2016 Conference Review

Global Burden of Disease

Interview with Peter Tuchin

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The combined COCA and Chiropractic Australia 2016 National Conference was a turning point in the direction of our great profession.

It embraced the core principles of modern chiropractic in the context of evidence based practice and served to highlight our place as experts at the forefront of non-surgical spinal care and management of back pain and dysfunction, a condition that sits at the top of the list in terms of the global burden of disease.

The keynote speaker was Professor Scott Haldeman DC, MD, PhD, an individual who over many years has been instrumental in the recognition of chiropractic as a mainstream primary healthcare profession.

The conference, which was held over three days, comprised research presentations on day one, plenary presentations on day two and a combination of plenary sessions and workshops on day three. All three days showcased some of the best minds in the chiropractic profession in Australia, both newcomers and veterans alike and the calibre of the scientific research presented was of a superb quality.

It serves to remind us that the only way forward for the profession is through rigorous scientific enquiry and research on the efficacy of chiropractic as a leader in spinal healthcare, specifically through our university system and its translation to clinical practice.

On day one conference attendees had the privilege of hearing from some of the very special individuals who have given their time and talents in this direction when they presented their research projects. These included Kenneth Young, Bruce Walker, Hazel Jenkins, Kiera Burns, Stanley Innes, Katie de Luca, Craig Moore, Julie Kendall, Michael Swain, George Hardas, Stephen Sharp, Christopher Burrell, Matthew Stevens and Michael Azari. Adequate time was allowed for conference delegates to ask questions of the presenters, all of who displayed great professionalism and confidence in their answers. A special mention goes to Katie de Luca who was awarded this year’s prize for the best research to be presented at the conference podium.

Some excellent research posters were also on display by Matthew Fernandez, Sasha Dorron and Maria Bernard-Giglio as well as a further 8 posters submitted by teams of post graduate students from Murdoch University.

In summary, this was an excellent day and highlighted the need for further funding and research into chiropractic for non-surgical spinal care. All of us should be prepared to step up and play our part in either donation or fund-raising to this essential cause.

On day two the conference was treated to some wonderful presentations by the keynote speaker Scott Haldeman. A giant of the profession over many years and a champion of evidence based practice, it was a great pleasure to see Professor Haldeman in his element as a talented and seasoned speaker. The easy-going and conversational tone of his presentations made for some entertaining and easy listening to some complex topics including the global burden of disease in relation to spinal disorders both in developed and developing nations, the importance of evidence based care and his personal journey as both a chiropractor, a medical physician and a researcher. Other topics covered by Professor Haldeman included informed consent and the role of the patient in clinical decision making, the importance of client education in terms of positive clinical outcomes and the very important point of chiropractors owning the realm of primary spinal health care practitioners and in doing so retaining our cultural authority as the top spinal care experts.

Of these topics it is worth mentioning Haldeman’s presentation on the importance of evidence based medicine in chiropractic practice in the 21st century using the management of neck pain as the example. For too long there has been great division in the profession along the lines of adherence to the original and vitalistic origins of chiropractic and the newer and more progressive scientific and evidence based approach.

Professor Haldeman gave several entertaining common misinterpretations of EBM and what it isn’t, culminating in the definition of what it actually is. That is, in practice we must constantly remind ourselves that “I will change my practice based on the evidence to avoid making mistakes and provide the best possible care to my patients”. In addition, “Evidence based medicine cannot be evaluated without a credible evaluation of the evidence.” In this case critically evaluating the best literature.
on EBP chiropractic, reaching a consensus between old and new research which has been done using the scientific method and the appropriate and properly conducted trials.

The outcomes of this lecture provided us with some very significant points in relation to the future direction of our profession:

• “The Spine Care Specialist must be more knowledgeable about the science and literature than any other clinician.”
• “This requires changes in undergraduate and postgraduate education.”
• “This requires constant reading of the scientific literature and attendance at research conferences.”

In summary, Professor Haldeman’s final take-home message to us were the following points:

• “Consider becoming the Primary Spine Care Provider in your community.”
• “Be aware of the benefits, harms and research on each of the treatment options for spinal disorders.”
• “Practice according to current evidence informed and evidence based guidelines.”
• “Keep up to date with the literature.”
• “Attend the spine research meetings: WFC, RAC, NASS, ABS, ISSLS”

Overall, this particular presentation was the most relevant in regards to the path the chiropractic profession must follow if we are to truly become the Primary Care Spinal Experts that we are.

The other presenters on the day were of a similar high quality, including Dr Rudi Gerhart who presented a fantastic review on the differential diagnosis of dizziness and a knowledge refresher that every delegate would have greatly appreciated.

Dr Katie de Luca, who recently completed her PhD with assistance from a scholarship from the COCA Research Fund, gave a presentation titled “Getting to Know Your Grandma – Back Pain in the Older Adult” which was eye opening and informative in terms of back pain and comorbidities in the older patient, an area that is frequently overlooked in clinical practice.

Dr de Luca’s presentation was followed by veteran teacher and researcher Dr Peter Tuchin on headache diagnosis and treatment using manual therapy with some great clinical pearls to take away and put into practice on Monday morning, one of the bread and butter presentations in all chiropractic clinics.

We also heard from two medical physicians, Professor Darren Rivett who discussed the latest findings on the association between vertebral artery dissection and neck manipulation and Dr Geoff Harding, a musculoskeletal specialist who spoke on spinal examination which was, gratifyingly, largely identical to the chiropractic spinal examination along with some interesting pointers on assessment of allodynia and hyperalgesia.

The afternoon consisted of workshops by many of the presenters from the weekend with some practical demonstrations of their earlier discussions which were highly informative and often eye opening.

In summary, the conference was a great success and provided an opportunity for like-minded chiropractors to come together and share experiences and thoughts on evidence based practice and how this will move us forward into the future of mainstream health care as primary contact spinal health care experts.
Global Burden of Disease

By: Dale Comrie BAppSc (Chiro)


A major arm of the study was the ‘Global, regional, and national incidence, prevalence, and years lived with disability for 310 diseases and injuries, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015.’

Since its release this study has been the topic of much debate in chiropractic circles and you can be assured in the rest of the medical world. It was also discussed at the recent CA and COCA National Conference by the esteemed Dr Scott Haldemen.

The place of chiropractic in the world of health care and management of spinal pain is not a new topic of debate and continues to be a source of frustration and at times animosity between the various camps.

This study highlighted many important findings about which diseases and injuries are causing our populations to live with disability between 1990 and 2015. This is a significant and comprehensive study ‘using 60900 data sources to estimate the incidence and prevalence of 2619 sequelae of 310 causes for 591 geographic regions.’

Of primary interest to chiropractors and osteopaths is the significance that musculoskeletal conditions play on a global and regional, and national incidence, prevalence, and years lived with disability.

It concludes that of the 310 conditions studied:

- Low back and neck pain were the leading global cause of disability in 2015, in the vast majority of countries.
- Low back and neck pain cause more disability than all cancers combined.
- Low back and neck pain cause more disability than all cardiovascular diseases combined.

