An Aspirin a Day May Take Your Vision 
& Hearing Away

Non-steroidal anti-inflammatory drugs (NSAID's) are widely used for general pain relief and specific inflammatory control after an injury. Additionally, there is an increasing number of people that are using specific NSAID's and aspirin for perceived cardio-

vascular protective effects. Of concern, there have been a number of scientific publications discussing the potential negative health effects of regular use of NSAID's whether for prevention, pain, or other use. Two recent publications have identified some serious negative health risks that appear to be linked to regular aspirin and NSAID use:

The Beaver Dam Eye Study

In a longitudinal population-based study of age-related eye diseases, Klein and colleagues examined the association of aspirin use with the incidence of age-related macular degeneration (AMD). They performed examinations every 5 years over an approximate 20-year period (1988-2010). There were 4,926 participants between the ages of 43 to 86 years. Study participants were asked if they used aspirin at least twice a week for more than 3 months; which they termed ‘regularly’.

The study identified that ‘regular’ aspirin use 10 years prior examination was associated with late AMD with an estimated incidence of 1.76%.

The Passing of a Chiropractic Pioneer, 
A Family Man, A Dear Friend & Mentor to Countless

Dr. Sidney Earl Williams
March 18, 1928 - December 27, 2012

Most of the profession is already aware that Dr. Sidney Earl Williams, founder of Life University in Marietta, passed away peacefully in his sleep early Thursday morning the 27th of December. He was 84 years old.

Visitation was set from 2 to 4 p.m. on Saturday, December 29th, 2012, at Mayes Ward-Dobbins Funeral Home in Powder Springs and services were held at 2 p.m. on Sunday, also at Mayes Ward-Dobbins, located at 3940 Macland Road in Powder Springs.

Along with his wife, Dr. Nell Williams, Dr. Sid Williams founded Life Chiropractic College in 1974, which became Life College and is now Life University. Twenty Two students attended the first classes in January of 1975. These students became known as the “Day one class”. Under Dr. Williams’ direction, Life Chiropractic College became the largest chiropractic college in the world with an 89-acre campus and more than 3,500 students.

On a personal note, for me (Dr. Deed Harrison), I was deeply touched by Dr. Williams loss. Though I met Dr. Williams just a handful of times and exchanged only simple cordial conversation; it is a man like him that keeps a person like me continuing to strive for excellence through Chiropractic principles, purpose, and passion. When I heard of Dr. Williams loss, I was reminded of one of my late father’s (Dr. Don Harrison) favorite sayings: “The person who says it cannot be done, should not interrupt the person doing it”! Looking at Dr. Williams’ life achievements I bet that he lived by this motto in some regard. In the end, Dr. Sid Williams did what few of us can but all of us strive for; he left
Studies that claim that those
It is wrong to claim that chronic
Research & Evidence
The best methodologically

INTRODUCTION
Reverse causality refers to a
direction of cause-and-effect in
reverse. That is to say the effects
refers to

The contemporary leaders in
the research pertaining to injury
compensation, health outcomes,
and systematic reviews supporting
these have been used to influence
policy and practice. However, such
reviews are of varying quality and
See Reverse Causality on page 24

Reverse Causality and Whiplash In-
jury: Three Recent Reviews

Dan Murphy, DC — Private Practice of
Chiropractic. northwest American Board of
Chiropractic Orthopedic. Faculty Life
Chiropractic College West, Vice President

It is usually stated in published
studies, by insurance companies, and
by their representatives (lawyers, claim adjusters, DME,
doctors, etc.) that injured patients who seek compensation (ask for
compensation, hire a lawyer, etc.) (A), have worse health outcomes
and slower recovery rates (B). However, such adverse health
outcomes do not consider or
suppose these concepts:

• Studies that claim that those
suffering from chronic problems
following whiplash injury do so in hope of gaining
financial compensation have
methodological flaws.
• The best methodologically
done studies show there is no
association between litigation, (B)
and compensation and recovery from
whiplash injuries.
• It is wrong to claim that chronic
whiplash symptoms are primarily
the consequence of litigation and
desire for monetary gain.

