

Condensed Case Management *for Chiropractors*

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Introduction

Common Clinical Conditions and with a Condensed Version of Best Conservative Treatment.

This text is designed for the practicing clinician. These chapters are short, direct, and to the point. We take a variety of common clinical conditions and give keys for diagnosis and treatment. These chapters allow a doctor to quickly scan for things to check and suggested treatments for their patients in a busy practice.

Although this book is designed to assist you in the treatment of patients during a busy day, diagnosis of the condition is key. Part of the diagnosis procedure includes patient categorization. We try to place patients in one of three categories. The first category is the "bad stuff" that needs to be referred out for other treatment. Examples might include a spinal infection, avascular necrosis, or metastatic carcinoma. The second category includes patients who are too stiff, too locked up, or fixated, and need to be adjusted. This second category can also include muscles that are shortened and need to be stretched. Or, the patient has adhesions or trigger points that need to be reduced via soft tissue treatments. The third category is the patient with joint instability, or too little joint compression. These patients typically need low tech rehabilitative exercises to help stabilize an area.

We are not suggesting that the emotional component is not critical for your patients or that sleep is not important or that other factors are not involved. We want to evaluate and treat patients effectively and in a time efficient manner. It is important to provide best care while being aware of time constraints to help build a clinically and financially successful practice.

There are 5 key treatment components that will be discussed throughout this book. The first component, and the foundational treatment, includes specific chiropractic adjustments. Chiropractic adjustments restore more normal joint movement, help to balance/relax muscles, and reduce pain via mechanoreceptor stimulation and subsequent inhibition of nociception.

The second component is the treatment of shortened muscles. Janda introduced us to upper and lower crossed syndromes. These shortened muscles need to be lengthened to help create balanced function.

The third component includes addressing soft tissue adhesions and trigger points. There are many soft tissue techniques including Graston technique, Active Release Technique, and many others. Soft tissue adhesions will not allow normal function of muscles and joints and can be specifically addressed leading to an improvement in your patients condition. The same applies for trigger points.

The fourth component is rehabilitation of deconditioned and inhibited muscles. Strengthening these functionally weak muscles leads to a better functional balance.

The fifth component is the nutritional status of the patient. If patients are in a pro-inflammatory state as taught by Dr. Seaman, they will not heal as well. While the subject of nutrition is very large, you can narrow this down to make it practical and effective for many of your patients in your busy practice. The focus can be on the anti-inflammatory diet approach thereby helping many patients who routinely eat a pro-inflammatory diet or have special needs. Emphasize fruits, vegetables, raw nuts, grass-fed meats, wild game and fish. More on this subject can be found in David Seaman's Clinical Nutrition for Pain, Inflammation, and Tissue Healing textbook.

The chapters in this book will be bulleted, brief, and will not cover the vast amount of information available on each specific topic.

Use these chapters as quick references to help you with your patients and build your practice. Good luck.

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Chapter 1: Plantar fasciitis

History/diagnosis:

- Not just runners. Can be runners from overuse or it can be the deconditioned. Both scenarios can be difficult to treat as runners are sometimes difficult to convince to take a break from running and the deconditioned have no strength.
- Two typical scenarios – too much compression or too little compression. The foot is either too stiff and too tight and needs stretching and adjustments; or there is too little compression and the foot is sloppy and needs strengthening and support, possibly orthotics and taping.
- Heel pain is the worst in the morning or after sitting for a while.
- Occasionally there is pain with passive dorsiflexion of the foot and toes, but often not so.
- Tenderness on the medial/plantar surface of the calcaneus. Take your thumb and get in and palpate on the calcaneus to elicit areas of tenderness.
- Think about the locomotor chain. Short hamstrings/gastroc/soleus lead into subsequent tightness of the plantar fascia.
- The soleus muscle is particularly implicated with tightness and subsequent tightness of the plantar fascia.
- Is there a stress fracture? Medial and lateral compression squeezing of the calcaneus is often tender with stress fractures.
- The possibility of a stress fracture sometimes needs to be ruled out via an MRI, as an x-ray will typically not show it.

Treatment:

- Cortisone – use only in extreme stubborn cases as it tends to weaken the tendons and ligaments in the area and demineralize the bone. Cortisone also has negative systemic effects if used a lot.
- Surgery. The spur is a result of traction on the periosteal attachment, it is not a cause of the pain. Occasionally surgeries are performed to remove a bone spur detected on x-ray. Sometimes, cutting of the medial 1/3 of the plantar fascia surgically is done and this will often temporarily relieve pain. Long term, the problem is that now you have even less plantar fascia to support the foot, so support via orthotics would seem very important after such a surgery.
- Adjustments, especially the subtalar joint. You need to decide whether the foot is too stiff or too loose. If too stiff, then adjustments are quite important. There are some patients where you will have a stiff foot that is also weak and you will need adjustments and strengthening.
- Physiotherapy – be careful with ultrasound because if there is a stress fracture, this will be painful for the patient and aggravate the condition.
- Stretch, especially the soleus if it is shortened. If the patient complains of aggravation of the condition with the stretching, then discontinue and reevaluate.
- Short foot and ski jump exercises and other rehab exercises for the foot. Ask the question, Is the foot weak? Because if it is weak, then these rehab exercises are critical.
- Balance work and various lunges are a good progression of rehab.
- Tape – would the patient benefit from 48 hours of a plantar fascial support taping. The taping for plantar fasciitis does not need to be particularly complicated, but rather it needs to give the plantar fascia a relative rest.
- Soft tissue work – your choice as to ART, Graston, or other soft tissue techniques. Be comprehensive in your soft tissue work in that you do the plantar fascia and check to see if work is needed on the gastroc/soleus complex also.
- Nutrition. The emphasis is on anti-inflammatory nutrition to include fish oil, ginger, turmeric, and nexrutine, etc.
- Orthotics? These are often needed in these cases to support a weak foot. They can be non-custom or custom, depending on the individual patient.