There were many other pertinent facts, found throughout the paper, which are extremely relevant to chiropractors and osteopaths including:

- There is a substantial ‘challenge to the world’s population to live in full health’. This has become more relevant as ‘progress has been made towards reducing mortality and extending life expectancy’.
- The 2013 report attributed the large increase in YLD to musculoskeletal disorders, mental and substance use disorders, neurological disorders, and chronic respiratory disorders, as well as population growth and aging.
- Musculoskeletal disorders occupied 3 of the leading 25 causes of disability; lower back and neck pain were the largest causes, with tension-type headache, migraine, ‘other musculoskeletal’ disorders and osteoarthritis holding significant positions.
- The leading cause of disability varies between the age groups.
  - In adolescents lower back and neck pain become a significant cause of disability, behind iron deficiency, skin disorders, and depression.
  - Middle age is dominated by musculoskeletal disorders.
  - In the older and oldest groups musculoskeletal disorders are still significant but sense organ (hearing, vision etc) disorders, heart disease and dementia obvious become relevant.
- In 2015 most of the world’s population experienced mild or greater disability.
  - From age 60 years plus, greater than 50% of the population has severe or worse disability
- YLDs due to musculoskeletal disorders was greater at higher socio-demographic Indexes and more so for women.
- In general, YLDs was higher in lower socio-demographic index countries.
- The USA and Australia were the only 2 high-income countries where drug use disorders were a top 10 cause of disability.
- Aging of the world’s population and the general increase in YLDs with age has resulted in the global increase in YLDs.
  - 18.5% of all YLDs globally were due to musculoskeletal disorders in 2015
  - 18.4% were due to mental and substance use
  - 17.9% were due to non-communicable disorders like hearing and vision loss and skin disease
- When considering musculoskeletal disorders a key consideration is that painful disorders have a great effect on mobility and can compromise health further; therefore a key clinical goal to improve health and prevent disability would be maintenance of mobility.
- The paper made comment about the increases in deaths attributable to drug use in the USA and the considerable policy and media attention.
  - Australia rated a mention as one of the top ten countries for high prevalence of opioid dependence and the lowest mortality rate amongst these countries.
  - In the USA prescription opioids have been estimated to account for 37% of drug overdose deaths in 2013.

In the US, it was found that the annual cost of pain was greater than the annual costs in 2010 dollars of heart disease ($309 billion), cancer ($243 billion) and diabetes ($188 billion) and nearly 30% higher than the combined cost of cancer and diabetes.

Bruce Walker et al (2008), estimated that in 2001 the ‘direct’ and ‘indirect’ cost of low back pain to be AUD $9.17 billion.

Medicine is heavily invested in management of spinal pain; pharmaceuticals, physician care, hospital and surgical management, rehabilitation, pain management…..the list goes on.

The other disciplines of physical therapy; physiotherapy, occupational therapy, exercise physiologists etc are invested and investing heavily in spine care.
Where are chiropractic and osteopathy?

There are those who see this as the perfect domain for us to fill; the non-surgical spine care expert. And those who believe that addressing pain and spine alone is selling out on our principles.

Most chiropractors and osteopaths would agree that we want to serve our communities and enhance the health of the population. It would seem that addressing the number one global cause of disability would be a great place to start.

It is apparent that chiropractors and osteopaths can become more valued in society if we assume the essential role of ‘spine care expects’. Being more valued means we may attain cultural authority and move further from the fringe of health care. We can then be better positioned to survive, thrive and have a bigger impact in our community.

Of interest has been the American Chiropractic Association marketing campaign, based on chiropractors assisting in ‘pain management’ rather than the USA’s unhealthy obsession with dangerous opioid drugs. From the GBD, it is obvious that Australia too has a significant problem with opioid dependence and that chiropractic and osteopathic could play a significant and important role in addressing musculoskeletal pain and reducing opioid abuse. It must be said that spinal pain is often a significant reason for opioid use and the use of opioids in the treatment of non-cancerous pain has received attention.

At the recent CA and COCA national conference Professor Haldeman also spent some time highlighting the fact that various research findings have found that the public identifies us as spine care practitioners, and only a small percentage consult us with non-musculoskeletal disorders.


Musculoskeletal pain and more specifically spine pain is the number one reason why the public consults chiropractors and osteopaths, yet some seem to want to keep ignoring this and the massive ‘burden’ that it places on our communities, in the pursuit and protection of what is, at best a minor component of practice or, at worse, a fanciful idea.

Chiropractors and osteopaths are well positioned to fill the role of ‘non-surgical spine care and musculoskeletal care experts’. Our education provides us with the skill set. The research consistently demonstrates that manual therapy is as least as effective as most other forms of care and has a positive benefit in the management of spinal pain.

Whilst there will always be special interest groups in our professions that serve an important function and we must acknowledge the role that the other aspects of our clinical practice play (nutrition, exercise prescription, lifestyle advice, sleep advice, smoking cessation etc…), the GBD and the public appear to have decided our course.

Will we accept the role?

References
3. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education. Washington (DC): National Academies Press (US); 2011
5. Darrell J. Gaskin, Ph.D. and Patrick Richard, Ph.D., M.A.
Interview with Associate Professor Peter Tuchin

By: Matthew Bulman BHSc, MChiro

In 2016, Associate Professor Peter Tuchin was awarded the CAA’s Researcher of the Year award. While we did not get a chance to interview him previously, we wanted to acknowledge his award and interview him on recent publications.

Q. Congratulations on your award. What does the award cover, and what were the most recent publications from you?

The award is based on recent contributions to research for chiropractors and the merit of publications. In 2015, I was lucky to have 4 papers published and I also had 7 conference papers, which included the WFC Congress in Athens, FICS conference, COCA Biennial and the CAA NSW conference.

My 2015 publications included:


Q. From my understanding, much of your work looks at cerebrovascular accidents and associations with cervical SMT. How would you best summarize the relative risk to date?

The papers that I have published on CVA and chiropractic have concluded that it is unlikely that chiropractic was the cause of the VAD. However, there may be some associations with VAD and chiropractic in that some papers have reported an immediate CVA after chiropractic SMT. One theory (which I agree with) is that the early symptoms of VAD are neck pain or headache, which may then prompt the person to seek chiropractic treatment, but the VAD had already begun.

I have had several articles on chiropractic treatment and stroke published in non-chiropractic journals. I believe this is important as it helps to demonstrate to non-chiropractors that the risk of a CVA from a VAD is miniscule, and that medical practitioners should feel safe referring patients to chiropractors.

Whilst a number of my publications have focused on vertebral artery dissection and stroke, I am also still active in research on headache and migraine.

Q. Do you have any recent or upcoming publications in print or review that we should look out for?

I have recently had 2 letters to the editor published on VAD stroke and chiropractic, and I am currently working on developing a risk assessment questionnaire for spontaneous VAD stroke. I also have some higher degree students working in the areas of the relationship of workplace factors to neck pain, and low back pain during pregnancy.

Q. What are the publications you are most proud of?

Aleksander Chaibi has recently finished 2 RCT’s on chiropractic treatment for migraine and cervicogenic headache, with the first one being published in the European Neurology Journal. He has also just submitted his PhD thesis, for which I was one of his supervisors. Alek is a clinician who also wanted to contribute to his profession by conducting research. We published his first articles on case reports from his clinic, and then we completed a systematic review of the literature on manual therapy for migraine, before he completed the RCT.

My RCT on chiropractic treatment for migraine (published in JMPT 2000), is still one of the largest studies conducted on SMT and migraine, and was the cornerstone of my PhD thesis. I was also happy that we had 2 stories on “A Current Affair” which at that time had over 1 million viewers. I believe these stories greatly improved the public’s knowledge about chiropractic treatment for migraine, and helped many chiropractors gain extra patients for their clinics.

Q. If you had to pick 3 papers in your area of interest that every chiropractor had to read, which 3 papers would you recommend?


Q. What are the upcoming topics of interest that the profession needs to fund and explore?

I am a clinical researcher, so I always promote clinical research, and believe that we can get more clinicians publishing their case reports. Once a patient case report gets published, it becomes data, even though the scientific quality is low. However, it also helps clinicians get a feel for research and improves their capability as a clinician. If every chiropractor in Australia published one case report each year, we could have 5000 case reports to analyse! I am happy to help clinicians publish case reports and get them started in providing more chiropractic research. If case reports don't get published, they remain stories (ie anecdotal evidence).

I am also involved in several research projects with Prof Pierre Cote and his team at University of Ontario Institute of Technology (UOIT), which is very exciting.

