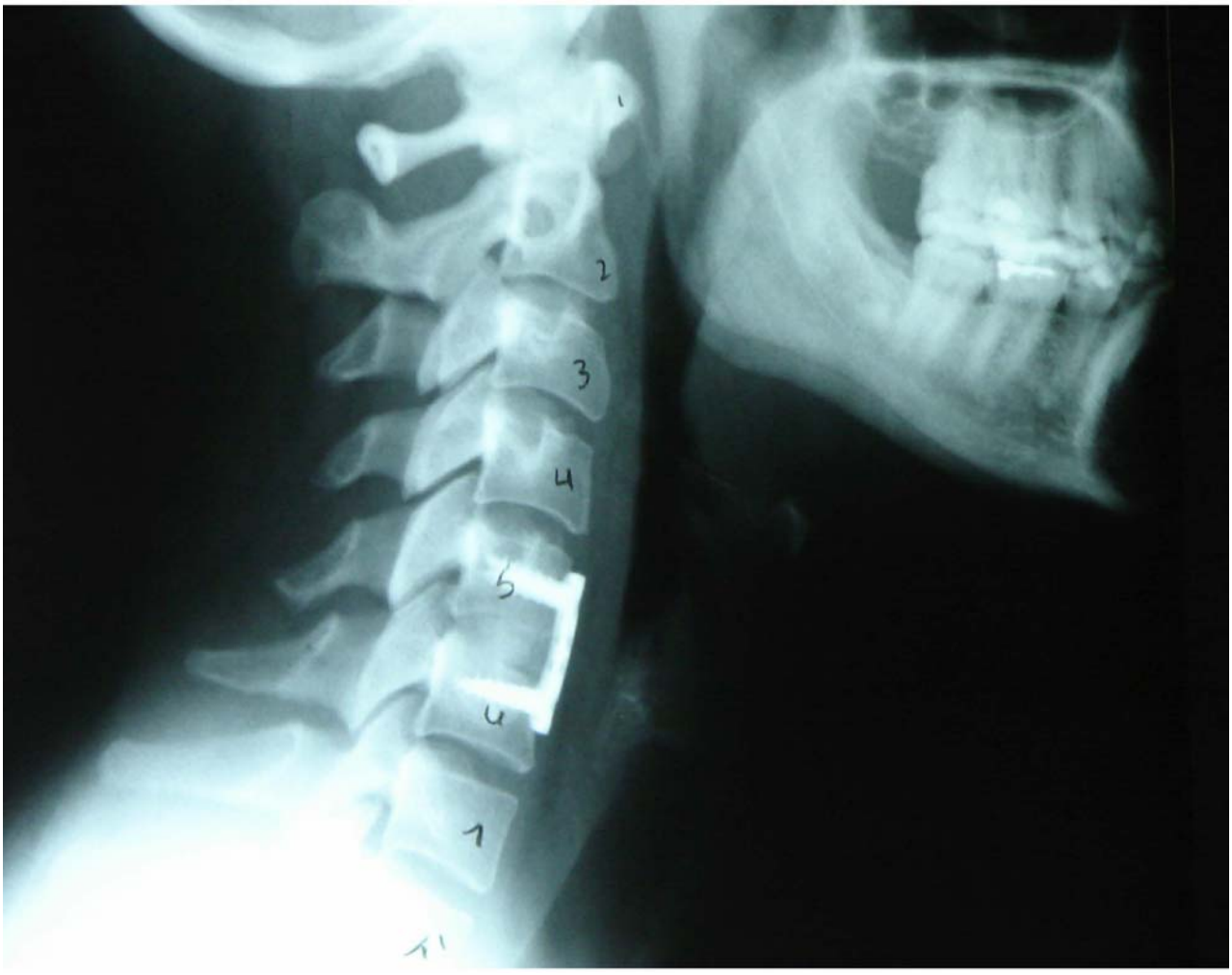
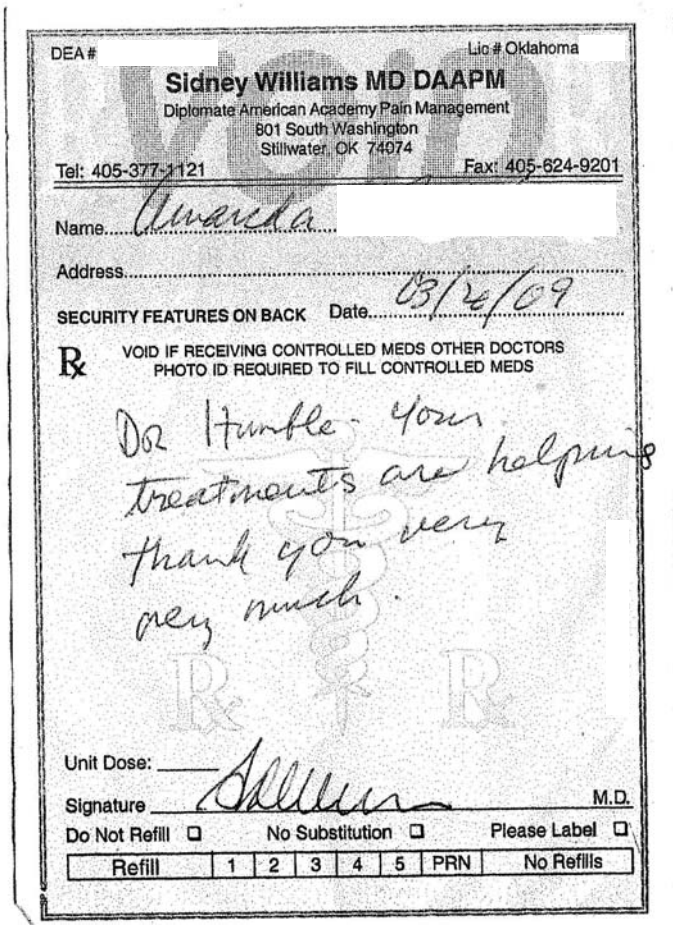