These authors conclude: “There is a common perception that injury
compensation has a negative impact on health status among those
with whiplash injuries and as a result, their ability to work and live.
However, such adverse health outcomes do not consider or
verify the following: (A) a
cause. The problem is
when the assumption is A
causes B when the truth may actually be that
B causes A.

Research & Evidence
The best methodologically
INTRODUCTION

Previously, the midfoot was modeled as one rigid segment based on the assumption that negligible motion took place within the midfoot.1 We now know that movements including walking and slow running involve considerable motion between midfoot bones.2 This knowledge of midfoot motion is logical to consider these motions in any attempt to control the foot with an intervention such as a foot orthosis. Perhaps there is evidence that returning the focus to the midfoot, medial longitudinal arch, and plantar vault could yield measurements that relate more to the dynamic gait cycle and result in improved clinical outcomes.

One recent attempt called Foot Posture Index (FPI) was designed to be a valid, simple and clinically useful tool. Its most recent version is based on 6 static foot morphology criteria (talar head palpation, curves above and below the navicular, tuberosity and the other passing through the midfoot; talonavicular subtalar and the other passing through the midfoot of the medial aspect of the first metatarsal head to the navicular tuberosity [ft]). What is concerning about the work done with these angles, is that they are starting to reveal movements that show good interrater reliability,3 are prognostic of dynamic foot posture during walking and running and may have some value in predicting the risk of lower extremity injuries.4-7 This is good news for the clinician who looks to the published research to confirm and validate his clinical measures. It seems plausible that the closer the measurements get to a measure of the medial longitudinal arch and plantar vault of the foot, the more applicable they are to the dynamic gait cycle. This correlates with the knowledge that significant more motion occurs in the sagittal plane during each step of the gait cycle when comparing transverse and frontal motion. Put quite simply, there is an accepted clinical relevance to the arch of the foot and its perceived position—either low or high—and it may very well be that the closer a measurement gets to describing this posture, the more dynamically relevant it is.

Therefore a distinction is needed between those foot type classifications that focus on frontal plane measurements, and foot posture that is evaluatable by the medial longitudinal arch or recent measurements that have focused more on the medial longitudinal arch reveals that there has been progress with regards to defining more reliable, clinically relevant measures.

To date, much of the study of foot posture has included discussions of frontal plane orientations such as calcaneal inversion. Given the above mentioned evidence it becomes clear that more clinically relevant measurements may be found in the midfoot and medial longitudinal arch. Accounting for the entire plantar vault may give us a better understanding of what changes in foot posture are relevant to our clinical decisions. In an ideal scenario, a measurement would be accurate, reliable, backed by clinical outcomes, describe the entire foot, perhaps most importantly predict the dynamic function of the foot.

So what is the ideal foot posture? The MASS (Maximal Arch Subtalar Stabilization) theory as proposed by Glaser et al12 is designed to capture the foot in the most corrective posture.

SEUMMARY

Foot posture measurements taken in the MASS posture may prove more applicable to clinical decision making with regards to orthosis manufacture as they can be compared volumetrically to a premarked foot posture or relaxed calcaneal stance position. Knowing that there is an optimal foot posture that may be different for each individual, but based on the same reference points, logic follows that there is a spectrum of function (or dysfunction) and a zone of optimal control. Future writings and investigations will focus on the zones of postural control and their application to treatment with foot orthoses.

REFERENCES


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From lifting injuries to poor posture, falls to awful ergonomics, abnormal lordosis affects a lot of people. And that means pain, muscle tension, and more pain. In the end, abnormal lordosis has been linked to a reduced quality of life and poor health.

