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Mechanical Diagnosis And Therapy®
of the spine and extremities

GUEST COMMENTARY

»» What is an ordinary clinician doing in a place like this?

Carol P. Dionne, PT, PhD, OCS, Cert MDT

Dr. Dionne recently was awarded the University of Oklahoma Health Sciences Centers College of Allied Health's Outstanding Faculty Member in Research/Scholarship Achievement for her accomplishments in research. Dionne's most recent projects include a \$40,000 grant from the Center for Hispanic Health Disparities for The Effectiveness of McKenzie Low Back Pain Management System Among Hispanics.

We asked Dr. Dionne to share with our readers how her career had evolved to reach this esteemed moment.

When working strictly in the clinic back in the early 1990s, I struggled to find an effective manner with which to treat patients with spine pain. I became rather frustrated. The list of unanswered questions I had on care for the spine grew. I became a consumer of the research literature, and no or few answers were to be found. I decided it was time for me to "put my money where my mouth was" and at least try to find answers to my questions. So, with encouragement of my family, I pursued my PhD, for formal training in the conduct of research. During that time, I became credentialed in MDT and part of the MDT community.

I have met and befriended intelligent and intriguing individuals within the MDT community who have assisted in affording me opportunities, have shared ideas, and *always* have given me encouragement to continue on, regardless of circumstance. Vert Mooney, MD was instrumental to my admission to graduate school; Ron Donelson, MD, MS served as an *ex officio* member of my dissertation committee. Mark Miller, PT, Dip MDT and Scott Herbowy, PT, Dip MDT allowed me to collect data in their clinics and participated in an additional study concerning the REPEX. Jeannette Saner, PT, Dip MDT from MI Switzerland kindly translated my manuscripts and assisted me in getting my initial studies into print in Europe.

Being part of the MDT community has many advantages, one being participating at the Institute's international symposia. Over the years, I have been privileged to witness many a "meeting of the minds" (some would call them "clash of the Titans") and have been greatly influenced by high-profile individuals like Michele Battié, PT, PhD, Nicolai Bogduk, MD, PhD, DSc, Alf Nachemson, MD, Charles Aprill, MD, Michael Adams, PhD, Karim Khan, MD, PhD, Julie Fritz, PT, PhD, along with our very own Audrey Long, PT, Dip MDT and Mark Werneke, PT, Dip MDT. Ideas discussed at these conferences have spawned more ideas for present and future research.

I have had the privilege of presenting my work at The McKenzie Institute's Conference of the Americas and at incredible venues of International McKenzie MDT Conferences. In a taxi on the way to the International Conference in

Maastricht in 1999, I met Ron Bybee, PT, DPT, OCS, Dip MDT who later not only became a faculty colleague, but also became my partner in research for 5 years. At the 2003 International McKenzie Conference in Rome, I met Stephen May, PT, MACP, Dip MDT, MSc, who has been instrumental in assisting me in organizing ideas for study, always being accessible for lively scholarly conversations at the click of the mouse. Ron Schenk, PT, PhD, OCS, FAAOMPT, Cert MDT and I are presently comparing a clinical prediction rule for manipulation with MDT.

Now in Oklahoma, I am in an environment that is extremely conducive for major research across many disciplines. We have radiologists, geneticists, and pathologists on campus with an established infrastructure, ready to work with clinicians in translational research. As Primary Investigator, I am setting the stage to study lumbar disc disease and how MDT may indeed influence this very complex condition. I would be unable to examine the number of patients required for this undertaking without Don Stover, PT, Cert MDT as a co-investigator.

How did an ordinary clinician get to become a researcher? I enjoy the investigational process, the "hunt". However, not all clinicians want to direct research, but we professionals should be part of the process. This is how we prove or disprove of what we do for a living – is it effective? If so, on whom is it effective? Read the pertinent research literature. Be a part of the bridge between clinical research and the clinic.

