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## *e-Journal*

Quarterly Journal of ACO – September 2004 –

## Original Articles

### Abstracts

Abstract/Commentary

by Michael D. Smithers, D.C.

### *Patient-oriented assessment of back pain in pregnancy*

**Eur Spine J 2002 Jun;11(3):272-5**

Padua L; Padua R; Bondi R; Ceccarelli E; Caliandro P; D'Amico P; Mazza O; Tonali P

Institute of Neurology, Catholic University, Rome, Italy

### Abstract

*Aim:* Back pain is a common symptom in women during the last trimester of pregnancy. Only a few studies using validated patient-oriented tools have been undertaken on this topic. The authors report on a multicenter study on back pain in women during this last period of pregnancy, which involved seven Italian institutions.

*Methodology:* Seventy-six women in their 8<sup>th</sup> and 9<sup>th</sup> months were studied using the Italian validated version of the Roland Questionnaire. Sixty-two

percent of the women had gone through at least one previous pregnancy, and clinical data concerning both the period before all pregnancies and the period before the current pregnancy were acquired.

*Results:* The study found that 31% of the women had no back pain symptoms (Roland score 0); 40% scored from 1 to 4; 21% scored from 5 to 10; and 8% scored more than 10. With regard to the predictive factor, history of back pain and sciatica before the pregnancy were found to be associated with occurrence of back pain symptoms during pregnancy. However, back pain was not associated with having gone through previous pregnancies, nor was the Roland score related to the weight before pregnancy or to increment of weight during pregnancy. Unexpectedly, the authors results showed that male sex of the fetus seems to be related to occurrence of back pain during the last trimester of pregnancy.

*Conclusions:* Evaluation of the patient's perspective made it possible to identify predictive factors for occurrence of back pain.

## **Commentary**

There are two generally accepted questionnaires which relate to activities of daily living (ADL) and low back pain (LBP). These are the the Roland-Morris Low Back Pain and Disability Questionnaire and the Oswestry Low Back Pain Questionnaire. The Roland-Morris form is considered a more sensitive reporting mechanism in acute and subacute patients, whereas the Oswestry Low Back Pain Questionnaire is felt to be more sensitive for identifying activity intolerances in chronic patients. The Roland-Morris form follows this article.

There have been copious research articles written over the past few years whose point was to provide predictive values for low back pain. Every article I have reviewed has always had one overall finding - prior history of back pain and sciatic neuritis was the single strongest predictive indicator for future episodes of LBP. Even though this Italian study was oriented to females in their last trimester of pregnancy, the discoveries were essentially the same as with all other predictive research trials. Prior incidence of low back pain was the greatest single predictive factor despite being currently pregnant or multi-parous, and weight gain was not considered etiological in any fashion. The surprising finding in this European article was that LBP was statistically significantly higher when the fetus was a male.

Do you feel like being an uncannily accurate crystal ball in predicting your pregnant patient's baby's sex if she has not had an ultrasound providing this information? If she has had no history of any low back pain prior to pregnancy, but the patient is experiencing significant enough LBP to bring her into your office, then there is a good chance she is going to have a boy.

## ***Back pain in pregnancy-magnetic resonance imaging correlation***

**Clin. Radiol 2002 Dec;57(12):1109-12**

Chan YL; LamWW; Lau TK; Metreweli C; Chan DP

Prince of Wales Hospital, Shatin, Hong Kong

### **Abstract**

*Aim:* To study the relationship of disk abnormality and signal changes of the uterine cervix on magnetic resonance imaging (MRI) with back pain in pregnancy at 36-39 weeks of gestation.

*Material and Methods:* 105 pregnant Chinese women with previous Caesarean section at 36-39 weeks gestation undergoing magnetic resonance pelvimetry performed for a study for trial of vaginal delivery were questioned for back pain. Sagittal T2-weighted images were analysed for intervertebral disk abnormality, and signal intensity of the uterine cervix on the same sagittal images. The findings on MRI were correlated with back pain.