ABNORMAL LUMBAR LORDOSIS CURVE [RED LINE] NORMAL LUMBAR LORDOSIS CURVE [GREEN LINE]

LUMBER DENNEROLL


PAUL A. OAKLEY, M.S., DC
C.P.R. Research & Demartor
Private Practice, Roca Market
Ontario, Canada

Chiropractic BioPlex® Non-profit, Inc. is a 501 (c)(3) non-profit corporation dedicated to the advancement of chiropractic principles through scientific research. Dr. Don Harrison (deceased) and his second wife Dr. Deed Harrison (deceased) founded CBP research foundation in 1982. It was registered as CBP Non-Profit, Inc. in 1983 by Dr. Sang Harrison (Don’s 3rd and final life’s love). Through this organization Dr. Don and colleagues have published 140 peer-reviewed spine and Chiropractic research publications. Further, CBP Non-Profit, Inc. has funded many scholarships as well as donated chiropractic equipment to many chiropractic colleges, always trying to support chiropractic advancement and education. Dr. Don Harrison was the acting president of CBP Non-Profit, Inc. since 1982. Currently, Dr. Deed Harrison (Don’s son) is the President of CBP Non-Profit, Inc. Results of our studies have been published in prestigious research journals and presented at respected conferences around the world. Your (Chiropractic donations) support enables us to continue important research and gives you a voice in the course our studies take. Join today, either as a regular member or member of the President’s Circle. The result will be better chiropractic practice, stronger chiropractic patients.

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- Posture modeling studies.
- Reliability of measurements and evaluation of patients (e.g., posture).
- Validity of the measurements and evaluation of patients.
- Randomized trials evaluating technique outcomes.
- Non-randomized trials evaluating technique outcomes.
- Case series studies evaluating technique outcomes.
- Literature reviews and professional commentaries.

Paul A. Oakley, M.S., DC
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January 2013

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January 2013

Secrets to Business Success from page 8

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As Apire® Day–cont’d from page 8

in regular users versus 1.03 in non regular aspirin users. Klein and colleagues concluded: “Regular aspirin use 10 years prior was associated with a small but statistically significant increase in the risk of incident late and nonmalignant AMD.”

Hearing Loss from Department of Medicine, Brigham and Women’s Hospital in Boston, MA.

In 2001, Carhan and colleagues examined “the independent association between self-reported professionally diagnosed hearing loss and regular use of aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs), and acetaminophen.” The participants were 26,917 men between the ages of 40–49 beginning in 1986 and were administered a follow-up every 2 years for the duration of the study. They found: “For NSAIDs and acetaminophen, the risk increased with longer duration of regular use. The magnitude of the association was substantially higher in younger men. For men younger than age 50 years, the hazard ratio for hearing loss was 1.33 for regular aspirin use, 1.65 for NSAIDs, and 1.59 for acetaminophen.”

In a follow up investigation in 2012, these authors’ prospectively evaluated the frequency of aspirin, ibuprofen, and acetaminophen use and risk of hearing loss in 62,261 women aged 31–48 years. In this study of females, the regular use [1 or more times per week] of ibuprofen and acetaminophen (not aspirin) was statistically linked with an increased risk of hearing loss.

REFERENCES


The Crossing–cont’d from page 1

Chiropractic and the World: a better place through his humanitarian, personal, and entrepreneurial achievements.

A Williams family statement Thursday morning (December 27, 2012) said: “Doc was a person of immense presence and personality. He will be greatly missed by his family and many other choose he has touched. In additional to his wife, Dr. Williams is survived by his children, Dr. Kim Williams, of Powder Springs, and three grandchildren.

"For NSAIDs and acetaminophen, the risk increased with longer duration of regular use."

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learn to talk to a person with a subluxated posture at your rof

problems for money. this means people MUST know their problem and be very clear in a spinal corrective program we correct the whole spine. every spinal problem involves the whole spine. the question is, “do you know the system that has the 98.2% of patients understanding their whole spine needs correction?” the next question is, “do they tell you they know their whole spine and poster is weak and subluxated?” the fact is, you can’t tell them. they MUST say it to you to truly understand. it’s not what will say that matters. it’s what they say that changes their behavior.