Use the literature to your favor. Collect clinical outcomes (e.g., satisfaction surveys, ODI, etc) to observe how well your practice "stacks up" with what is reported in the literature. This could be used as a very effective marketing tool! For example, Werneke and Hart (2004) demonstrated that the centralization phenomenon is predictively valid. Long, Donelson and Fung's (2004) work demonstrates that directional preference "works." Even the very assessment sheet in use by MDT practitioners around the world has been shown reliable (Clare, Adams, & Maher, 2004). Print out and present these research articles to referral sources and insurers.

Research substantiates what we clinicians do for a living. And let us not forget that it was astute observations of Robin McKenzie in the clinic with a certain patient, Mr. Smith, that made it all possible. We are indebted to you.

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Correspondence of diagnosis to initial treatment for neck pain

Carol Dionne, Ronald F. Bybee and Joe Tomaka

Reviewed by Allan Besselink, PT, Dip. MDT

Brief review of Dionne et al (2007):

This study was designed to examine the potential link between McKenzie mechanical diagnosis and the appropriate initial treatment. Videotaped examinations of 20 consecutively selected patients were assessed by 54 clinician raters. Though at first glimpse the study results provide a solid conclusion regarding the ability of MDT to link diagnosis and treatment, in many ways this result should be expected. Inherent to the McKenzie educational process is an understanding of the relationship between directional preference and the classification of “derangement” – they are mutually exclusive factors. The study assesses the ability to not simply state that there is a derangement, but the appropriate treatment for it – which should

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have been understood in order to make the initial diagnosis of “derangement”! This is a good methodical study that in many ways simply validates the educational process of making a mechanical diagnosis and subsequently providing the next appropriate step in the diagnosis-treatment algorithm. Research has shown that we have moderate reliability in making a mechanical diagnosis – and in prescribing an appropriate directional exercise for treatment based on the educational paradigm. What remains in question is whether or not being able to categorize the patient in such a way has any effect on their overall functional outcome as compared to a control group.

Case Study: Jack*

Submitted by Amanda Dalcourt, PT, Dip. MDT

Sept. 27:

Initial examination**

Patient does a lot of traveling and complained of trouble sitting. It was felt that detailed education and postural correction were warranted on Day 1, seeing as he was unsure as to when he could come back. He also was more interested in a home visit and a ‘quick fix’, due to his heavy traveling schedule. As the repeated movement exam was occurring, the patient was obviously getting impatient and kept looking at his watch. He mentioned being in a hurry. I decided to keep the exam to a strict minimum, in view of his chronic presentation. He seemed very interested that by simply sitting erect, his pain decreased. To him, this made the visit ‘worth while’. He was provided with ‘Treat Your Own Back’, postural education, a lumbar roll and practice in finding his ideal sitting posture (slouch–overcorrect).

Oct. 1:

Appointment cancelled by telephone. Patient mentioned that he was extremely satisfied with his new posture and his significantly increased comfortable sitting time. He mentioned that his chronic back pain is now much more manageable. This made his job much easier. He wanted to continue exploring this new posture and the information in ‘Treat Your Own Back’ and stated he would call in the future if needed.

Discussion

After finishing the subjective portion of the exam, it was obvious that Jack was becoming impatient with all of the seemingly unrelated questions. I acknowledged the fact that he appeared to be in a hurry, we discussed his time constraints, and the objective exam began. In view of his short amount of time, repeated movements were not tested. Everything tried with one repetition showed an increase, not worse. Amongst the sighs, the rolling eyes and the watch-glancing, I was able to determine that he did at least appear to have a preference for erect sitting. I capitalized on this discovery by going into postural education and correction. I told myself that I would further examine the effects of repeated movements on the next visit, perhaps after the patient had been ‘WOW-ed’ by the simple correction of his posture. To my dismay, he cancelled his next appointment and wanted to continue on his own. I did explain to him that he had a good prognosis of further decreasing his pain following further evaluation, by determining a series of simple exercises for him – he simply was not interested,

as this was his busy time. He was quite happy to have found a very comfortable sitting position, mentioning that sitting with the lumbar roll was even more comfortable than simply erect sitting. Frankly, I think he had decided that he was meant to have back pain for the rest of his life – “after all, my pain has been there for 25 years already and there is just no way some exercises will make it all go away, just like that.”

