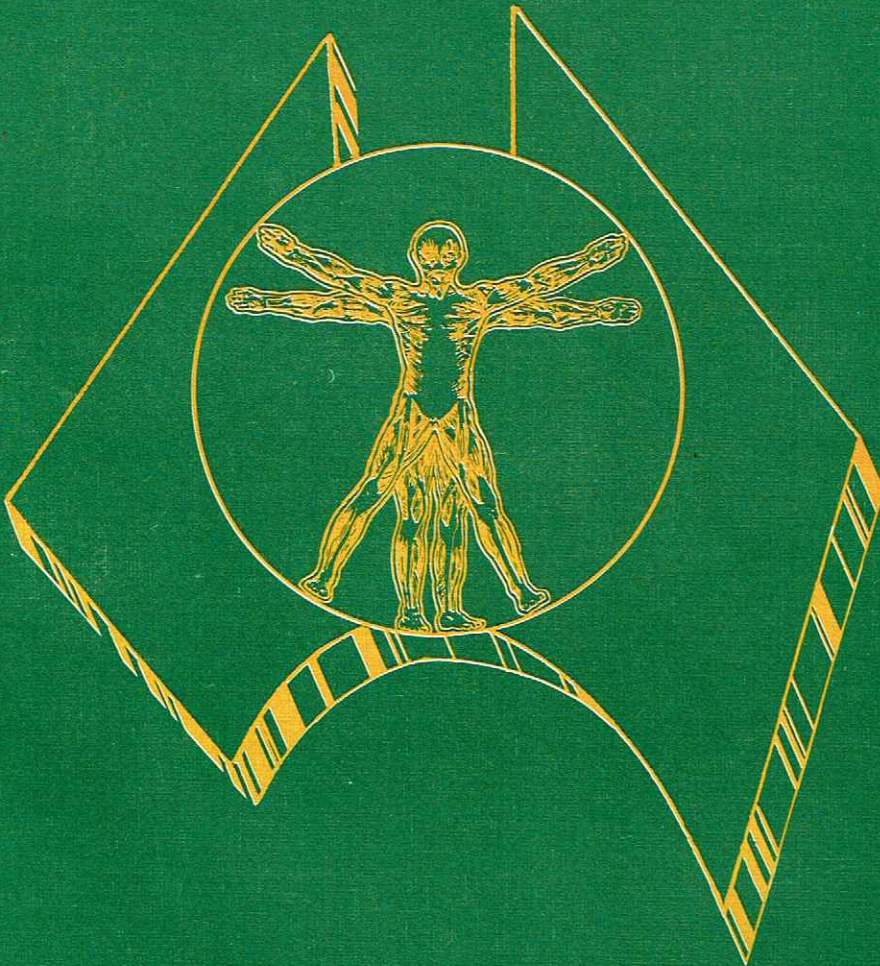


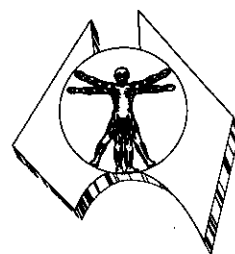
Australian
Association of
Musculoskeletal
Medicine

Bulletin



Functional Pathology of the Locomotor System.
The Upper Limb Tension Test.

Australian Association of Musculoskeletal Medicine



Bulletin

Vol. 2 No. 1

March, 1986

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The A.A.M.M. Bulletin is published by the Australian Association of Musculoskeletal Medicine for medical practitioners interested in the aetiology and management of musculoskeletal disorders. Opinions expressed are those of the authors and not necessarily those of the editor or the Association. Editorial comment may reflect the opinions of the editor alone. Contributions on any relevant topic are welcome for submission to the editor, Dr. Wade King, 131 Marius Street, Tamworth, NSW, 2340, telephone (067) 66 6166, after hours (067) 67 8262. Assistant editors Dr. Norm Broadhurst, Adelaide, (08) 295 1890, Dr. Bruce Kinloch, Melbourne, (03) 420 5300 and Dr. John Prineas, Sydney, (02) 639 4402.

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About the



The Australian Association of Musculoskeletal Medicine is comprised of medical practitioners interested in disorders of the musculoskeletal system.

The Association was formed on 6th December, 1971, when thirteen doctors met in Melbourne to discuss their common interest in the conservative management of back pain and other musculoskeletal problems. Ten others sent their apologies and these twenty-three became the foundation members of the association. The name Australian Association of Manipulative Medicine (A.A.M.M.) was chosen to reflect the common interest in manipulation, especially of the spine, as one form of conservative physical management. The name was distinctive, as most doctors then professed no interest in spinal manipulation and the scientific basis for such treatment was known to few. Several founding members of the new association were already members of the British Association of Manipulative Medicine (B.A.M.M.), which had been formed some ten years previously with similar objectives.