1. they must say, “i don’t want to be like this anymore.”

out of our greatest crisis comes our greatest breakthrough. before people are willing to make a change in their life, they must want to leave the condition they are in. they must reach the point of climactic frustration to change and be ready to move. many patients that don’t commit, never say, “i don’t want to be like this anymore.” this is a crucial emotional decision people must make to be ready to move in another direction. they must have a strong emotional desire to change or they will stay in their misery, whether it is their pain or their disease.

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3. eliminate all other options: once a person makes the emotional commitment to move in another direction, they need guidance as to the proper direction to move. you don’t achieve this by telling them “what to do.” you achieve this by telling them “what not to do.” research shows that people with chronic back pain who do only exercise have a greater probability of becoming disabled than if they did nothing at all. this eliminates traditional physical therapy, medical care, yoga, pilates, and all the other exercise related excuses, including, “getting a second opinion.” if you don’t eliminate all other options, you will receive common objections to care and non-commitment at your rof.

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4. they must know what they do want: once a person is ready to move in a specific direction they must have a goal. without a goal, they will not buy and say, “i have to think about it.” the problem is you didn’t direct them to have a vision in advance. “where there is no vision, people perish,” right out of your office.

there are 5 steps a patient or any person who is going to make an empowered action toward a life change must progress through in a specific order.

1. they must say they have a full spine problem: entrepreneurs solve people’s problems for money. this means people must know their problem and be very clear in a spinal corrective program we correct the whole spine. every spinal problem involves the whole spine. the question is, “do you know the system that has the 98.2% of patients understanding their whole spine needs correction?” the next question is, “do they tell you they know their whole spine and poster is weak and subluxated?” the fact is, you can’t tell them. they must say it to you to truly understand. it’s not what will say that matters. it’s what they say that changes their behavior.

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see learn to talk on page 25

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Dr. Deed Harrison® is an internationally renowned professional lecturer and spine researcher in the Chiropractic profession. Usually, he’s on the road 35-40 weekends per year teaching doctors around the USA and Internationally. Accordingly, Dr. Deed has chosen Eagle, ID as the new head quarters for CBP Seminars Certification Training programs for Chiropractors. Part of the Ideal: Spine Health Center’s facility will be dedicated to a state-of-the-art Chiropractic BioPhysics (CBP) training facility. Chiropractors around the world, interested in learning all aspects of CBP, will come to Eagle, ID to receive the knowledge and skills necessary to practice CBP and become CBP Certified Chiropractors.

This is a dream come true for Dr. Deed Harrison and his wife, Dr. Sklar. It has always been challenging to train Chiropractors in the technicalities and nuances of CBP Technique in hotel conference settings without the necessary equipment (adjusting tables and instruments, traction equipment, exercise and rehabilitation equipment, and radiographic facilities). Also, the perspective of how a full-scale CBP office looks, feels, functions, and operates is lost in the hotel conference center environment. This new facility will solve these dilemmas. In the end, Dr. Deed is truly trying to slow down his trips a bit so he can stay close to home with his wife and two young children.

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Note: Conferences are Saturday 9am-7pm (Registration 8:30am); Sunday 9am-Noon. Except Dates:
- Eagle Seminars Held at Dr. Deed’s New Facility: The CBP Doctor Institute: Fri 4pm-8pm (optional).
- Includes a tour of Mirror Image Treating Sat: 9am-7pm Catered lunch 1:00pm-2:00pm 2 hours of Mirror Image Treating Sun: 9am-noon - limited to the first 10 attendees
- ** Feb 22-24: Friday 2pm-7pm, Saturday 2pm-7pm (Lunch included);
- ** Sep CBP Annual: Friday 2pm-7pm, Saturday 9am-7pm, Sunday 9am-Noon.