I have encountered many patients who are skeptical about the effectiveness of finding a directional preference and turning that movement into an exercise that helps to abolish their pain! Even when I tell them that I have seen cases like this before and had great results, the patients will often confess to me a couple of days later that they really thought I was ‘crazy’ to think that in a day or two, the pain that had been present for so long could simply go away. Then, the patients continue to wonder why nobody had ever suggested such a movement/exercise before! (This is when the anger comes out!)

Posture alone, is such a simple and amazingly effective tool!! It is highly underrated and under-utilized. When presented with chronic pain patients, I believe that to begin with posture alone is often the best approach. If you can decrease the stress on the patient’s body by correcting his/her posture, perhaps after a few days of sitting and standing properly, his/her pain will have decreased to a more manageable level and this decreased level of irritability will allow the clinician to ‘fish out’ a clinical impression with repetitive movement testing. Chronic pain patients often test with increased, not worse or even increased, worse – with all directions of movement! Their bodies are hyper-sensitized to pain and everything hurts. Clinicians will be pleasantly surprised to see that after a few days of proper posture, this hyper-sensitization is decreased to a level that will allow them to make sense of the repeated movement testing results.

Try it for yourself and see!

When working with chronic pain patients, remember this: K.I.S.S. Posture!! (Keep It Simple Silly – Posture!!) ■

**These assessment findings are based on evaluations and follow-ups of real patients – names have been changed to protect the identity of the people involved.*

***For details of examination findings, please refer to the full assessment form posted on our website in the new MDT Resource Center.*

» Burning & shooting pain - a "humbling" experience.

Submitted by Sean Gupta, PT

Once again, a recent case discussion within the online MDT study group listserv has served up some good reminders about the importance of history taking and physical exam. Such is the case with this young PT. Our thanks to these clinicians who were willing to share their experiences.

The patient is my mother: a 64 year old lady complaining of insidious onset of left burning anterior thigh pain and frequent shooting pains in the knee. Symptoms were:

- 3 days since onset; occurred together (no gradual peripheralization of symptoms)
- intermittent in nature
- sporadic and inconsistent as she tells me that they appear not to change with movements, postures, or positions.

Lumbar ROM appears to be normal with a min/mod loss of extension (but appears to be attributed to age related changes). I go through the exam and it appears that the burning pain was decreased, abolished, and made better with REIL, but no effect to the shooting pain in her knee. I tried all forms of extension: sustained, sag, overpressure, but again no change to the sporadic knee pain she was still experiencing while lying prone. No change with REIL hips off centre (nor with 1 or 2 leg traction in prone which I decided to try to see what would happen).

Over a span of 60-75 minutes while she was in prone, we tried various forms of extension. Then it appeared that all the pain had gone away, except I couldn't figure out which exact movement may have caused it. But, as soon as she changed position to side lying, both pains reappeared. I tried again the same procedures above with REIL, but nothing helped this time. Even the burning pain didn't change with REIL this time. So I tried RFIL to see if this would worsen the pain - but it too had no effect.

I was puzzled and told my mom I really did not know what was going on. A few hours later, while my mom was showering/dressing, she told me that she could see small rashes along her thigh as well as a few rashes on her low back. Being a nurse, she said that she thought she might have Herpes-Zoster. So I checked her rashes, and some appeared to vesicular in nature. I also did some reading on the internet about Herpes-Zoster and came to the conclusion that her s/s did appear consistent with the virus. Eventually that night the pain became too unbearable and she was taken to the clinic where the diagnosis was made: shingles. She was given the appropriate meds and finally felt some relief within a few hours.

Here are my thoughts: My first clue should have been in the history that no position was known to change the nature of the pain. Flags should start buzzing in my head when someone says that the pain doesn't appear to change with motions/movements. But instead, I tend to think everyone is a derangement and when I can't find the directional preference, I just keep trying. It must be me doing something wrong or I haven't yet found the correct movement.