*Results:* 73% of the pregnant women had back pain. Disk bulge or prolapse were infrequent but correlated significantly with the presence of back pain. Women with back pain in the current pregnancy tended to have higher signal intensity of the uterine cervix compared with those without. Women with a history of back pain also had higher cervical signal intensity compared with those without.

*Conclusion:* disk bulge or prolapse was associated with back pain in pregnancy but were relatively infrequent. The significant correlation of high signal intensity in the uterine cervix and back pain suggested that soft tissue laxity may be a more important cause of back pain in pregnancy or prolapse.

## **Commentary**

This article, like many others, also reflects that prior history of low back pain (LBP) is predictive for future episodes, pregnant or not. However, it clearly demonstrates a very important finding that chiropractors always need to consider when diagnosing and treating back pain.

Low back pain is frequently not related to neuro-musculo-skeletal disorders.

Pancreatitis, liver and gall bladder disease, gastric problems, cardiac and pulmonary pathology, pleurisy, cancerous tumors, bowel and colon bleeding disorders, just to name a few, all have one common complaint - back pain. This research article clearly tells us that the authors found another cause of low back pain in females. Soft tissue laxity, as in uterine suspensory ligament failure (Broad and Round ligaments), and possible uterine prolapse, may be the causative factor for female patients having LBP.

Sure, we may discover what we believe are physical findings that allow us to diagnose her problems as sprain-strain-subluxation complexes. However, if the condition persists, despite the best of our efforts, consider referring your patient to her gynecology provider. You won't lose a patient, but will, instead, gain more trust, more respect, and probably even more clientele.

## **Case History**

### **HISTORY:**

This 43-year-old presented on the kind referral of his family medical physician (PCP). He presented with the chief complaints of neck pain, left shoulder pain, weakness in his left hand, and loss of fine motor skills. He also complains of intermittent "sharp stinging" pains radiating down both upper extremities (Lhermitte's Sign) more pronounced on his left side. He goes on to mention that these symptoms have come on when he is looking up or putting his head/neck in to extension. He owns a dry wall business, which requires him to look upward frequently. He also notes that when he coughs or sneezes he also develops the same electrical sensation.

He has had the above intermittent symptoms for approximately 6 to 8 weeks when he was simply toweeling off.

### **PAST HISTORY**

He notes that approximately 8 months ago he took a bad fall while dirt bike riding landing on his head/face/neck and chest with his lower back apparently being forced into hyperextension. He was seen at the local hospital ER and he believes films were taken of his "entire spine" including his neck, and was released.

He has a history of asthma and has had an anaphylactic reaction to penicillin.

### **SOCIAL HISTORY**

He drinks a beer or two on occasion and has smoked a pack of cigarettes each day for the past 20 years.

### **REVIEW OF SYSTEMS**

Review of systems reveals no abnormalities of consequence.

### **PHYSICAL EXAMINATION**

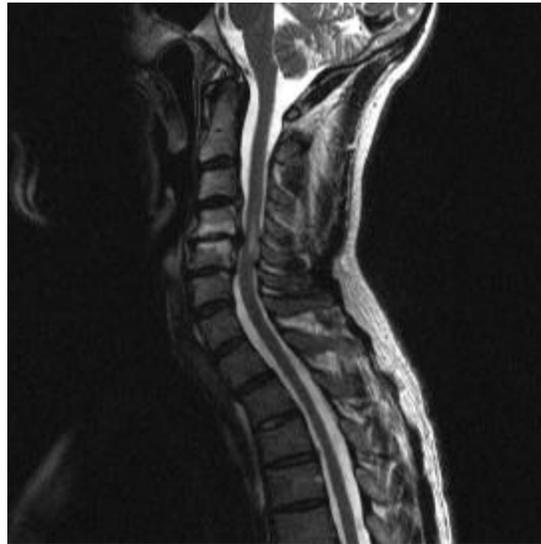
The patient is a slender 6' 2" and 185 pounds, and appears rather apprehensive and fearful. His affect is appropriate and he asks many bright and appropriate questions. There is no hint of aphasia, agnosia, or apraxia, cranial nerves