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The Why and How of Practice Outreach

Randall Hannett, DC  
Private Practice of Chiropractic

Certainty and INTRODUCTION

The one consistent thing is change, and I talk to you for sure will be a challenge for many chiropractors. With changing health laws both federal and state changing insurance policies to cover chiropractic care or patients can expect more financial stress and more focus on documented care with less reimbursement. In my town I've already been notified that several government-funded insurance plans are increasing their deductibles and copayments by vast amounts to cover shortages. This is news, and it's good news! The health industry has typically been inflamed and reformation proof. Don't get me wrong, doctor's incomes have dropped, but there has been an estimated that 5 to 7% of doctors' incomes have increased. The question is what will your practice hold for you in 2013? The last three years have seen many financial games played in the profession and in my experience the low volume high-chiropractic offices eventually collapse financially, it's not only what my opinion about your fees is simply charge what you believe you are worth and the true value of your services you provide. One of the things I recommend that you do is receive chiropractic care from a colleague near you and pay them their full fee for each treatment. It may be an emotional, it amazes me to today the limits of the care that they provide and the extent to which a chiropractic practice can properly and correctly can change people's lives. In 2013.

It is not unusual to schedule 50 to 100 great patients at a 2-day screening, or schedule 20 to 30 patients from a 20-minute dinner, or corporate presentation. The strategies being discussed were screenings, corporate talks, and patient dinners. These three strategies have been around for decades and many falsely assume that they no longer work. Nothing could be further from the truth. While internet marketing, social media presence, and a great website are crucial in today's wireless world, you do not replace getting outside of your four walls and personally interacting with the people in your community. Warner Coaching clients receive hundreds of new patients every month using those tried and true strategies. As a matter of fact, some companies are even more effective today than they ever have been in the past. It is no unusual to schedule 50 to 100 great patients at a 2-day screening, or schedule 20 to 30 patients from a 20-minute dinner, or corporate presentation.

DISCUSSION

One of the advantages of doing the outreach in person is that the doctor has to wrestle with the question of why they are doing it, and the fear of getting outside of their four walls. Are they doing this talk to get new patients to build their practice and pay their bills, or are they doing it to save the sick people in their community? It is the answer to why they do the outreach, and “the how”—how do we reach into our community?—why do we do outreach, and “the why”—do we do outreach, and “the how”—how do we reach out into our communities effectively to attract the sick and lost. What strategies work best?

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LATERAL TRANSLATION TRACTION

Randall Hannett, DC  
Private Practice of Chiropractic

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Combining Specific Chiropractic Techniques with CBP Corrective Care Techniques: Case #2

- **Postural Analysis:** Posture analysis revealed a significant left thoracic translation, a right lateral flexion of the spine, a right posterior pelvic rotation, a suspected left leg length inequality, a large posterior thoracic translation, and a slight forward head translation.
- **Radiographic Analysis:**
  1. In April of 2012, modified AP femur head-femur view was obtained. On the left of Figure 1, this x-ray is shown. The PostureRay™ software system was utilized to identify and quantify the extent of leg length inequality. A 5mm leg length inequality was identified with consequent spine abnormality.
  2. In April of 2012, a full spine lateral radiograph was obtained. While in June of 2012, a follow up full spine lateral was obtained to document the response to intervention and potential modifications that might be warranted. Figure 2 depicts these full spine radiographs.
- **Intervention:** A total of 24 treatment sessions over the course of 2 months was utilized in this case. For segmental adjusting technique, the teaching Chiropractic Technique (TP) exclusively adhered to and utilized the Corechiro Technique system for identified spine subluxations including:

  1. Abnormal temperature differential patterns (normo-temps / tempo-scopes)
  2. Static palpation data indicating the presence of edematous tissue around the injured segment.
  3. A decrease in motion of the segment in question, as compared to the surrounding area.
  4. Palpable muscle spasm or splitting around the area in question.
  5. Visualization of the area (looking for presence of pitting edema, asymmetry in the tissues, etc.

   - Then, consulting the 3-shot, digitally-stitched, AP full spine x-ray and the lateral (2-shot) full spine x-ray to analyze the “foundation principle” and relate this to the examination findings.