The fledgling A.A.M.M. held clinical meetings and annual conferences and encouraged members to present and publish scientific papers on relevant subjects. For several years the annual conferences were held in conjunction with the Australian Association of Physical and Rehabilitation Medicine (A.A.P. & R.M.), another group with some interests in common. Some members belonged to both associations, as indeed is still the case.

By 1978 membership of A.A.M.M. had grown to 130 and the organisation was strong enough to sponsor a large meeting with international guest speakers. Professor Malcolm Jayson of Manchester and Professor Justin Lehmann of Washington joined Australian academics and clinicians for a three day conference in Sydney on back pain research. The meeting was well reported in the Australian medical press and the activities of the Association were seen to be providing leadership in an important area of need in medical practice. The A.A.M.M. seemed to have come of age.

In 1982 the Association met to consider a change of name. By then membership had reached 200 and encompassed a range of interests not adequately described by the term "Manipulative". After considerable discussion the name Australian Association of Musculoskeletal Medicine was chosen, with the same initials as used previously. At the same time the constitution of the Association was amended to give better expression to the interests of members in all aspects of conservative management of musculoskeletal disorders.

Today the A.A.M.M. has a membership of approximately 300 doctors in all states of Australia. Their activities are spread over a broad range of musculoskeletal disciplines including orthopaedic medicine, manipulative medicine, osteopathic medicine, physical medicine, rehabilitation, rheumatology, acupuncture, neurology and orthopaedic surgery. The Association fosters interests in all musculoskeletal treatments consistent with scientific principles and encourages a wide range of treatment options with the use of the least invasive method appropriate to the management of each individual patient. In addition, the Association is active in the fields of education and research.

Local meetings are held regularly in a number of centres and annual conferences now usually feature international guest speakers. As well, the Association often sponsors speakers of high standing in other countries to come to Australia for lecture tours and instruction courses, which members and other doctors are encouraged to attend.

The Association conducts its own courses for medical graduates to learn or improve particular skills in musculoskeletal management. It also co-operates with other bodies active in postgraduate medical education, such as the University of Sydney's Coppleson Postgraduate Medical Institute and the Royal Australian College of General Practitioners. Some members are involved in the education of medical undergraduates and physiotherapists.

Dissemination of information about musculoskeletal medicine is another area of activity. Through its own publication, the A.A.M.M. Bulletin, and through letters and articles in other medical publications, members' perceptions are shared with a wide medical audience. The Association also acts in an advisory capacity to professional organisations and government bodies when musculoskeletal issues arise.

Some members are engaged in research, both laboratory projects and clinical studies. The Association encourages this and a committee on research and education meets regularly to consider ways of facilitating research and to develop better methods of spreading musculoskeletal knowledge and skills. A research proforma, to assist in the collection of comparable data by practitioners engaging in clinical studies, is available to members on request.

The A.A.M.M. liaises with other groups with similar interests, both in Australia and overseas. In this country, the Association is affiliated with the Australian Medical Association and maintains relationships with the A.A.P. & R.M. (as mentioned above), the Australian College of Rehabilitation Medicine and the Royal Australian College of General Practitioners, as well as numerous universities, hospitals and other bodies. Outside Australia, the A.A.M.M. has close ties with its sister organisations the New Zealand Association of Musculoskeletal Medicine (N.Z.A.M.M.) and the British Association of Manipulative Medicine (B.A.M.M.). All three, together with some twenty other national bodies, are affiliated with the International Federation of Manual Medicine (F.I.M.M.). By correspondence, and when possible by direct contact at meetings and conferences, members share in a world-wide movement towards

improved management of musculoskeletal disorders.

The A.A.M.M. is not an association of specialists. Some members, certainly, are registered specialists in physical medicine, rehabilitation, rheumatology, neurology and orthopaedic surgery. Some others practise full-time in the fields of orthopaedic medicine, physical medicine and manipulative medicine. The majority of members, however, are general practitioners interested in the problems of musculoskeletal disorders and many have been drawn to the Association by the inadequacy of some widely-practised methods of management of these conditions. Membership of the A.A.M.M. is open to all medical practitioners who share the desire to improve methods of alleviating the suffering caused by some of the most common and most painful afflictions of mankind.

A.A.M.M. ROLL OF HONOUR

The following members have held executive office in the Association since its formation in 1971:

PRESIDENTS:

Dr. Frank May	1971 - 73
Dr. Brian Corrigan	1974 - 76
Dr. Bunt Burnell	1977 - 78
Dr. Gordon Byth	1979
Dr. John Bosler	1980 - 84
Dr. Conrad Winer	1985 -

HON. SECRETARIES:

Dr. Gordon Byth	1971 - 72
Dr. Murray Ingpen	1973
Dr. Conrad Winer	1974 - 84
Dr. David Vivian	1985 -

TREASURERS:

Dr. John Livingston	1971 - 74
Dr. A. (Kitch) Kitchener-Smith	1975 - 76
Dr. M. (Toby) Arnold	1977 - 78
Dr. Alex Ganora	1979 -