reveal no obvious deficits, gait and station are normal. Examination of his reflexes revealed absent biceps and distal radial reflexes bilaterally. He has an interesting flexor response (paradoxical reflex) at the left wrist when I attempt to elicit the left biceps reflex. Hoffman's and Tromner's pathological reflexes are present on the left and though Babinski's Sign was absent bilaterally he clearly has hyperactive patellar reflexes. Motor examination revealed weakness in the left biceps, profound weakness in his wrist extensors, and concomitant significant slowing of his fine motor skills on the left. Sensory examination revealed bilateral hypesthesia in the C5 and C6 dermatomes. Jackson's compression, maximum cervical compression, and shoulder depression tests/maneuvers were equivocal and Bakody's sign was absent.

### **RADIOGRAPHIC EXAMINATION AND SPECIAL IMAGING**

Plain films exposed here of the patient's cervical spine were positive for moderate cervical spondylosis C4-C6 and with apparent compromise of the saggital depth of the cervical canal at these spinal levels.

Subsequent cervical MRI revealed critical spinal canal narrowing at the C4-5 levels with deformation and flattening of the cervical cord. There is a concomitant increase signal within the cervical spinal cord itself indicating changes of compressive myelopathy. There is spondylitic narrowing of the neuroforamina bilaterally at the C4-5 level and at C5-6.



### **IMPRESSION/WORKING DIAGNOSIS**

Cervical myelopathy (C4-5) with a concomitant left C6 radiculopathy both secondary to cervical spondylosis C4-C6.

### **RECOMMENDATIONS/TREATMENT/PLAN**

No chiropractic spinal manipulation was given and in fact I instructed the patient that he was not a chiropractic case. I suggested that he was a very likely neurosurgical emergency candidate and that I would refer him for a neurosurgical consult immediately.

### **CLINICAL CONCLUSION**

The patient indeed had a subsequent neurosurgical consultation and examination. The surgeon's recommendation was for an anterior cervical discectomy and interbody fusion at C4-5.

Submitted by: *Vern Saboe, DC., DACAN., FICC., DABFP., FACO*

# Clinical Pearl

*Ronald C. Evans, DC, FACO, FICC*

## Posttraumatic Syringomyelia (PTS)

Posttraumatic syringomyelia (PTS) refers to the development and progression of a cyst filled with cerebrospinal fluid (CSF) within the spinal cord. PTS is characterized clinically by the often-insidious progression of pain and loss of sensorimotor function that may manifest many years after traumatic SCI. Untreated, PTS can result in loss of function, chronic pain, respiratory failure, or death.

- **Pain is the most commonly reported symptom. Pain may be localized or diffuse and commonly is reported as a dull ache or a burning or stabbing sensation.**
- **Other symptoms include increasing weakness, numbness, increasing spasticity, and hyperhidrosis.**
- **Postural change or the effects of the Valsalva maneuver aggravate symptoms often.**
- **Decreased reflex micturition, progressive orthostasis, autonomic dysreflexia, and relatively painless joint deformity or swelling may be reported**

### Physical Findings

- **Spasticity often is increased compared to findings noted in prior examinations. Deep tendon reflex changes may be noted compared with findings from prior examinations.**
- **Ascending sensory level and sensory dissociation are very sensitive indicators for detecting progressive PTS. Numbness may involve the face if the syrinx has ascended into the brainstem.**
- **Progressive weakness and wasting can occur but may be a late finding.**
- **Other signs may include a complete or partial Horner syndrome or other evidence of dysautonomia.**
- **Signs may be unilateral because ascension of syrinxes often occurs unilaterally.**

Assuming that basic neuro-orthopedic examinations and advanced imaging findings are consistent with the presence of syringomyelia, serial quantitative strength measurements including pinch and grip tests or hand-held myometry are useful in confirming progression of weakness.

Calculation of the central motor conduction time (CMCT) using motor evoked potentials (MEPS) is useful in monitoring PTS; however, this technique is not widely available.

Standard electromyographic techniques, including nerve conduction studies, F-wave latencies, and needle electromyography, are less sensitive and specific in detecting PTS. These studies are best used to exclude other causes for the person's symptoms.