   - For the full spine and postural corrective care, CBP mirror image adjusting, exercise, traction procedures were utilized. Additionally, body weighting using the thoracic belt from Circular Traction was applied 5mm per week for 15 min walking intervals. These procedures were administered on each visit to the patient. Lastly, a full foot lift of 9mm was administered to the patient and was placed in the left shoe.

**Mirror Image Adjustments**

The patient was administered mirror image adjustments to correct posterior thoracic translation with hyper-kyphosis and anterior head translation with head posture fixations. See Figure 3.

**Mirror Image Exercises**

The patient was administered mirror image exercises to correct posterior thoracic translation with hyper-kyphosis and anterior head translation postures. See Figure 4.

**See Corrective Techniques on page 10**

**Figure 1**

Before and After AP femur head – femur view is a view on the left is the initial neutral film. On the right is the follow up x-ray taken in June with a 5mm lift on the left side.

**Figure 2**

Before and After corrective care full spine lateral radiographs.

On the left is the initial neutral film demonstrating a significant posterior translation of the spine. On the right is the follow up x-ray demonstrating considerable correction of the spine and postural abnormality.
Mirror Image: Exercise Videos

As a recap, once you have performed a postural analysis you can then choose Mirror Image® exercises to prescribe to your patient (assuming they are in the mid-phase of care). These static exercise videos were hand selected by CBP as the most common postural abnormalities and have been available in PostureScreen Mobile for last 6 months. Now with the recent January release of the new video content, your patients will be guided through their mirror image exercises by Dr. Harrison himself.

Dennert Prescription Feature

In January we will also be introducing new video instructions for Dennert use, again demonstrated by Dr. Dennert. These videos will provide your patients with instruction on the proper set up and use of the Dennert traction device. Both the corrective exercises and Dennert videos are delivered to your patients via email utilizing WebExer’s secure cloud based system. This will allow your patients to review their personalized rehabilitation program anytime whether traveling or from the comfort of their home. (Figure 2).

Motion Capture Analysis

Additionally, coming in early 2013 we will be relocating full motion Capture and analysis as an on-app upgrade. This new module will give you the ability to quickly assess any movement pattern from spinal ROM to a golf swing. Full running gait analysis can also be performed as well as pre- and post Rock Tape movement analysis. The videos will all be stored under your account providing companions that you can review later to track functional improvements with your patient. PostureScreen mobile continues to strive forward giving the structurally based rehabilitation specialist the tools they need to accurately assess posture and movement patterns while aiding in exercise prescription—all within the palm of the clinician’s hand.

PostureScreen Mobile is a technology company focusing on radiographic and postural based Driff products. PostureScreen Mobile is available in Apple iLlunes Appstore as well as Google Android Play Store. The exercise module for Android is targeted for release in mid 2013. www.PostureScreen.com

Correction Techniques—cont’d from page 17

Mirror Image® Body Weighting and Dennert Traction

Mirror Image™ traction was administrated to the patient. The patient received the dennert traction system to correct the abnormal thoracic translation posture as shown in Figure 5. In addition the patient was instructed in the use of the dennert thoracic orthotic and was advised to do this 5 times per week at home.

Case Outcome

Subjectively, at the end of 2 months of corrective care, the patient’s postural changes were remarkably improved. NRS = 1-2 / 10. According to the patient’s parents, in their own words, “It’s great to see how quickly he has improved. The leveling of his shoulders and hips is apparent and he carries himself; he is dramatically more upright and balanced”.

Objective, the patient’s follow up full spine radiographs in Figure 2 show remarkable reduction of the spinal displacements.

CONCLUSION

The authors’ opinion is that the patient’s improvements were directly related to both the segmental adjusting and spinal corrective procedures applied using CBP technique. Accordingly for optimum patient response, traditional Chiropractic adjustments would seem to be enhanced by the addition of spinal corrective procedures as in CBP. In the end, it is the positive response of the patient that should dictate this combined approach of classical Chiropractic care, with more contemporary corrective Chiropractic systems.