(See Addendum 3 – MRI Report – for more information.)

TREATMENT:

After reviewing the patient's examination and radiographic findings with her and explaining the rationale behind the treatment, a series of treatments were begun the day following the examination. Treatment was performed on the seventh generation Cox® Table by Track Corporation. This allowed the doctor to perform long y axis decompression while applying a small steady force into the areas of joint dysfunction. No forceful HVLA thrusts were given to this patient. The treatment was well tolerated and the patient expressed some relief after the first treatment. The patient was given Cox® exercises one through three initially and graduated quickly to one through seven and flexion/extension stretches on a stability ball. Glucosamine sulfate and chondroitin sulfate in the form of Discat Plus were to be taken daily. Electrical muscle stimulation in the form of interferential therapy and moist heat were applied after the Cox® spinal decompression in the office.

On her second visit, this patient stated she felt better and had slept well for the first time in months. On her seventh treatment this patient brought a note from Dr. Williams which reads, "Your treatments are helping. Thank you very much."



DEA # Lic # Oklahoma

Sidney Williams MD DAAPM

Diplomate American Academy Pain Management
801 South Washington
Stillwater, OK 74074

Tel: 405-377-1121 Fax: 405-624-9201

Name Amanda

Address

SECURITY FEATURES ON BACK Date 03/26/09

℞ VOID IF RECEIVING CONTROLLED MEDS OTHER DOCTORS
PHOTO ID REQUIRED TO FILL CONTROLLED MEDS

Dr Humble - Your treatments are helping thank you very very much.

Unit Dose:

Signature M.D.

Do Not Refill ☐ No Substitution ☐ Please Label ☐

Refill	1	2	3	4	5	PRN	No Refills

A total of ten treatments were given over a period of six weeks. This patient was released from active care and told to return for evaluation and/or treatment if her symptoms returned. On July 1, 2009, she returned for follow up stating her pain had returned although not to its previous level. One week later she stated that she was feeling much better again and had resumed doing her stretching and strengthening exercises at home.

SUMMARY:

Overall this patient was very satisfied with her care. This was a challenging case that until three years ago when I started doing the work with the new Cox® Tables would have been very difficult to treat. (I have been in practice for twenty three years.) The addition of long y axis decompression and the ability to manipulate under distraction is a powerful tool.

Respectfully submitted,
Chris A. Humble DC, CCSP, CSCS

ADDENDUM 1 – Examination by MD

DOB:
SSN:
Exam Date: February 26, 2009
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HISTORY/PHYSICAL

Sidney Williams MD

Opiate Agreement and Consent and Therapy Plan:
Completed 09/23/2008 and in the chart/with application packet

Chief Complaint:
Chronic Intractable Pain

Interval History:
Was seen by neurosurgeon, and is scheduled to see again. Improved analgesia, activities of daily living, quality of life w/o adverse effects or side effects.