<b>Causes of Spinal Cord Injury</b>	<b>Patients Studied</b>
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Motor Vehicle Accident		29
Falls		12
Diving		6
Gun Shots		3
Sports		2
Industrial Accident		2
Other		4
<b>Type and Location of Spinal Cord Injuries Type</b>	<b>Location</b>	<b>Number</b>
Complete (40)	Cervical	22
	Thoracic	15
	Lumbar	3
Incomplete (18)	Cervical	6
	Thoracic	8
	Lumbar	4

### Conservative Care

The focus of conservative therapy in patients with syringomyelia should be preservation of range of motion (ROM) and maintenance of function, including transfers, wheelchair mobility, and gait if applicable. Exercises and other mobilization activities that produce effects like the Valsalva maneuver should be avoided until normal CSF flow has been restored. The function of the person in performance of activities of daily living (ADL) needs to be assessed. Splinting to maintain functional positions of the upper extremities and prevent contracture formation may be required.

### Prognosis

The natural history of untreated syringomyelia is variable, with stabilization of symptoms in some persons and slow but persistent progression in others. Healthcare professionals should educate the patient with PTS to avoid actions such as straining or Valsalva-type activities that may worsen symptoms. After successful treatment, this precaution may be lifted.

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## Review of the Literature/Reprints

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### ***Altering Patient Records Can End Your Credibility***

**There is no faster way to destroy your credibility in a courtroom than to watch the plaintiff's lawyer prove that you altered a patient's records.**

It's a natural reaction, especially if you've never been involved in legal action. You're served papers saying a patient is suing you for negligence: A condition you did not diagnose has caused serious health problems, and the patient is charging that you should have "caught" the condition and prevented it from becoming more serious.

You access your records for that patient. To your dismay, you find that your records weren't as complete as they should have been – and also, they include statements that indicate further testing should have been ordered. You visualize yourself in court as the plaintiff's lawyer flashes your notes for all to see, and the picture isn't one you want to experience. You panic – those notes need to be changed! – and you reach for the correction fluid while searching for the pen you used when you created the original records.

**Stop.**

**There is no faster way to destroy your credibility in a courtroom than to watch the plaintiff's lawyer prove that you altered a patient's records.** You could be totally innocent of the charges of which you're being accused. But if you're forced to admit you added to, deleted, or in any other way changed information in a patient's records, chances are the court's verdict will not be in your favor.

Jerry L. Brown, a certified forensic document examiner since 1979 and administrator of the Iowa Division of Criminal Investigation Crime Laboratory, says it's "pretty difficult, if not almost impossible" to alter records in such a way that your handiwork can't be exposed.

“If the file is already intact and then all of a sudden there are notes in the margins, or a new piece of paper clipped to the original file, those are going to be red flags,” Brown says. “You look at the out-of-place things first, then go from there.”

Less-than-obvious “tricks” are almost always revealed as well, Brown says. Say you finished your last set of notes on a patient immediately after the most recent appointment, and you have a half-page of blank paper remaining on the original page. If you use the same pen, you can add notes to that same page in a chronological fashion, and no one will be the wiser, right? Wrong.

“Indented writing on the pages underneath can demonstrate that part of the notes were written at a different time,” he says. “We also look at the way the lines intersect – what lines were placed on the paper first, and in what order. If you made a notation on July 1 and the next entry was July 12, maybe you’ve made up an entry for a date such as July 7 and tried to squeeze that entry into the margin, or between the two original entries. That’s going to be suspect.”

If all else fails, document examiners will call on the services of others in the industry – most often ink chemists, who are able to determine not only what writing instrument a sample came from, but how long the sample has been on a piece of paper. The chemists break down inks into components that can’t be seen by the naked eye.

“Black ink isn’t just black ink – it’s made up of other colors that become evident when the ink is chemically treated and placed on a plate,” Brown says. “The ink separates into individual components. If you have two black Bic pens, you can tell the difference between the inks in those identical pens.”