REFERENCES


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A C T I V E C L A S S I F I E D

May 2013
A m e r i c a n J o u r n a l o f C l i n i c a l C h i r o p r a c t i c
Three Point Bending Traction for Scoliotic Curvatures Using the New 3-D Denneroll Traction System: A Case Report

DESCRIPTION

The traction employed by the CBP® practitioner for scoliosis management requires critical reasoning and a thorough understanding of the displacements of the spine and posture. Generally speaking, this traction is of the 3-point-bending type of load application or a transverse load applied at the apex of the curve with and without lateral bending, axial rotation, or other movements depending on the specific case. The traction setup must always be performed in a pre-determined optimum sequence of movements using stress x-rays in guiding the decision making process. Mirror Image® traction sessions and duration should be a minimum of 20-30 minutes. The patient starts with 2-3 minutes and over consecutive sessions progresses in time.

CASE REPORT

The current patient had a history of thoracic pain and had been under chiropractic care for many years which she indicated gave her relief. She is 35 years old, hispanic, and has pain and frequency worsened over the last 4 months to a stage where she was experiencing daily headaches and thoracic pain rated as severe on a numerical rating scale (7-10).

Initial Radiography

1. Primary Right Thoracic curve = 43 degrees (see Figure 1).
2. Secondary Left Lumbar curve = 28 degrees (see Figure 1).

Figure 1. Shows the ScoliRoll under the thoracic region. The specific effects of using the block under the pelvis is that when shortened ligaments in spinal curvatures are situated so that they cannot straighten the spine (serious lateral deviation of the spinal column). The specific use of a block under the pelvis is to raise the lumbar spine off the table which can potentially help the patient in sitting since they are often unable to sit for any length of time.

Bending type of load application or a transverse load applied at the apex of the curve with and without lateral bending, axial rotation, or other movements depending on the specific case. The traction setup must always be performed in a pre-determined optimum sequence of movements using stress x-rays in guiding the decision making process. Mirror Image® traction sessions and duration should be a minimum of 20-30 minutes. The patient starts with 2-3 minutes and over consecutive sessions progresses in time.

2nd in traction x-ray - In response to the first in traction x-ray, we decided to raise the pelvis to a level of 2" (2 cm) blocks under the right hip to address the concerns of the lumbar spine trans.

From these in traction x-rays we can accurately assess that the block under the pelvis is best for the patient's spine.

A medical image shows the three-point traction radiography setup on the denneroll table. Note that the postural-based orthotic is placed just below the patient's apices of the thoracic scoliosis.

A remarkable reduction of the PA Thoracic scoliotic curve was identified from 41 degrees down to 28 degrees on the post A (13° net improvement).

SUMMARY

The traction employed by the CBP® practitioner for scoliotic curvatures was employed using the 3-D Denneroll Traction Table. The patient is continuing care and perhaps a second article will address her response.

REFERENCES


C L A S S I F I E D A D

LIVE IN PARADISE PRACTICE

Do you want to ENJOY YOUR LIFE outside of your practice in a recreational paradise? The largest, most remote and must be able to accommodate multiple large groups of people. By selling your practice and embarking on a new career, you can enjoy an outdoor lifestyle with the freedom to pursue your personal and professional goals.

For more information, please visit http://www.practicesales.com.
Kinesiology Tape for Postural Control

By stimulating large skin mechanoreceptors, kinesiology tape can also downregulate painful stimuli from the noxious, which decreases pain perception.

Early and persistent reasoning suggested that using the tape in an "origin to insertion", or "muscle action" methodology, best serves to support/spacer external body areas. While this approach probably makes the most intuitive sense to medical practitioners as it follows anatomical "rules of engagement", emergent theories, which consider entire postural muscle groups, are making a strong case.

Recent research indicates that kinesiology tape has a greater stimulatory effect with compromised tissue (due to injury or fatigue due to poor posture).