Q. How political is research? From my perspective, there are often times single case studies that blame chiropractors for causing stroke, with researchers later on looking at the same study and finding that either it was not a chiropractor who performed the treatment, or perhaps the time frame between treatment and onset of symptoms was many days or weeks later. Any reason you can think of that this happens?

I would like to think that research isn’t political, but it can certainly have bias. This bias may be intentional or accidental, but still alters the conclusions of the study. This is very common in VAD and chiropractic research, and was the reason why I replicated the 2007 Ernst study. There are unfortunately many examples in VAD and chiropractic research, and many of the so called “smoking gun” cases are in fact very poorly written. Meaning the conclusion of the case is often incorrect or very unclear. Chiropractors should always try to read the whole paper and if there are errors, or significant mistakes, then write a letter to the editor of the journal and point out the weaknesses (I am always happy to help with this).

Q. From my perspective, evidence based practice no longer seems to be a luxury, but rather a necessity. Any thoughts on how evidence based practice and research can empower our profession?

I could write pages on this! In my opinion, EBP is the best way to expand the significance of chiropractic and ensure more people see chiropractors for treatment. We have strong evidence to support chiropractic treatment for a range of MSK conditions (LBP, neck pain, HA, migraine, TMD, shoulder, etc). If we focus on these conditions and gain a significant market share, all chiropractors will be booked solid. That doesn’t mean we can’t treat other conditions. It is the emphasis that I think is the problem. By promoting or emphasizing cases in the media where the evidence is poor or sometimes non-existent, we raise the strong probability of being seen as un-scientific or quacks.

If you inform your patients that the evidence for treatment of a condition is poor, but they still want to trial treatment, then there are no issues. What would then be ideal is that the chiropractor WRITES A CASE REPORT ABOUT THE CASE! A published case report then becomes the beginning of evidence for the condition.

Q. Are there any words of wisdom for burgeoning researchers?

We need much more research and more researchers in chiropractic! But it is not as hard to get started in research as many people think. My suggestion is begin your journey by writing case reports, on a topic which interests you. Then you can complete a systematic review of the literature on your topic of interest (eg migraine), before trying to complete some clinical trials such as an RCT.

Q. Any other comments you’d like to make?

In my opinion, it is a critical time now for the chiropractic profession to create a plan for a way to move forward, and this could be a great opportunity for the chiropractic profession to take a big step forward.

As an Australian chiropractic researcher and academic clinician, I often feel very under supported by my profession. Many chiropractors spend $1000’s on personal development seminars, or seminars with dubious evidence based credentials. Yet, supporting high quality seminars or donating to granting bodies for chiropractic research get nothing!

At the recent COCA Biennial conference, where we had arguably the most credentialed chiropractor in the world (Prof Scott Haldeman), we had less than 200 chiropractors attend. Scott made the point, that if there were 1000 chiropractors attending, then COCA would have much more money to support research, which in turn supports the whole profession.

However, we also do not want to bring “researchers” or “experts” from overseas that do not have well established credentials. That is, do they hold university positions, are they active in research, where does their research get published, how much are they publishing, who are their academic advisors, are they “researchers” or “experts” from overseas.

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Scope of practice

By: Rod Bonello BSc(Syd), DO, DC(SCC), MHA(UNSW) FICC

On October 7th the Council on Australian Governments (COAG) Health Council reported the following:

“The Health Ministers agreed to ask for information from the Chiropractors Board of Australia (CBA) and the Australian Health Practitioner Regulation Agency (AHPRA) on evidence of any treatments provided by chiropractors that are not appropriately within the chiropractic scope of practice and may be harmful to patients. The agencies were asked to advise on potential regulatory responses.”

This followed public and stakeholder pressure on the Victorian Minister for Health. In reaction to the Rossborough incident. Memorably tagged by the media as “the crack heard round the world”, the YouTube video of chiropractor Ian Rossborough creating audible cavitation in a four-day old baby did indeed create a media storm internationally. The issues were safety, the making of unfounded claims and the appropriateness of spinal manipulation in newborns and infants. As a result Rossborough has had conditions placed on his practice by the Chiropractic Board of Australia. Essentially he is not permitted to examine and treat children. In addition, other chiropractors have been investigated and now the scope of pediatric practice is under scrutiny.

How has the profession reacted? Looked at globally this is a complex issue traversing several boundaries - political, social, ethical and so on. Initial knee-jerk reactions (and there have been a few) were inappropriate and unwise. Issues with this complexity and sensitivity must be carefully dissected and dealt with on principle.

First of all there was the understandable emotional reaction of viewers of the video who were aghast at the sight of a baby being hyperextended and its spine audibly cavitated. Even seasoned chiropractors experienced to the various noises that can be extracted from a spine were made queasy by the video. Imagine the reaction of mothers and others not used to spinal manipulation seeing this as their introduction to chiropractic. So, irrespective of other (more important) issues, the video was damaging to chiropractic on a prima facie basis.

The continued making of unfounded claims has been an embarrassment to the profession for some years now but the recent acute interest in this problem made the presence of the YouTube video most unfortunate. Chiropractors with the best intentions who genuinely advocate what they believe even when this goes against reasonable evidence, are doing themselves, their patients and this profession continued harm. It is a privilege to be a registered health care practitioner. It is a position of great respect in our community and it comes with responsibilities. Registered professionals cannot rely simply on what they believe, what they were taught many years ago, and the unfounded dogma that gurus in the profession promulgate.

All health care practitioners are expected to frame their diagnoses and proposed management against a background of scientific evidence and the experience of the profession in light of a patient-centred paradigm. Advocating profession-centric dogma is unacceptable in the modern health care system and is not compliant with the Board’s Code of Conduct.

The more thorny issue of scope of practice is now upon us. Should chiropractic include the care of neonates and infants? Of course. All paediatric conditions? Of course not. So how is scope properly determined? It hinges on the direction and quality of the evidence available. The evidence base for the care of the very young is less developed than for any other age group. Unfortunately for chiropractic it is limited in both volume and quality. Much of the research that has been published is generally of very poor quality and tends to appear in journals more concerned with waving a flag for chiropractic than genuine health science enquiry. We do have a wealth of anecdote, practitioner experience, happy patients and an enviable safety record. But we need so much more. This is because the plural of anecdote is not evidence.

Chiropractic Australia recommends that only those chiropractors who possess the appropriate training should provide such care and we will advocate for the continued right of chiropractors to care for patients of all ages. Where solid evidence is lacking practitioners must use their best judgment in determining if and how they can make a valuable contribution to patient care. However, in such cases patients and or parents and guardians must be informed that the proposed therapy is not supported by quality scientific evidence. Chiropractors are partners in the health care team and there is no place for practitioners who promote maverick interventions or denigrate other professionals and their treatments. Only by playing a responsible role will the rightful place of chiropractic in paediatric and other forms of care be determined.
The Integrative health care Model development & Evaluation project

Seeking the Views of Australian Health consumers and Health Care Providers on Integrative Health Care

Researchers from the University of South Australia, in partnership with Flinders University and Endeavour College, are looking for health consumers and health providers (from disciplines such as acupuncture, chiropractic, dentistry, dietetics, exercise physiology, general practice, western herbalism, homeopathy, massage therapy, naturopathy, occupational therapy, osteopathy, pharmacy, physiotherapy, podiatry, practice nursing, psychology and social work) to participate in an exciting new study that will examine the views and needs of health consumers and health care providers in relation to integrative health care - a new approach to delivering health services to Australians by bringing together a broader range of services to better meet the needs of health consumers. Findings from this research will be used to develop a new health care service delivery model for primary care.

If you are a health consumer (i.e. have used a health service within the last 12 months) or are a practitioner of one of the above disciplines (including clinicians and academics), the research team invites you to participate in a brief, 15-20 minute, online survey to explore your views and needs in regards to integrative health care. As a gesture of gratitude for your participation, participants completing the survey will be eligible to enter a draw to win one of ten $50 gift cards.