History:
This 25 year-old white female has chronic intractable pain due to cervical postlaminectomy cervical syndrome. Her first date of service at this clinic was 09/23/2008. The etiology of the pain involves postsurgical pain, and failed back/neck surgerical factors. Likely the pain was permanent before the surgery. In fact after the surgery she was told she had fibromyalgia by the surgeon, but no one would have operated fibromyalgia in the first place if they believed that viewpoint. She says that operated her neck for the pain (?fibromyalgia.) a the . He did advise her to seek additional treatment for the pain when he dismissed her, she says. of Ponca City, Ok for a time was her primary care physician but left that community causing the patient to seek care at this clinic with this doctor.

The pain is severe, as high as 8 on 0/10 numeric rating scale. Radiates down her legs in a sciatic pattern. Constant, worsened by bending lifting sitting, standing, and lifting. Throbbing, tingling, burning, and numbness are descriptors used by the patient to describe the pain.

PSFH/Allergies:
Family history of diabetes, heart disease, strokes. Social history is negative for use of tobacco, ETOH, and coffee. Married. Surgical history of tonsillectomy, c-sections, and neck surgery. **Results Drug Screen**[1]: Negative for abuse of street drugs since first visit on 09/23/2008. **Aberrant Behavior Assessment:** Negative **Morphine Blood Level** drawn on 01/29/2009. **No allergies.**

Review of Systems: *Except as specified elsewhere above, the ROS is negative. Pertinent negatives below:*

Psychiatric:	No depression or signs or symptoms of bipolarity, anxiety symptoms
Hematologic:	No **fatigue**, night sweats, loss of appetite
Cardiovascular:	No chest pain, dyspnea, PND, orthopnea, palpitations
Dermatological:	No redness, cyanosis, **rashes**, **itching**, , bruises
Neurological:	No **nightmares, confusion, disorientation, drowsiness.**
Endocrine:	No **abnormal sweating**, hot- cold intolerance
Respiratory:	No cough , **snoring**, dyspnea at rest or with exertion,
Immunologic:	No allergic symptoms or infections
Constitutional:	No **weight** gain or loss. Alert. Oriented
HEENT:	No tinnitus, epistaxis, slurred speech, aphasia,
Gastrointestinal:	No dysphagia, **constipation**, melena
Genitourinary:	No **hesitancy**, dysuria, frequency, incontinence, bleeding
Musculoskeletal:	No **clonus**, **twitching**, or change in strength

Medications:
MSER 15mgTID
Cymbalta 60m daily
Lyrica 150mg HS
HC 7.5/325 one BID
Physical Therapy for EMB US for neck pain in Ponca City
Moist Heat/cold QID prn at home.

Examination:

Vital Signs:	106/76 P88 R16 Ht 62 Wt 150
HEENT:	PEERL, EOMI, normocephalic, nasal septum midline, pharynx normal
Neck:	Full motion, w/o JVD, bruits, masses
Neurological:	Alert, oriented, DTRs and Cranial Nerves intact. SLR negative. Romberg negative
Lungs:	No rales rhonchi. Lungs CTA.
Chest:	AP diameter WNL, nontender.
Abdomen:	Lean, w/o masses, megaly, hernias, w/ normal bowel sounds
Cardiovascular:	S1, S2, PMI in 5thICS, MCL on the left. W/o murmer, Good peripheral pulses
Psychiatric:	No depression or anxiety symptoms
Back:	Full range of motion w/o tenderness w/o scoliosis
Extremities	Restricted ROM and tenderness in the left shoulder with some allodynia left arm. No erytherma, or clubbing.
Skin:	Large surgical vertical scar left of midline neck w/o jaundice, skin lesions, or loss of turgor
Gait:	Ambulatory

DOB:
SSN:
Exam Date: February 26, 2009
Page 2 of 2

Diagnosis:
338.29 Chronic Intractable Pain due to
722.81 Cervical poslaminectomy Syndrome
722.11 Thoracic Disc Syndrome
V58.69 Long Term Use of Medications

Assessment of Therapy:
The patient is alert, oriented, w/o aphasia, agnosia, apraxia, with good speech and memory and intact thinking processes. Considering all factors and based on examination, it appears to be within the realm of reasonable medical certainty that the medications are efficacious without side effects, adverse effects, with improved ADLs and improved analgesia. Therefore it is my professional opinion that the medication should be renewed for another period of time.

Counseling /Coordination:
Over ½ the time of this visit counseling about differential diagnosis, this particular diagnosis, treatment options and the Pain Outcomes Assessment Tool #6. Counseled with chiropractor not to use forceful manipulation.

Lab Orders:
UA, Immunoassays

Time with the Patient:
25 minutes.

Complexity [1]:
Medium Complexity of Decision Making.

Plan[1]:
MSER 15mgTID
Cymbalta 60m daily
Lyrica 150mg HS
HC 7.5/325 one BID
Physical Therapy for EMB US for neck pain in Ponca City
RTC 28 days.

