

Dysfunction...

A review of the literature

Dynamic Chiropractic

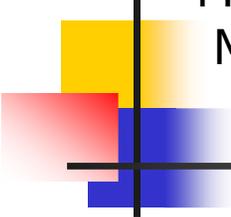
June 26, 2000 Volume 18, Number 14

***“Goals of Care: Minimize Pain and
Maximize Function”***

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“Dysfunction”



Malik Slosberg, DC, MS, Professor. Goals of Care: Minimize pain and Maximize Function. Dynamic Chiropractic June 26, 2000 Volume 18, Number 14. Pages 8,12,42

Dysfunction may become self-perpetuating....One of the common criticisms of the diagnosis of soft tissue sprain and strain is that such an injury is normally followed by healing.

Symptoms should settle over the expected tissue healing time.

However, if the problem is dysfunction, then symptoms can persist for as long as dysfunction continues. Dysfunction may be self-sustaining, so symptoms may persist indefinitely.

“Dysfunction”

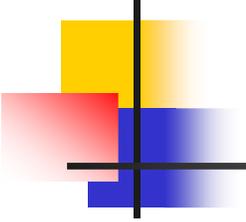
Mayer TG. Neurologic Clinics of North America 1999; 17 (1): 131-147

“The majority of injuries to the low back involve soft tissue or discs with sprains and strains of musculoligamentous tissues, which have a relatively brief healing period. When healing is temporally complete, but biomechanically imperfect, leading to permanent impairment or supporting elements, chronic pain disability may follow.”

If tissues are allowed to heal without functional restoration, chronic disability can occur.

“Dysfunction”

Ameis A. Can Fam Physician 1986;32 (Sept) : 1871-76.



Ameis explains that,

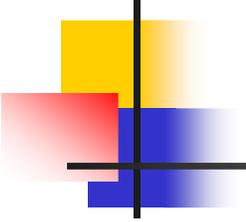
“As time passes, the rehabilitative program should become progressively more active...Patients invariably expect treatment to result in pain-free status. Instead, it should be stressed that recovery of function is the primary goal.”

The restoration of function, so that a patient has an adequate capacity to tolerate activities of daily living and work tasks, is the single most important goal of care.

“Dysfunction”

Bigos SJ, Davis, GE. JOSPT 1996;24 (4) Oct: 192-207.

“The Agency for Health Care Policy and Research defined low back problems not as pain but activity intolerance due to back symptoms. The actual treatment relates to regaining activity tolerance. Controlling symptoms supports, not replaces, the true treatment. Don’t let patients confuse recommendations to be more comfortable (pain relief) with conditioning, which is the real treatment for an activity limitation.”



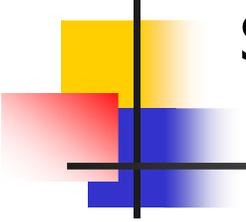
“Dysfunction”

Abenhaim L, et al. Spine 2000; 25(4S):8S.

The primary conclusion of the recent Report of the International Paris Task Force on Back Pain, states:

“Individuals who have back pain reduce their activity... The longer they reduce their activity, the greater the risk of the conditioning becoming chronic. The prevailing management approach to the treatment of back pain considers a return to normal activities to be a more important goal than pain relief.”

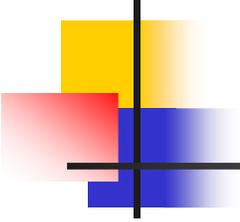
Function vs. Pain Relief



Saal JA. 1996 North American Spine Society Presidential Address, Spine 1997;22(14):1545-15

- *“We must adopt the principle of improving patient function as our new paradigm...Improving patient function must be the credo of care.”*

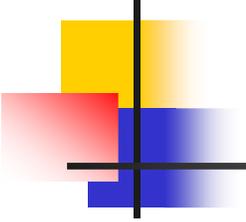
Saal



Waddell, G. The Chiropractic Report 1993; July:1-6.

“Failure to restore function means any pain relief will be temporary and reinforces chronic pain.”

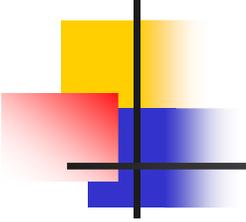
Waddell, MD.



Owens, MS, DC; Top Clin Chiro 2000; 7(1):74-79.

Preventive Care

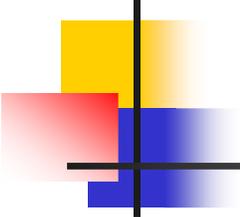
- Degeneration of tissues is thought to occur in areas of disturbed kinematics, which can eventually lead to arthritic changes if not addressed. Evaluation should be focused on areas of dysfunction in order to correct before symptoms occur. In this case, chiropractic care is indicated whether symptoms are present, or not.



Waddell G. The Back Pain Revolution Churchill Livingstone
1998;145

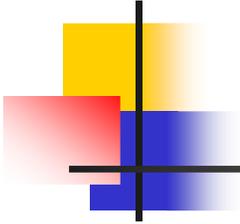
Residual dysfunctions that can frequently persist long after tissues are healed if the dysfunctions which occur with tissue damage are not identified and corrected:

- (1) Abnormalities of joint movement
 - A. Limited movement
 - B. Hypermobility
 - C. Abnormal patterns of movement
- (2) Acute joint locking
- (3) Muscle fatigue, weakness, tension, shortening, stretching.
- (4) Reflex muscle spasm



Waddell G. The Back Pain Revolution Churchill Livingstone
1998;145 (cont'd)

- (5) Connective tissue (fascia, ligs, joint capsule, muscle)
 - a. Adhesions
 - b. Scarring
 - c. Trigger points
 - d. Fibrositis
- (6) Neuromuscular incoordination: muscle imbalance
- (7) Abnormal patterns of movement
- (8) Altered proprioceptor and nociceptor input and neurophysiologic processing.



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