If you would like to participate in the project, please go to https://www.surveymonkey.com/r/IHCS However, if you have any questions or would like to receive more detailed information about the study, please go to the project website at www.time-project.net. Alternatively, you can email Dr Matthew Leach (Chief Investigator) at Dr.Matt.Leach@gmail.com


In a number of jurisdictions, chiropractors have developed advanced standards of practice including the ability to order advanced diagnostic imaging as well as prescription rights for a limited formulary of medications. Despite this, the right to prescribe medications continues to be a contentious issue for many in the chiropractic profession.

The objective of this commentary was to examine the arguments for and against limited medication prescription rights for chiropractors and to discuss the implications of implementing such privileges for the profession.

If limited to a musculoskeletal scope, medication prescription rights have the potential to change the present role of chiropractors within the healthcare system by paving the way for practitioners to become comprehensive specialists in the conservative management of spine / musculoskeletal disorders. This is in keeping with a current move within the profession towards “rebranding” itself with more of a musculoskeletal scope. Limited prescribing rights for chiropractors could also benefit patients and the healthcare system by providing potential cost savings, more streamlined care plus reduced waiting times for patients, and an overall positive influence on public health. However, if the chiropractic profession wishes to expand its scope of practice to include limited prescriptive authority, necessary changes to chiropractic education and legislation must be addressed. For this, the profession could look to Switzerland where an excellent educational and legislative model for chiropractic has been developed.

Chiropractors who wish to pursue limited prescriptive authority should lobby their professional associations and regulatory bodies to engage in dialogue with like-minded politicians and third-party payers to highlight and promote the benefits of making such changes to the existing healthcare system. Prior to this, discussions should take place within the chiropractic profession so as to ensure that a uniform stance is taken on whether or not medication prescription should be implemented in different jurisdictions. This would ensure that governing bodies can fulfill the wishes of their individual members. One way of determining how the profession and its individual members want to move forward on this topic would be through national surveys conducted by relevant associations.
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I must start by saying that when I set out to write this article, I thought I would easily find guidelines in the literature to summarise and provide an easy ‘go-to’ formula for stretching. The literature, however, is not clear-cut and leaves a fair bit to be desired. So take this as an exploration of why we should stretch, and what potential benefits stretching may have.

The type of stretching we do generally falls into one of four categories:

1. **Static** – slowly lengthening the muscle until a stretch or resistance is felt and holding for a period of time.
2. **Dynamic** – Moving through a range of movement in a controlled fashion, gradually increasing the degree of movement performed. It is often sports specific, such as lunging side to side before volleyball.
3. **Proprioceptive Neuromuscular Facilitation (PNF)** – A combination of active and passive movements, as well as a held stretch. Can involve concentric, isometric or eccentric contractions of the muscle depending on which technique is being used. Common PNF protocols are Hold-Relax, Contract-Relax and Contract-Relax-Agonist-Contract.
4. **Active Isolated Stretching (AIS)** – where multiple repetitions of a 2 second or less duration of stretch are performed, whilst also contracting the agonist muscle. (Longo, 2009)

There are a number of proposed theories as to how stretching works, mostly focusing on mechanical changes within the muscle and surrounding tissue. The viscoelastic deformation theory relates to the change in muscle length over time. As a tensile force is applied to a muscle, its resistance to stretch will gradually decrease and hence an immediate change in the muscle tendon unit (MTU) length occurs. This is a transient deformation. Another theory is that there is a permanent change in the connective tissue within the muscle, called plastic deformation. For this to actually occur there would have to be a sufficient enough intensity of the stretch to move past the muscle’s elastic limit and into its plastic region. After the stretch force is removed the muscle would not return to its original length.

Once again, there is no existing evidence for this theory.

Looking at animal studies and long-term immobilization of a limb in a fully extended position, it was found that such a position increased the number of sarcomeres in a series, and therefore should increase the length of the muscle. This increase in the number of sarcomeres was, however, offset by a decrease in the length of the individual sarcomeres, and hence the total length remained the same (Weppner & Magnusson, 2010).

Finally the neuromuscular relaxation theory suggests that a muscle’s reflex involuntary contraction when a stretch is applied is gradually decreased over time and would therefore increase muscle extensibility (Weppner & Magnusson, 2010).

As far as we currently know, the above theories, although occurring to various degrees, are transient and some might not occur at all. So perhaps the changes to flexibility and attainable muscle length are not mechanical, but neurological? Put simply; over time our perception and tolerance to stretch changes. Studies found that there was no change in the tension curves for muscles after stretching.

A shift to the right would indicate a physically longer muscle; but this did not occur. Instead, the subjects being studied reported the stretch/pain/discomfort sensation later along the curve. Their body and their nervous system’s tolerance to tension seems to have increased (Weppner & Magnusson, 2010).

The effects stretching (mainly static) can have on flexibility, sports performance and injury rates have been widely researched. A systematic review by Thacker et al (2004) found that ‘by whatever method was used… stretching was demonstrated to increase joint flexibility...’ This is helpful because for some clients prescribing a more complex stretch may lead to poor compliance. If they are more likely to actually do a static stretch then prescribe that, as it will still help. There is some reported evidence that PNF stretching is more effective, however, it is not demonstrated consistently. Once again, this may be due to the more complex nature of the intervention. Thacker et al’s (2004) findings suggested that a 15s or 30s passive stretch is more effective than shorter duration stretches but just as effective as a longer duration. In an earlier study, Bandy et al (1997), concluded the same; 30 seconds was an effective duration of stretch of the
hamstrings, with no greater change for a 60s stretch or if frequency was increased to 3 times a day. The length of time post stretching that the increased flexibility lasted ranged from 6-90 minutes, however an extensive stretching program over many weeks produced flexibility increases that persisted for several weeks (Thacker et al 2004).

There has been a lot discussions suggesting that ‘acute stretching’ (stretching done within an hour before the activity) diminishes performance. Shrier (2004) found that one bout of static stretching had a negative effect on maximum voluntary contraction, power, jump height, jump force, and jump velocity. However both Kay & Blazevich (2012) and Simic et al (2013) found that static muscle stretches totalling <45 seconds can be used in pre-exercise routines without risk of significant decreases in strength-, power-, or speed-dependent tasks. Outside of the sporting arena, regular stretching such as that done after training or at home may be beneficial, with Shrier (2004) suggesting that it can improve force, jump height, and speed over time. Of interest may also be that most studies of stretching and performance are over time. Of interest may also be that most studies of stretching and performance are measuring skills requiring concentric muscle contraction. As we know muscular strains often occur during an eccentric load on the muscle and so research into this might give us a better picture of the overall effects of stretching prior to sports.

There is quite conflicting evidence on stretching and the effects on injury rates, from having no effect, to Behm et al (2016) suggesting that stretching negatively influences injury risk. Witvrouw et al (2004) provided a quite interesting suggestion that could perhaps explain some of this conflicting evidence. They classified sports as those that involve a lot of bouncing and jumping, therefore having a high intensity of MTU stretch-shortening cycles (SSC) e.g. sports such as soccer and football, and those with a low intensity or limited SSC – e.g. jogging, cycling, swimming. The first group requires a MTU that is compliant enough to store and release high amounts of elastic energy. They therefore conclude that the rationale for injury prevention in this group is to increase the compliance of the MTU. Conversely the second group does not necessarily require a very compliant MTU, and as such stretching (and making the tendon unit more compliant) may not be advantageous. This theory was also explored by Behm et al (2016), suggesting that ‘pre-activity stretching may be beneficial for injury prevention in sports with a sprint running component but not in endurance based running activities with a predominance of overuse injuries.’