This case appeared to have a directional preference initially, but when the symptoms returned, the same movements now had no effect. Even the opposite motion didn't worsen the symptoms. This should have been my second clue that perhaps this was not mechanical.

Actually, my second clue SHOULD HAVE been in the observations. I didn't even examine her visually to see her skin. Because I had biased my exam and became too involved thinking she had to have a derangement, I spent over an hour doing various forms of lumbar motions. If I had just decided to look at her skin where she was complaining of burning, I would have realized that perhaps something else was going on after seeing a rash.

From this case, I learned that I need to pay more attention to my history taking. It seems I become obsessed with trying to find a directional preference rather than taking a step back to review the history and see if I missed anything in the objective findings.

It helps to have cases like these that humble me rather than thinking just because I use MDT I am a better therapist and can help everyone. Such cases also help in preventing my ego from getting too big. Every now and then I need my ego deflated to bring me back down to reality to remind me that I'm not perfect - I'm human.

Responses:

Sean,

Thanks for a wonderful lesson. Such a case becomes even more challenging when the examination precedes the formation of the skin lesions. Two points you made very well: guarding for bias means taking an objective history and resisting the temptation to leap to a favorite conclusion despite the facts (I know this problem well, as I am a chiropractor!) AND "inspection" is part of the examination. I am as guilty as others of not always looking at the skin where the pain is. Thanks again for an interesting case.

-Mitch Miglis, DC, Cert MDT

Hi Sean

Join the "be humbled" crowd. You are not alone. My most recent visit to humble-Ville was: A 45 yr old woman with no red flags, woke up fine in the morning but bent over at the sink to brush her teeth and ZAP - acute low back pain. Having been treated successfully in our clinic in the past for a knee problem, she appeared at our clinic at about 11 am and I was able to fit her in. She had so much "spasm-like" pain and virtually no ROM in any direction (usually we see one or two movements more severely blocked than the others) and was better "still" for moments only. Any movement gave twinges of pain.....No problem, I thought, I'll sort her out with static positions.

She also had some intermittent pain in the anterior groin area (I've seen that with derangements from L2). But alas, no positions were of any help except very momentarily. No hint of directional preference by history or exam. The ache was intense enough that she could not stay still for long despite my efforts to encourage her to try the standard 3-5 minute tests. As soon as she attempted to move, the sharp pains were back. Something seemed "odd" but I was not sure what it was. I really had no idea what position to advise her to try for 24 hours to calm it down. I am not sure why I said this, but I told her if this gets any worse then you need to see your doctor or go to ER. She left our clinic feeling no better than she arrivedwe really try to avoid that! :)

I got the call the next day.....Kidney stone.

-Audrey Long, PT, Dip. MDT

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» Treat Your Own Business

Physicians' Waiting Rooms – A Great Place To Begin Capturing The Attention Of Your Prospective Patients

By David C Steinberg, CEO Marketing Turnkey Systems & PTreferralMachine.com © 2007

In the last MDT Bulletin Business Corner, we talked about how to turn your special McKenzie knowledge and training into a competitive advantage by communicating your unique approach to assessment and treatment at key points of contact in the marketplace. We listed examples of some contact points, and posed a challenge to readers to think of a few on their own. Today, we will take one of those contact points, the physician's waiting room, and show how to make it a continuous source of potential new patients.

To begin with, it's helpful to think about the typical conversation between physician and patient. How does that "private" conversation go, and how does it impact **YOU**? Will the physician recommend physical therapy, and if so, what kind of information will the physician offer *on the fly*? And what about the patient, what do they want to know?

For the physician, long stories advocating the benefits of physical therapy are probably not going to happen. Physicians will be short on time, and explanations about treatment options or how to select the right PT are routinely reduced to, "Where do you work, and where do you live?" No new insights there, but how do you as McKenzie practitioners turn this age old problem into an opportunity?