Altered computerized records are also easier to spot than one might assume. “It’s not unusual for a court to subpoena the computer’s hard drive to determine when each notation was created,” he explains. “If the record shows that someone went in on July 12 and dated a record for June 27 of the previous year, that person is probably trying to do something sneaky.”

The moral of the story, then, is that your records should be complete and honest enough in the first place that altering them wouldn’t cross your mind, even in a high-pressure situation. Easier said than done? Not if you follow some simple suggestions.

- **Build enough time into your schedule to compile detailed notes after each patient visit.** Automatically adding a minute or two will keep you from feeling you’re taking time from patients to make notes. Begin by honestly assessing the way you work – if you really don’t like making hand-written notations on a patient’s chart, speak your notes into a tape recorder, then ask a member of your office staff to transcribe the notes at the end of the day. Or use a laptop to type your notes.
- **Slow down.** Complete notes can be a big help to you – but only if they’re legible. Again, a computer or tape recorder might come in handy here. If you’re like most people, when you’re stressed, your handwriting becomes more difficult to read.
- **Make sure your records are complete.** Clinical records should contain a diagnosis upheld by exam findings, lab reports, and support data. Progress reports should contain therapy details as well as positive and negative symptoms reported by the patient. Any time you create a record, keep risk management in mind. If you write “Mrs. Youngblood troubled by visual disturbances – this warrants further testing,” make sure you order the tests.

Your records should be complete and honest enough in the first place that altering them wouldn’t cross your mind, even in a high-pressure situation.

## **Computerized Records**

### Can they Help or Hinder Your Case?

As computerized offices have become the norm, many doctors have rejected handwritten records in keeping with the technology of their work environment. Instead of making handwritten notes at the end of a patient's visit, some doctors now use dictation or voice-recognition software or visit their laptops or desktops to create records in a word-processing program. Many doctors continue to print and date the records and enter them in a patient chart or log book.

### **Can computerized record keeping increase or reduce your risk in the event of a malpractice allegation?**

It's difficult to say, as a doctor's record-keeping method is a matter of preference. If you do compile your records by computer, here are a few things you should keep in mind:

- **No matter what kind of system you choose, keeping a concise, accurate and contemporaneous record of each patient's visit is certain to lower your risk and benefit your practice.** Remember that the patient has the right to see and/or request copies of anything you've written. So why not keep the process as open as possible by making your notes – either by hand, into a Dictaphone, or onto a laptop or hand-held computer – as you sit in the room with the patient? If you're dictating, the patient will be able to comment as you make your remarks. If you're writing or typing the notes, make a point to read them to the patient when you've finished. That way, if there's any discrepancy between your view and your patient's, it can be resolved then and there.
- **In a court of law, computerized records may have the potential to be more suspect than handwritten ones.** Why? While it's relatively simple for a document examiner to detect changes to a handwritten record, it's not quite so easy to detect such changes in a computerized one. That's not to say computerized records are foolproof when it comes to alterations – but since there are no determining features as there are in handwriting, computerized records can simply arouse more doubt.
- **Computer records can be more susceptible to outside interference.** If a staff member terminates employment in a negative way, it would be relatively simple for the staff member to delete documents from your hard drive. It would probably be more difficult to destroy your handwritten notes without being detected. Prior to terminating an employee, deny access to all computer terminals.
- **All computers crash at one time or another.** If you don't print and back up your records daily and your hard drive experiences problems, you could lose information that can't be replaced. If your computer goes down, even temporarily, keep a handwritten log during that period. Keep all backup files off-site to prevent destruction by fire or water.
- **Computer records may encourage a certain degree of apathy and complacency.** If your visit with Mr. Johnson on Friday is similar to your visit with him on Tuesday, you may be tempted to cut-and-paste Tuesday's log to Friday's date. Remember that you owe it to your patients to document each visit individually and thoroughly, so do not allow your record of a patient's visit to simply become as routine as a click of your mouse. Make sure each record is specific and relevant, and that it reflects the particulars of each patient's diagnosis and treatment plan.