Considering all these studies, the question stands – what type of stretching and when? Of course it’s not a clear-cut answer, and will depend on the type of activity it precedes. McHugh and Cosgrave (2010) suggest a warm up which:

• Targets muscle groups known to be at risk for that sport. E.g. hamstrings in soccer and AFL

• Applies at least 4-5 60 second stretches to pain tolerance on both sides in order to decrease passive resistance to stretch (I would question this and suggest no more than 45sec, as was discussed earlier in terms of effects on sports performance)

• Includes drills: After stretching, perform some dynamic pre-participation drills to reduce any lingering stretch induced strength loss

• Is Multi-modal: Avoid Static Stretching as the sole form of warm-up

As a side note I also looked into foam rolling and the literature behind it. Beardsley & Skarabot (2015) and Schroeder & Best (2015) concluded that self-myo-fascial release had an acute effect of increased flexibility and reduced muscle soreness but did not impede athletic performance. The long-term effects have not been investigated, and the optimal timing and duration of the rolling has also not been determined. Peary et al (2015) found that foam rolling had a positive effect in reducing delayed onset muscle soreness in the recovery period after a weighted squat workout.

In clinic we should encourage a regular home/ post-exercise stretching program which incorporates static stretching, PNF and AIS, depending on the clients abilities. As musculoskeletal specialists we should easily be able to identify which muscles are at risk of injury during the client’s sports activity and encourage them to include pre-participation static stretching of these muscles (<45 sec duration), followed by a dynamic warm up. As part of recovery we could teach foam rolling or other self-myo-fascial release techniques.

References
A report was posted on the WHO website in September 2016 by Dr Chan (WHO Director-General) and Mr Bloomberg (WHO Global Ambassador for Non-communicable Diseases [NCDs]) about the importance of using political influence to win the fight against non-communicable diseases (aka chronic diseases).

http://www.who.int/mediacentre/commentaries/political-noncommunicable-diseases/en/

They discussed how the modern way of life has contributed to many non-communicable diseases (NCDs). These chronic, lifestyle-related diseases i.e. heart disease, stroke, cancer and diabetes have become the deadliest diseases of modern times.

Rating NCDs as the “world’s biggest killers is fueled largely by air pollution, tobacco and alcohol use, and unhealthy diets that are heavy on highly processed foods rich in fat, sugar and salt”. The modern sedentary lifestyle has also played a huge role, and has contributed to the obesity epidemic.

According to the WHO there is good news, in that many of these diseases can be prevented by making healthy lifestyle choices. The WHO is urging leaders around the world to tackle this increasing NCD crisis by introducing population-wide measures that make healthy lifestyle activities more accessible to everyone.

Furthermore, the WHO has “issued recommendations for protecting children from unhealthy foods and beverages, including removing sugar-sweetened beverages from schools and implementing restrictions on the marketing of these products”.

The WHO wants governments to “ensure that children have safe places to play, encourage people to cycle and walk, and address urban “food deserts” that offer abundant junk food but little fresh fruits and vegetables”.

Having read that report, I thought it was important to share it with you. I believe chiropractors are in the perfect position, as primary health care practitioners/providers, to advise their patients about healthy lifestyle activities. I would also like to share with you what I am doing to contribute towards the solution to this global crisis.

As some of you know, I am passionate about making a difference to the lives of children with Attention Deficit Hyperactivity Disorder (ADHD). My own daughter was diagnosed with ADHD in 1994, and that is where my journey began. In 2005, I enrolled in the Department of Chiropractic at Macquarie University to undertake a Masters of Science via research. I conducted an RCT in paediatric ADHD. What I discovered after reading the extensive literature on ADHD was that many lifestyle activities impact the behaviour and learning of children with ADHD.

As a result, I used my personal, clinical and research experience and created a series of evidence-based children’s books called “But why…?”

This series includes important lifestyle activities that are designed to enhance the lives of children with or without ADHD between the ages of 4 and 8. There are six books in the series with Book 1 introducing the characters and the themes while the other five books cover the important areas of: nutrition, exercise, relaxation and sleep as well as learning. The books are filled with simple, practical and fun ways to inspire both parents and children to make healthy lifestyle choices.

If you are interested in taking a look at the healthy lifestyle activities outlined in the book series, please go to my website and download a free copy of Book 1 called: “But why… HELP like that?” http://www.butwhyseries.com/bookpreview

For those of you who place an order on my website, I will donate 10% of proceeds to the COCA Research Fund. Please place the code: COCA after your name when you make your payment. This will show that I need to make a donation to COCA Research Fund.

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CONSENSUS ON THE CLINICAL DIAGNOSIS OF LUMBAR SPINAL STENOSIS: RESULTS OF AN INTERNATIONAL DELPHI STUDY.

OBJECTIVE: The aim of this study was to obtain an expert consensus on which history factors are most important in the clinical diagnosis of lumbar spinal stenosis (LSS).

SUMMARY OF BACKGROUND DATA: LSS is a poorly defined clinical syndrome. Criteria for defining LSS are needed and should be informed by the experience of expert clinicians.

METHODS: Phase 1 (Delphi Items): 20 members of the International Taskforce on the Diagnosis and Management of LSS confirmed a list of 14 history items. An online survey was developed that permits specialists to express the logical order in which they consider the items, and the level of certainty ascertained from the questions. Phase 2 (Delphi Study) Round 1: Survey distributed to members of the International Society for the Study of the Lumbar Spine. Round 2: Meeting of 9 members of Taskforce where consensus was reached on a final list of 10 items. Round 3: Final survey was distributed internationally. Phase 3: Final Taskforce consensus meeting.

RESULTS: A total of 279 clinicians from 29 different countries, with a mean of 19 (±SD: 12) years in practice participated. The six top items were "leg or buttock pain while walking," "flex forward to relieve symptoms," "feet relief when using a shopping cart or bicycle," "motor or sensory disturbance while walking," "normal and symmetric foot pulses," "lower extremity weakness," and "low back pain." Significant change in certainty ceased after six questions at 80% (P < .05).

CONCLUSION: This is the first study to reach an international consensus on the clinical diagnosis of LSS, and suggests that within six questions clinicians are 80% certain of diagnosis. We propose a consensus-based set of "seven history items" that can act as a pragmatic criterion for defining LSS in both clinical and research settings, which in the long term may lead to more cost-effective treatment, improved health care utilization, and enhanced patient outcomes.

Tomkins-Lane, C et al., Consensus on the Clinical Diagnosis of Lumbar Spinal Stenosis: Results of an International Delphi Study. Spine: 1 August 2016 - Volume 41 - Issue 15 - p 1239–1246

PREVALENCE AND LOCATION OF NEUROPATHIC PAIN IN LUMBAR SPINAL DISORDERS: ANALYSIS OF 1804 CONSECUTIVE PATIENTS WITH PRIMARY LOWER BACK PAIN.

STUDY DESIGN: A cross-sectional study of 1804 consecutive patients.

OBJECTIVE: The aim of this study was to investigate the prevalence of pathological pain and its distribution features in patients with chronic lumbar spinal disorders.

SUMMARY OF BACKGROUND DATA: Clinical spinal disorders can involve pathological neuropathic pain (NeP) as well as physiological nociceptive pain (NocP), as they have varied pathology, including spinal cord injury, stenosis, and compression. A study conducted by the Japanese Society for Spine Surgery and Related Research (JSSR) has determined a prevalence of 29.4% for NeP in patients with lumbar spinal disorder. However, the data did not include information on pain location.

METHODS: Patients aged 20 to 79 years with chronic lower back pain (≥3 months, visual analog scale score ≥30) were recruited from 137 JSSR-related institutions. Patient data included an NeP screening questionnaire score and pain location (lower back, buttock, and legs). The association between the pain pathology and its location was analyzed statistically using the unpaired t test and Chi-square test followed by Fisher test. P < .05 was considered significant.