Sidney Williams MD DAAPM
Internal Medicine, Diplomate American Academy of Pain Management

[1] Principles of management being used in this case are in accordance with the "Model Guidelines for the Use of Controlled Substances for the Treatment of Pain" by the Federation of the State Medical Boards of the United States, Inc. 1998. Available at: www.medsch.wisc.edu/painpolicy/domestic/model.htm. Accessed on January 30, 2002.

Phone to Dr. Humble the chiropractic, let me talk to him and fax him a copy of this note. He practices in Ponca City.

ADDENDUM 2 - LETTER TO REFERRING PHYSICIAN

HUMBLE CHIROPRACTIC, P.C.

CHRIS HUMBLE, D.C., C.C.S.P., C.S.C.S.
1717 N. Fourth
Ponca City, OK 74601
Telephone: (580) 762-1122

Sidney Williams MD DAAPM
801 South Washington
Stillwater, OK 74074

Dear Doctor, March 9, 2009

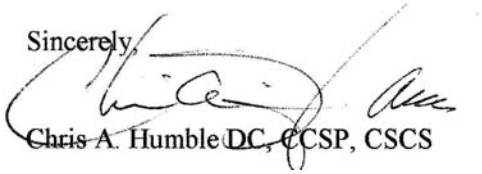
Amanda presented to my office on March 2, 2009, for evaluation and treatment of her chief complaints; neck and upper back pain along with lower back and left leg pain to her foot. Her history is significant for a cervical laminectomy with anterior fusion at C5/C6 in May of 2008. I reviewed your notes from the February 26, 2009, exam as well as the report on the February 25, 2009, lumbar MRI without contrast ordered by

Upon examination I found Amanda to stand 5'2", weight was 150 lbs, resting pulse was 104 bpm and blood pressure was 113/76. She was in pain. On a VAS of one to ten she rated her pain an eight today. She had taken morphine, hydrocodone, cymbalta and lyrica for pain in the past 24 hours. Cervical range of motion was surprisingly good with pain elicited only in the mid thoracic spine. Lumbar range of motion was limited on flexion at 70 d, extension at 20 d with pain noted at L4/L5. Right and left lateral flexion were mildly limited with pain in the contra lateral lower back. Spinal palpation revealed joint dysfunction with muscle spasm at C2/C3, T3/T4, T4/T5, T9/T10, L3/L4/L5. AP and lateral lumbar X-Rays reveal hyper lordosis of the L4/L5/S1 segment due to the sacral base anterior migration. I see very little to support the spondylolisthesis that Amanda states she has. It is more of an extension misalignment of L4 on L5, a slight retrolisthesis, than anything else. The lateral cervical film confirmed the C5/C6 fusion.

I agree that traditional HVLA thrust is contraindicated in this patient. I use a technique developed by Dr. James Cox at the National University of Health Sciences. It utilizes a specifically designed table that allows long y axis decompression while the doctor controls the amount and direction(s) of the small force that is applied. I have enclosed a brochure for you to review at your convenience. Amanda stated that she did feel some relief after the first two treatments.

Thank you for allowing me to participate in the care of your patient.

Sincerely,



Chris A. Humble DC, CCSP, CSCS

ADDENDUM 3 – MRI REPORT

Ponca City OPENMRI

2112 N. 14th Street
Ponca City, OK 74601

Bus:
Fax:

DATE OF EXAM: 02/25/09
NAME: AMANDA
DATE OF BIRTH: 05/07/83
REFERRING PHYSICIAN:
EXAM: MRI OF THE LUMBAR SPINE WITHOUT CONTRAST

COMPARISON: None.

HISTORY: Low back pain.

TECHNIQUE: MRI images of the lumbar spine are obtained without contrast utilizing T1, T2 and STIR pulse sequences. Sagittal and axial projections were obtained.

FINDINGS: All five lumbar vertebral bodies demonstrate normal height and alignment. The disc spaces are fairly hydrated. The distal spinal cord signal and cauda equina are within normal limits.

At T11-12, a disc bulge is demonstrated mildly effacing the thecal sac.

From L1-2 to L5-S1, the thecal sac and foramina are within normal limits. The exiting and traversing nerve roots at each level of the lumbar spine are preserved. No obvious disc herniation or protrusion is seen. The retroperitoneum is within normal limits.

IMPRESSION:

1. Subtle disc bulge is present at T11-12 mildly effacing the thecal sac.
2. The thecal sac and foramina at each of the disc spaces of the lumbar spine are within normal limits.