A good place to start is to *do what you're supposed to do*, and provide educational materials (marketing) that patients *actually* want, and physicians *actually* use. If you can accomplish that, then you can be in hundreds of waiting rooms all at the same time, and capture the attention of prospective patients via your marketing materials. When done properly, these materials will position YOU as the expert as well as the standard bearer. These materials should educate about the basics, review treatment options, and provide standards for comparison. The idea is to teach prospective patients enough so that they feel more in control of their choices. Once prospects feel more in control, then they seek a way to take the next step in the process, **YOUR PROCESS**. This is no different than what the drug companies do. They provide detailed information on how their drugs work, when to use them, when not to use them, and cap it off with *free samples*. As a McKenzie practitioner, when you understand how powerful this strategy is, you can use your McKenzie knowledge as a solid foundation to make this happen.

Since the space here doesn't permit, take a minute now to look at a set of sample materials at www.PTreferralMachine.com/SampleSet. When *offered in a compelling way* to the physician, these kinds of materials will become a welcome fixture in many physician waiting rooms. We've all been in waiting rooms that have displays of literature on various topics. The waiting room is the perfect point of contact to place your material, but remember, *first* you must have something physicians *actually* want to hand out, and that prospective patients *actually* want to use.

Here's an example of what I mean from one of my last doctor visits. I was picking out a magazine to read in the waiting room, and while sifting through the pile, I noticed a brochure about acne treatment. Since I have four teenagers, and acne was part of our current set of problems, I picked it up and learned about a special light therapy used for acne. As a health care marketer, I was reminded how really simple and effective this is. Almost every prospective patient will wait around at their doctor's office, looking for something to read, and that's a *perfect* opportunity to provide helpful information on treatment options. If they trust their doctor (which most people do), then the fact that the physician selected that material and placed it in his or her waiting room means they probably endorse it. Now, do you think a significant percentage of people **LOOKING** for something to read at the doctor's office will have, or know someone who has, back, neck, or leg pain? OF COURSE! It doesn't get much easier than that, does it?

But the marketing job isn't done yet. You still have the job of "closing the deal." Good marketing spurs the audience to take some action. Once we've done the hard work of getting the material into waiting rooms, then what? The informational brochure or booklet needs an obvious **call to action**. With my acne experience, there was only one brochure laid out, it didn't say TAKE ME I'M FREE, it had no coupon to offer a FREE screening or trial, no website resources, and no free ANYTHING I could just take and stuff in my pocket. So I just left the brochure on the table. The point here is that after getting your material into the waiting room, you still have the job of capturing prospective patients into YOUR marketing and booking system. In the acne brochure, the chances of me taking the next step would have increased **EXPONENTIALLY** if I was offered an appropriate call to action. Crafting effective offers or calls to action takes experience. Take this article for example; can you spot all the different calls to action (offers)?

That "**call to action**" can be the critical tool that keeps the education and trial process going. In addition, your call to action provides you with a way **to measure direct response** along with the appeal of your message. After seeing the sample set at www.PTreferralMachine.com/SampleSet, you should get a better idea of how your marketing material can be set up to include a variety of attractive offers. Usually, as the sample set shows, this requires a series of materials that all tie together as a *system*.

In the next MDT Business Corner, we'll talk about how to use three different types of offers that get results. Until then, send any comments, questions, or marketing materials you would like critiqued to:

MDTbulletinTips@PTreferralMachine.com

We hope you take advantage of this NEW free service available to McKenzie members.

* David and his team have already engaged their services with some certified MDT practitioners and are becoming well versed in the uniqueness MDT practitioners have to offer. If you are interested in learning more about their services, visit – <http://www.ptreferralmachine.com>

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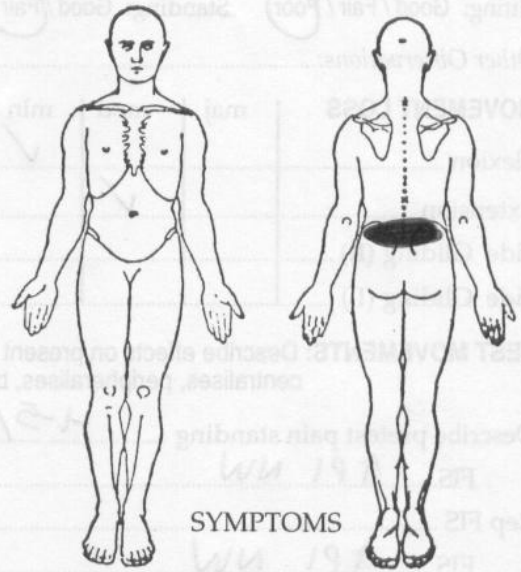
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The McKenzie Institute Lumbar Spine Assessment