RESULTS: Low back pain subjects showed 31.9% of NeP prevalence, and the pain distribution showed [NocP(%)/NeP(%)]: low back pain only cases: 44/22, while low back pain with leg pain cases showed a prevalence of 56/78. This indicates that low back pain alone can significantly induce NocP rather than NeP (P < .01). Buttock pain was revealed to significantly induce both lower back pain and leg pain with NeP properties (P < .01). Leg pain was revealed to be predominantly neuropathic, especially when it included peripheral pain (P < .01).

CONCLUSION: Low back pain with no buttock pain induces NocP rather than NeP. Buttock pain is significantly associated with NeP prevalence whether or not leg pain exists. Leg pain can increase the prevalence of NeP, especially when it contains a peripheral element.


HOW EFFECTIVE IS PHYSICAL THERAPY FOR COMMON LOW BACK PAIN DIAGNOSES?: A MULTIVARIATE ANALYSIS OF 4597 PATIENTS.

OBJECTIVE: The aim of this study is to evaluate whether the treatment of low back pain with physical therapy results in clinically significant improvements in patient-reported pain and functional outcomes.

SUMMARY OF BACKGROUND DATA: Low back pain is a major cause of morbidity and disability in health care. Previous studies have found poor efficacy for surgery in the absence of specific indications. A variety of nonoperative treatments are available; however, there is scant evidence to guide the practitioner as to the efficacy of these treatments.

METHODS: Four thousand five hundred ninety-seven patients who underwent physical therapy for the nonoperative treatment of low back pain were included. The primary outcome measures were pre-and post-treatment scores on the Oswestry Disability Index (ODI), Numeric Pain Rating Scale (NPRS) during activity, and NPRS during rest. Previously published thresholds for minimal clinically important difference (MCID) were used to determine the proportion of patients meeting MCID for each of our outcomes. Patients with starting values below the MCID for each variable were excluded from analysis. Logistic regression analysis was used to determine patient risk factors predictive of treatment failure.

RESULTS: About 28.5% of patients met the MCID for improvement in ODI. Presence of night symptoms, obesity, and smoking

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Abstracts

RESEARCH NEWS

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RESULTS: About 28.5% of patients met the MCID for improvement in ODI. Presence of night symptoms, obesity, and smoking
were predictors of treatment failure for ODI. Fifty-nine percent of patients met the MCID for improvement in resting NPRS, with a history of venous thromboembolism, night symptoms, psychiatric disease, workers’ compensation status, smoking, and obesity predictive of treatment failure. Sixty percent of patients met the MCID for improvement in activity NPRS, with night symptoms, workers’ compensation status, and smoking predictive of treatment failure.

**CONCLUSION:** We observed that a substantial percentage of the population did not meet MCID for pain and function following treatment of low back pain with physical therapy. Common risk factors for treatment failure included smoking and presence of night symptoms.


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**Systematic Reviews**

**ACCURACY OF MAGNETIC RESONANCE IMAGING IN DETECTING LUMBO-SACRAL NERVE ROOT COMPROMISE: A SYSTEMATIC LITERATURE REVIEW.**

MRI is considered to be the diagnostic tool of choice in diagnosing nerve root compromise among patients presenting with clinical suspicion of lumbo-sacral radiculopathy. There exists controversy among researchers and clinicians regarding the diagnostic utility and accuracy of MRI in detecting nerve root compromise and radiculopathy. This review evaluated 4 primary diagnostic accuracy studies that specifically assessed the accuracy of MRI in detecting nerve root compromise, as established in the current literature.

Only four studies qualified for inclusion in this review. The sensitivity of MRI in detecting lumbar nerve root compromise was very low at 0.25 (95% CI) while the specificity was relatively high at 0.92 (95% CI).

The authors concluded that there is lack of sufficient high quality scientific evidence in support or against the use of MRI in diagnosing nerve root compression and radiculopathy. Therefore, clinicians should always correlate the findings of MRI with the patients’ medical history and clinical presentation in clinical decision making.

Nassib Tawa Email et al. *Accuracy of magnetic resonance imaging in detecting lumbo-sacral nerve root compromise: a systematic literature review.* BMJ Musculoskeletal Disorders. 2016

**COMPLEMENTARY THERAPIES IN ADDITION TO MEDICATION FOR PATIENTS WITH NON-CHRONIC, NON-RADICULAR LOW BACK PAIN. A SYSTEMATIC REVIEW.**

The aim of this systematic review was to address the following question: among patients with non-chronic LBP, does spinal manipulation, massage, exercise, or yoga, when combined with standard medical therapy, improve pain and functional outcomes more than standard medical therapy alone. It is concluded that for patients with non-chronic, non-radiculotomous low back pain, available evidence does not support the use of spinal manipulation or exercise therapy in addition to standard medical therapy. There is lacking proof to figure out whether yoga or massage is valuable.


**SELF-MANAGEMENT PROGRAM FOR CHRONIC LOW BACK PAIN: A SYSTEMATIC REVIEW AND META-ANALYSIS.**

This systematic review aimed to investigate the efficacy of self-management programs (SMPs) on chronic low back pain (CLBP). As per the outcomes, for CLBP patients, there is moderate-quality evidence that SMP has a moderate effect on pain intensity, and small to moderate effect on disability.


**THE PREVALENCE OF PATELLOFEMORAL OSTEOARTHRITIS: A SYSTEMATIC REVIEW AND META-ANALYSIS. OSTEOARTHRITIS AND CARTILAGE.**

The aim of this study, with the use of population and symptom–based cohorts, was to assess and to analyse, the prevalence of radiographic patellofemoral osteoarthritis (OA) and whether knee pain, physical function and quality of life (QOL) differ between people with isolated patellofemoral OA, isolated tibiofemoral OA and combined patellofemoral and tibiofemoral OA, respectively. Results suggest the substantial prevalence of patellofemoral OA, demonstrating the need to specifically consider the patellofemoral joint in knee OA research and clinical settings.


**THE EFFICACY OF INTRA-ARTICULAR STEROIDS IN HIP OSTEOARTHRITIS: A SYSTEMATIC REVIEW.**

In light of the findings, in spite of poor evidence, this study suggests that hip intra–articular steroid injection (IASI) may be efficacious in short–term pain reduction in those with hip osteoarthritis (OA). In order to confirm, if intra–articular corticosteroids are beneficial and to what extent, further large, methodologically rigorous trials are necessary.


**MOTOR CONTROL EXERCISES (MCE) FOR NSLBP: A COCHRANE REVIEW**

The authors included 32 trials (n = 2628) in this Cochrane review. They concluded that MCE is probably more effective than a minimal intervention for reducing pain, but
probably does not have an important effect on disability, in patients with chronic LBP. There was no clinically important difference between MCE and other forms of exercises or manual therapy for acute and chronic LBP.


**SYSTEMATIC REVIEW OF PATIENT HISTORY AND PHYSICAL EXAMINATION TO DIAGNOSE CLBP ORIGINATING FROM THE FACET JOINTS.**

Patient history and physical examination are frequently used procedures to diagnose chronic low back pain (CLBP) originating from the facet joints, although the diagnostic accuracy is controversial. The aim of this systematic review is to determine the diagnostic accuracy of patient history and/or physical examination to identify CLBP originating from the facet joints using diagnostic blocks as reference standard. Due to clinical heterogeneity, the evidence for the diagnostic accuracy of patient history and/or physical examination to identify facet joint pain is inconclusive. Patient history and physical examination cannot be used to limit the need of a diagnostic block. The validity of the diagnostic facet joint block should be studied, and high quality studies are required to confirm the results of single studies.

**SIGNIFICANCE:** Patient history and physical examination cannot be used to limit the need of a diagnostic block. The validity of the diagnostic facet joint block should be studied, and high quality studies are required to confirm the results of single studies.