Always exercise great care when transmitting computerized records electronically, whether the recipient is another doctor, an insurance company, an attorney, or a reviewer, especially in light of new HIPAA guidelines.

## Current Events

Academy Certification Examination will be held on October 9, 2004 at Northwestern Health Sciences University in Bloomington, Minnesota. This is in conjunction with The American College of Chiropractic Orthopedists (ACCO) and the Council of Chiropractic Orthopedists (CCO of ACA). If you know someone who has completed their postgraduate orthopedics, and has not obtained certification have them contact Cheryl at 515-981-9427. You can direct them to the Academy web site at [www.dorthoacademy.com](http://www.dorthoacademy.com) for information. The website is update frequently with new information.

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**PROGRESS REPORT JULY 2004**

The Council on Chiropractic Guidelines and Practice Parameters (CCGPP) was formed in 1995 by the Congress of Chiropractic State Associations, with the assistance of all chiropractic organizations in the United States to develop and distribute a chiropractic practice document. CCGPP is a steering organization composed of representatives from national chiropractic organizations, supervising several research teams.

CCGPP is rapidly moving forward at the present time and has been seeking input from many within and outside of the profession. The mission we are charged with is designed to help the profession, patients, reimbursers, governmental agencies and other stakeholders effectively contend with a number of issues facing those who ever-increasingly employ and or interact in some manner with chiropractic health services.

We are utilizing a "best practices" format for this publication. This is not only the most contemporary and accepted for health and non-health professions, it also provides more information while allowing for decision-making latitude by chiropractic doctors. This promises to be the most thorough document to date.

The best practices document will be widely distributed to chiropractors, colleges, payors, governmental agencies and all stakeholders, as we are contracted and partnered with a research, distribution and publishing concern for this purpose, the Work Loss Data Institute (WLDI). We specifically chose WLDI because they have considerable experience in placing such documents into the hands of payors and governmental bodies and, thus, into common usage. The Foundation for Chiropractic Education and Research will also provide distribution within the profession.

Although CCGPP has already surveyed the profession in 2001-2002 in regard to needs and attitudes, conducted for us by the Palmer College research center, we will also be hosting multiple profession-wide reviews of the document prior to publication to allow for additional input. Additionally, since this is a living document, continual input will be possible indefinitely. Complete updates of the document will be written at intervals to not exceed every 24 months.

### *Current CCGPP progress:*

- Panels have been solicited from all quarters of the profession, including practicing chiropractors. Our personnel now total over 75. Every chiropractic college has also been asked to provide assistance in terms of personnel and resources. Colleges have provided funding and other support to CCGPP, as has the Association of Chiropractic Colleges.
- The lumbar spine team began work in April 2004 and are presently evaluating nearly 1000 pieces of specifically relevant literature. They are on schedule. The thoracic spine and extremity section teams began work early and are slightly ahead of schedule. The cervical spine team is on schedule.
- CCGPP continues to reinforce its cooperative information-sharing arrangement with the Canadian Chiropractic Association/ Canadian Federation of Chiropractic Regulatory Boards, who are involved in a similar project for the same reasons as U.S. D.C.'s and we have recently bid on performing cervical spine research for them.
- The first chapter of the text has been written
  - The first publication target is slated for November 2004 in the form of an early release for the lower back section, to respond to a specific call from the California Chiropractic Association, and then the entire document is planned for release in the first half of 2005.
  - Funding efforts continue in order to support our 2004 and 2005 budget of \$475,000 for each year. We have raised or have concrete pledges of \$135,000 since March 2004 and have reasonable expectancy of receiving a grant for \$250,000, which we should hear about within 45 days. Donors have been national, state and local chiropractic organizations, colleges, vendors and other groups.
  - We continue to develop relationships for dissemination, including those with internet health care portals, reimbursers, educational institutions, governmental agencies and others and should shortly have more information to distribute in this regard.
  - A new CCGPP website with much more information than the previous site will be available during the month of August 2004 at [www.ccgpp.org](http://www.ccgpp.org).

### [eLetter From The President](#)

If you are not receiving this, please contact Ed Payne and request to be added to the list.

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