Date Sept. 27 /
 Name Jack
 Address
 Date of Birth 55 yrs. Sex: M / F
 Occupation Vendor
 Postures / Stresses driving / sitting ++
 Telephone
 Referral: GP / Orth / Self / Other
 Off work because of current episode? Yes (No) Since / /



SYMPTOMS

Symptoms this episode to be marked on body diagram

HISTORY

Describe relevant symptoms 'chronic' LBP.
 Present since ++ years / Improving / unchanging / worsening
 Commenced as a result of: or no apparent reason

Symptoms at onset back / thigh / leg

Constant Symptoms: back / thigh / leg Intermittent Symptoms: back / thigh / leg

Worse: bending sitting / rising standing walking lying
 am / as day progresses / pm when still / on the move
 other.....

Better: bending sitting standing walking lying supine
 am / as day progresses / pm when still / on the move
 other.....

Disturbed sleep? Yes / No Sleeping postures: prone / sup / side (R/L) Surface: firm / soft / sag / w. bed

Cough / sneeze / strain: +ve / -ve Bladder: normal / abnormal Gait: normal / abnormal

Previous Episodes: 0 1-5 6-10 11+ Year of first episode: ~~10~~ 25 years.

Previous history: episodes on + off of LBP since work injury when younger -> now back pain all day, every day ++ years.

Previous treatments: Chiro, Massage

X-Rays: Yes / No degen. changes

Gen. Health: Good / Fair / Poor φ DM φ CA φ lung / heart problems

Medications: Nil / NSAID / Analg / Steroids / Anticoag / Other PRN

Recent or major surgery: Yes / No

Accidents: Yes / No Unexplained weight loss: Yes / No

EXAMINATION

POSTURE

Sitting: Good / Fair / **Poor** Standing: Good / **Fair** / Poor Lordosis: **Red** / Acc / Normal Lateral Shift: Right / Left / **Nil**

Other Observations:

MOVEMENT LOSS

	maj	mod	min	nil
Flexion			✓	
Extension		✓		
Side Gliding (R)				✓
Side Gliding (L)				✓

Deviation in Flexion: Right / Left / **Nil**

Deviation in Extension: Right / Left / **Nil**

TEST MOVEMENTS: Describe effects on present pain - produces, abolishes, increases, decreases, centralises, peripheralises, better, worse, no better, no worse, no effect

	PDM	ERP
Describe pretest pain standing: 4-5/10 = PI		
FIS ↑ PI NW	✓	
Rep FIS		
EIS ↑ PI NW	✓	
Rep EIS		
Describe pretest pain lying: 3-4/10 = PI		
FIL ↑ PI NW		
Rep FIL		
EIL ↑ PI NW		
Rep EIL		
If required SGIS (R)		
Rep SGIS (R)		
SGIS (L)		
Rep SGIS (L)		

*time constraints

STATIC TESTS If required

Sitting Slouched: **↑ PI W.** Sitting erect: **↓ PI B esp. c L roll.**
 Standing Slouched: Standing erect:
 Lying prone in extension: **↑ PI NW** Long sitting:

NEUROLOGICAL

Motor Deficit: Reflexes:
 Sensory Deficit: Dural signs:

OTHER

Hip Joints: **Not tested**
 SI Joints: **Not tested**

CONCLUSION

Posture: **Dysfunction** Derangement No.: **1-2** Trauma:

PRINCIPLE OF TREATMENT

Posture Correction: **T40B, posture education, roll "min. Slouch-overcorrect."**
 Extension:
 Flexion:
 Lateral:
 Other: **Re-eval. next visit**