Maas ET et al., *Systematic review of patient history and physical examination to diagnose chronic low back pain originating from the facet joints*. Eur J Pain. 2016 Oct 10

**FAI SURGERY COMES UNDER THE SPOTLIGHT**

A systematic review was regulated to look at the proof for surgical and non–surgical treatment of FAI on symptom and structural outcomes. This review highlights the lack of evidence for use of surgery in femoroacetabular impingement (FAI). Further to this, hip geometry may be modified by non–surgical factors, clearing up the part of non–surgical approaches vs surgery for the management of FAI is warranted.


**FROZEN SHOULDER REMAINS SOMEWHAT OF A MYSTERY**

Authors in this systematic review presented a report about the tissue pathophysiology of primary frozen shoulder. Studies are required to investigate changes in naive tissue at different stages of the condition.


**HOW EFFECTIVE IS PHYSICAL THERAPY FOR COMMON LOW BACK PAIN DIAGNOSES?**

These researchers looked at predictors that made a minimal clinical important difference (MCID) using the Oswestry Disability Inventory (ODI). About 28.5% of patients met the MCID for improvement in ODI. Presence of night symptoms, obesity, and smoking were predictors of treatment failure for ODI. 59% percent of patients met the MCID for improvement in resting NPRS, with a history of venous thromboembolism, night symptoms, psychiatric disease, workers’ compensation status, smoking, and obesity predictive of treatment failure. Sixty percent of patients met the MCID for improvement in activity NPRS, with night symptoms, workers’ compensation status, and smoking predictive of treatment failure. They concluded that a substantial percentage of the population did not meet MCID for pain and function following treatment of low back pain with physical therapy. Common risk factors for treatment failure included smoking and presence of night symptoms.

INCREASED BMI IS ASSOCIATED WITH GREATER LEG PAIN IN PEOPLE WITH SPINAL CONDITIONS.
This prospective observational study intended to identify the association between obesity, quantified by body mass index (BMI), and both back and leg pain in spinal patients. The study found that obesity, as measured by increased BMI, was associated with greater leg pain.
Segar AH, et al. The association between body mass index (BMI) and back or leg pain in patients with spinal conditions: Results from the Genodisc Study. Spine, 10/14/2016

PATIENTS BELIEVE ALTERNATIVE THERAPIES WORK AS WELL AS SURGICAL ALTERNATIVES
A prospective observational study was performed to determine pain, functional disability, surgical status, and health care use of patients who actively selected complementary and alternative medicine treatment and risk factors for lumbar surgery. Results demonstrated were favourable and satisfaction rates were high.

COST-EFFECTIVENESS OF NON-INVASIVE AND NON-PHARMACOLOGICAL INTERVENTIONS FOR LOW BACK PAIN: A SYSTEMATIC LITERATURE REVIEW.
The authors conducted a systematic review which aimed to recognize, document and appraise studies reporting on the cost effectiveness of non–invasive and non–pharmacological treatment options for low back pain. The outcomes highlighted that combined physical and psychological treatments, medical yoga, information and education programmes, spinal manipulation and acupuncture are likely to be cost–effective options for low back pain.

THE COMPARISON OF BEDSIDE POINT-OF-CARE ULTRASOUND AND COMPUTED TOMOGRAPHY IN ELBOW INJURIES. MORE AND MORE USES IN MSK PRACTICE?
The researchers’ motive behind this study was to analyse the adequacy of point–of–care ultrasound (POCUS) and computed tomography (CT) in the diagnosis of the fracture of the bones that form the elbow joint and the determination of treatment method in elbow injuries. This study concluded that POCUS was appeared to be effectively connected in the diagnosis and management of elbow injuries in which direct radiography (DR) was inefficient and CT scans were needed.

WHICH LEVEL IS RESPONSIBLE FOR GLUTEAL PAIN IN LUMBAR DISC HERNIA?
There are many different reasons why patients could be experiencing pain in the gluteal area. Previous studies have shown an association between radicular low back pain (LBP) and gluteal pain (GP). Studies locating the specific level responsible for gluteal pain in lumbar disc hernias have rarely been reported.

286 cases of lumbar disc herniation (LDH) in the Kanghua hospital from 2010 to 2014 were recruited. All patients underwent a lumbar spine MRI to clarify their LDH diagnosis, and patients were allocated to a GP group and a non-GP group. To determine the cause and effect relationship between LDH and GP, all of the patients were subjected to percutaneous endoscopic lumbar discectomy (PELD).
In the GP group, 159 cases involved the L4/5 level and 9 cases involved the L5/S1 level, while in the non-GP group, 43 cases involved the L4/5 level and 48 cases involved the L5/S1 level. PELD was performed in both groups. Gluteal pain gradually disappeared after surgery in all of the patients. Gluteal pain recurred in a patient with recurrent disc herniation (L4/5).
Guofang Fang, et al., Which level is responsible for gluteal pain in lumbar disc hernia? BMC Musculoskeletal Disorders. 2016

A PILOT STUDY INVESTIGATING A PROMISING APPROACH FOR THE MANAGEMENT OF CHRONIC LOW BACK PAIN.
In this study, authors examined the exploratory performance of a patient–led goal–setting intervention on bettering disability and pain in chronic low back pain. The goals of this study are based on patients’ personal preferences, and not on treatment guidelines, hence confirmed that a patient–centered goal–setting intervention is a substantially beneficial intervention for the management of chronic low back pain displaying remarkable development in both quality of life and pain intensity.

PAIN DISTRIBUTION IN PRIMARY CARE PATIENTS WITH HIP OSTEOARTHRITIS.
The centre of this study was to portray pain location and pain distribution in primary care patients with clinical and radiographic affirmed hip OA. The most common pain locations of patients with hip OA showing to primary care are the greater trochanter, groin, thigh and buttock areas. No patients recorded pain exclusively in the knee or lower leg.

LARGE VARIABILITY IN MEASURING LUMBAR LORDOSIS AND ROM EVEN ON THE SAME DAY!
Aim of this study was to correlate the consistency in lumbo–pelvic posture and movement in people with and without chronic
low back pain. As per the results, lordosis, range of movement and lumbo–pelvic rhythm typically demonstrate variability between same–day and different–day tests. This variability needs to be considered when interpreting posture and movement changes.


THE ECONOMIC BURDEN OF GUIDELINE-RECOMMENDED FIRST LINE CARE FOR ACUTE LOW BACK PAIN.

Study intended to address health care costs and the factors correlated with such costs in people with acute low back pain receiving guideline–recommended first line care. The results of this study displayed that, taking paracetamol as part of first line care for acute low back pain increased the economic burden. Higher disability, longer symptom duration and receiving compensation were independently associated with increased health care costs.

The mean cost per participant was AUD167.74 (SD = 427.24) for the entire cohort (n = 1365). Most of these costs were incurred in primary care through visits to a general practitioner or physiotherapist. Correlated to the placebo group, there was an increase in cost when paracetamol was taken. This analysis indicated that disability, symptom duration and compensation were correlated with costs. Receiving compensation was correlated with a twofold increase compared to not receiving compensation.


And Furthermore...

HIGH RED MEAT INTAKE AND ALL-CAUSE CARDIOVASCULAR AND CANCER MORTALITY: IS THE RISK MODIFIED BY FRUIT AND VEGETABLE INTAKE?

For this study, researchers assessed two large prospective cohorts of Swedish men and women (the Swedish Mammography Cohort and the Cohort of Swedish Men) to figure out if the relationship between red meat intake and the risk of all–cause, CVD, and cancer–specific mortality differs across amounts of FV consumption. High intakes of red meat were connected with a higher risk of all–cause and CVD mortality. The expanded dangers were reliably seen in members with low, medium, and high FV intake


CHEESE CONSUMPTION AND RISK OF CARDIOVASCULAR DISEASE: A META-ANALYSIS OF PROSPECTIVE STUDIES.