Let's look at a common complaint where chiropractors can utilize elastic therapeutic tape to enhance postural control (mechanoreceptors). Kinesiology tape is commonly used in chiropractic offices to enhance scapular retraction, alleviating upper extremity discomfort caused by internally rotating shoulders (especially when the scapula is in a protracted position). The tape, according to Dr. Capobianco's model, is applied in a functional manner to augment in therapeutic effect. Begin by addressing the neuro-myo-skeletal dysfunction (due to injury or fatigue due to poor posture).

1. Place patient/athlete into appropriate postural position that centralizes the thoracic spine, and associated myofascial chains.
2. Manually mobilize/manipulate the thoracic spine and shoulder girdle (manipulation, myofascial release, movement re-patterning, etc.).
3. Once the patient is able to appreciate an appropriate position, the tape is applied in an "auxiliary" system, such as the skin, to augment treatment and training outcomes.

A 2012 study of 32 surgeons, showed a statistically significant reduction in neck and back pain (using Oswestry Low Back Disability Index and Neck Disability Index) and functional performance (using neck and low back range of motion scores) with the use of kinesiology tape during surgery. This may have far-reaching implications for other jobs/activities where sustained positions result in musculoskeletal pain.

Recent research indicates that kinesiology tape has a greater stimulatory effect with compromised tissue (due to injury or fatigue due to poor posture).
January 2013

It is important to ascertain whether people who have access to compensation obtain the benefits they need. In 2012, Natalie Spearing and colleagues published another on-topic study in the journal Pain, titled: "Does injury compensation lead to worse recovery? A study published in the Journal of Clinical Epidemiology, titled ‘Is compensation harmful?’’

In November 2012, Natalie Spearing and colleagues extended their research on these topics with a study published in the Journal of Clinical Epidemiology, titled: ‘Research on injury compensation and health outcomes: Ignoring the problem of reverse causality led to a biased conclusion.’

This study highlights the serious consequences of ignoring Reverse Causality Bias in the evaluation of the relationship between compensation and health outcome. They note that Reverse Causality Bias occurs when the results of a study are interpreted to mean that whiplash-injured people who hire lawyers to obtain compensation have worse health recovery outcomes, when in fact it may actually mean that whiplash injured people with greater injuries, more pain and more disability are the people who seek lawyers to help them obtain the benefits they need.

The authors note that many believe that compensation after whiplash injury does more harm than good. There is a view that injury compensation leads to worse health, known as the “compensation hypothesis.” This view that compensation is harmful has been used as an argument for reductions to compensation benefits, to influence judicial decisions, and to advise people that compensation payments will impede their recovery. After their review of the literature, these authors state: “There is no clear evidence to support the idea that compensation and its related processes lead to worse health.”

Claiming “lazier morbidity leads to worse pain,” could also be interpreted as “worse pain may increase the likelihood of filing a claim.”

“It is important to ascertain whether causally significant negative associations between compensation-related factors and health do indeed lead to worse health, or whether they simply reflect the likelihood that people are comparatively worse health (eg, pain) to begin with.”

Of the 503 subjects who agreed to participate in the study, 80% developed neck pain within 7 days of collision (early whiplash).

In the evaluation of the results of a study are interpreted as if a beneficial effect, “because access to financial assistance and/or treatment may ‘induce’ claim filing behavior.”

The results of this study suggest that compensation claiming may not be disadvantageous to injured parties after all. This is, after all, one of the motivations for compensation. It is argued that compensation appears to have a beneficial effect,” because access to financial assistance and/or treatment may ‘induce’ claim filing behavior.”

SUMMARY

Clearly the use of kinesiology tape is popular (millions of users) and the applications are broad (from athletic injuries to edema). Specific evidence for efficacy is scant but growing, and plausible. There are currently no reported dangers associated with using this classic cotton mesh bandage, and the only significant contamination is on open wounds. Kinesiology tape benefits well and flexes like a second skin, unlike most braces that act more like restrains on top of the skin. It withstands shower and/or water and is by most comparisons a cost-effective treatment modality. While science is unclear to determine that kinesiology tape is the panacea for all aches, it is an option for physical therapists to keep in their tool box due to its vast possibilities in treating patient complaints and as a tool for education.

REFERENCES

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