For this study, researchers directed a meta–analysis of prospective observational studies to assess the dangers of total CVD, coronary heart disease (CHD), and stroke connected with cheese consumption.

Results showed that a total 15 planned studies was included in the final investigations. The majority of the studies avoided prevalent CVD at baseline (14/15) and had a duration >10 years (13/15). The restricted cubic model showed proof of nonlinear connections between cheese intake and risks of total CVD and stroke, with the biggest danger decreases seen at the intake of roughly 40 g/d


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CHOCOLATE INTAKE AND INCIDENCE OF HEART FAILURE: FINDINGS FROM THE COHORT OF SWEDISH MEN.

For this study, researchers assess the relationship of chocolate intake and heart failure in a large population of Swedish men. In this large prospective cohort study, there was a J-shaped relationship between chocolate consumption and HF (heart failure) incidence. Moderate chocolate consumption was connected with a lower rate of HF hospitalization or death, however, the protective affiliation was not seen among individuals consuming ≥1 servings every day.


CHEESE CONSUMPTION AND RISK OF CARDIOVASCULAR DISEASE: A META-ANALYSIS OF PROSPECTIVE STUDIES. EUROPEAN JOURNAL OF NUTRITION
FOR SALE

VIC – ESSENDON: Freehold Medical/Consulting Rooms at 143 Lincoln Road, Essendon Auction – Friday 16th December at 1.00pm. Substance corner block in the heart of Essendon North Village presenting an attractive investment opportunity along with future development prospects. Currently leased as a dental surgery. Contact agent NELSON ALEXANDER on (03) 9379 1313

NSW – LANE COVE: Chiropractic ABCO table for sale. Three drop pieces. Back in colour. The table was purchased second hand 4 years ago. There is some minor wear and tear. Located in Lane Cove (Sydney). Pick up only $4000 ono melorin.kheradi@gmail.com or 0421 551 257

BUSINESSES FOR SALE

NSW – SANS SOUCI: Pricedrop! Three generous treatment rooms and kitchen. 2 hydraulic tables, acupuncture machine and other equipment included. Also sells retail products. Price includes all equipment, fit out and clientele base – Modern fit out – Easy parking at the front and rear of the shop. Price 40K. For further enquiries please call Anne on 0410 619 469

ASSOCIATES REQUIRED

SA – NOARLUNGA: Southside Health Care requires an associate / long term locum. Our current associate will be going on maternity leave commencing April 2017. As such, we require a long term locum (at least four months) or a new associate to look after her busy patient base. Our current associate is part-time but there is plenty of scope to expand to a full-time position should this suit the successful applicant. Given our clinic’s emphasis on sports chiropractic, we are ideally located within a major health complex with a pool, gym & numerous other sporting facilities. Good manual adjusting skills are essential. Contact Ben 0410 415 970 or ben@southsidechiropractic.com.au

NSW – NORTHERN BEACHES: Coastal Chiropractic has an opportunity for a motivated and energetic chiropractor to join their clinic in either part or full time capacity. This position will best suit a female practitioner with excellent manual adjusting skills, experience with cranial work and an interest in family care. Contact Stacey at stacey@saunders.com.au or 0416 078 245

VIC – BLACK ROCK: It’s Your Time To Shine! We are a multimodality natural health clinic located in Black Rock, Melbourne looking for a Chiropractor with outstanding skills to join our team. As our principle chiropractor, your opportunity for success is outstanding. The successful applicant will be a self motivated, confident, enthusiastic Chiropractor who is passionate about chiropractic care, educating their community and who is committed to building on an existing patient base and creating a successful practice. If this sounds like you please send your CV to mart@shinehealthwellbeing.com.au or call 0402 277 294 to learn about this position.

NSW – NORTH RYDE: We are seeking an enthusiastic and highly motivated chiropractor for a part or full time position to take over an existing patient base in North Ryde. Must be proficient in manual adjusting and helping with marketing is essential. Excellent remuneration. Please contact Fiona on 0421 195 503 or fiona@riversidechiropractic.com.au

NSW – NEWCASTLE: We are looking for a Chiropractor or Osteopath to join our well-established practice located in Newcastle. We are seeking a confident, passionate and highly motivated Chiropractor to join our expanding team. The ideal candidate should be someone who wants a long-term position, who is self-motivated, mature and good-natured. The successful applicant must demonstrate strong manual adjusting skills, be proactive, and confident to build relationships with patients. The new associate will be taking on some of the primary chiropractor’s clients, as well as building their own clientele from our regular influx of new patients. Both experienced and new graduates are welcome to apply. Send your CV to innerwestchiro@gmail.com

QLD – MT SAMSON: Associate wanted: semi rural community but only 30 minutes from Brisbane CBD. The practice focuses on family wellness utilising low force techniques. The right associate would take over a portion of our existing patients while establishing own patient base. We believe that an enthusiastic person with a relaxed and friendly attitude would be extremely successful in growing their side of the practice. Initial remuneration and percentage would be discussed upon meeting. If you are interested please email us at samfordchiro@gmail.com

WA – PERTH: Exceptional Associate Opportunity in Perth’s Fastest Growing Residential Area A full-time position has become available for a passionate and wellness-oriented associate with an interest in integrated healthcare in Perth’s north-eastern suburbs. The successful applicant will be working with a group of wellness professionals with years of experience and should be highly motivated, with knowledge of diversified, drop piece and activator. The position requires one who is willing to be mentored whilst working with a team, as well as being self-motivated. Experience is preferred but enthusiastic graduates may also apply. Expressions of interest should be mailed to Elena at ellenbrookwellness@gmail.com or (08) 9296 7999.

VIC – CROYDON: Associate Chiropractor/Osteopath wanted – Commencing Feb. 2017 Unique opportunity in a 45yr old multi-modality Chiropractic & Natural Therapy Clinic. Owner is retiring overseas. The successful candidate has a permanent long term opportunity with tremendous growth potential, and an opportunity to buy into the practice once proven. Must have soft tissue and dry needling skills. Minimum 20 minute appointments. Email your CV to Dr Ray Dixon at: drray@netspace.net.au

QLD – BRISBANE: An established family practice, over 30 years on the north side of Brisbane, is looking for an enthusiastic Chiropractor available a few days per week, to take over from a current associate recovering from an operation and to help with patient load whilst principal chiropractor is on maternity leave. With new patients joining us each week we hope that the right chiropractor will continue with us for the long term. Immediate start. The successful applicant would be passionate and motivated with strong manual adjusting skills. We’re looking for a long-term practitioner with a proactive approach to building a successful practice. Please email CV to: reception@healthandwellnessnorthside.com.au

NSW – SYDNEY INNER WEST: Outstanding Associate Opportunity – Sydney Inner West – Take over from existing full time chiropractor – High income position. Associate positions like this do not come up very often! We are looking for an experienced Chiropractor with well honed adjusting, diagnostic, and interpersonal skills. We are offering a full time associate position. We need a career Chiropractor to take over an existing full time patient load. Our practice is well supported by other professionals and administration and reception staff. This is a lucrative position for an experienced professional who wants to work hard in inner Sydney. (May also be split into 2 part time positions). Please contact Sue Kelly on 0413 131 238 without delay. (Due to the autonomy required in this position we regret that applications from new graduates cannot be considered. Please accept our apologies)

NSW – QUEANBEYAN: Are You Looking for an Exciting, Growth-Centred and Patient-Oriented Career Opportunity? We are seeking a passionate, wellness-oriented chiropractor to join our team. Wonderful learning opportunities, amazing patients and excellent earning potential. Experienced or new graduate applications welcome. Email info@int.com.au or view www.int.com.au
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