A full list of present office-bearers is on Page 5

- * clinical physiotherapy
- * throat, upper and lower limbs
- * special investigations and X-ray techniques
- * medico-legal aspects of cervical manipulation
- * muscle energy techniques

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AUSTRALIAN ASSOCIATION OF MUSCULOSKELETAL MEDICINE

OFFICE-BEARERS 1986

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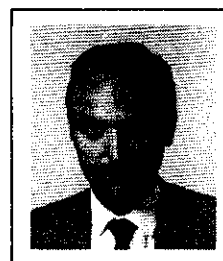
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Dr. David Vivian MB, BS
441 Bay Street, Brighton, Vic., 3186
telephone (03) 596 7211



HON. TREASURER:

Dr. Alex Ganora MB, BS, FRACGP, DPRM, FACRM
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telephone (042) 67 2811



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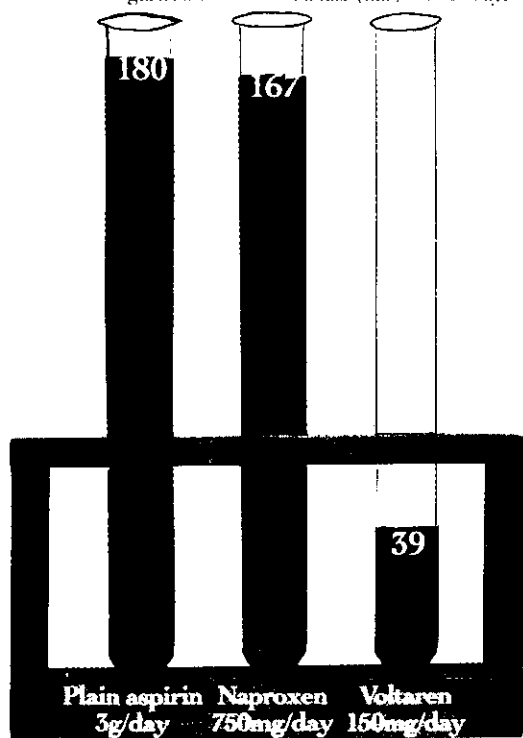
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Dr. Vern Vivian	Point Lonsdale, Vic.	(052) 52 2009

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Editorial

The two articles in this issue of the *Bulletin* focus attention on the assessment of the patient with musculoskeletal pain. No other aspect of practice is more important. Assessment provides the essential understanding of the patient's problems on which rational treatment is always based; the depth of that understanding is directly proportional to the likelihood of a successful outcome.

Diagnoses based on subjective factors and presumptions, such as "disc lesion" whenever the patient has distantly referred pain, lead to treatment "failures" when the treatment modalities have not so much failed as been misdirected. Even worse than this inaccurate use of valid diagnostic labels is the invention of terms such as "the fibrositis syndrome" to describe conditions which are poorly understood. Terms of this sort are often employed as an attempt by the diagnostician to state honestly that he cannot specify the pathogenesis of a patient's condition. Unfortunately, their interpretation generally has the opposite effect: they imply the presence of pathologic entities which are not supported by research evidence. The cause of intellectual honesty would be better served by the avoidance of such terms altogether.

The problem is that a definitive diagnosis of the pathology underlying a musculoskeletal pain cannot always be made in the clinical situation. The morbid anatomy is often microscopic and it can be difficult to distinguish between primary, secondary and even tertiary effects. The solution is to concentrate diagnostic efforts on what can be demonstrated objectively rather than on what cannot.

Effective musculoskeletal assessment has two aims: to detect evidence of pathological entities (such as ankylosing spondylitis, osteoporosis, disc herniation, etc.) and then, whether such entities are present or not, to detect evidence of altered function of musculoskeletal structures. Correlation of objective examination findings in these two areas with the patient's symptoms provides a working diagnosis of what is present and what is relevant.

Appreciation of biomechanical dysfunction has always been the stock in trade of the musculoskeletal physician. The article on functional pathology sets out the background to such an appreciation and goes on to discuss the clinical manifestations of dysfunction and the significance of assessments based on them. Objectivity is stressed as the essential factor which separates rational diagnoses from the presumptive and the imaginary.

Disorders of function are relatively easy to assess: either a structure performs its function in the usual way or it does not. Tests of function are generally simple, provided that the examiner understands the relevant anatomy and physiology and can interpret the information gained from the examination techniques used.

Diagnostic methods like most aspects of scientific medicine, are constantly being reviewed and refined. The article on the upper limb tension test sets out the results of recent work in this area by members of the Manipulative Therapists Association of Australia. The use of this test, and its interpretation in the manner described, adds another technique to the armamentarium of the practitioner committed to objective, specific biomechanical function testing.

The two books reviewed in this issue carry the theme further. Between them they contain a wealth of information on patient assessment, with details of specific objective tests for each musculoskeletal structure in the body. They also contain the relevant anatomic and physiological data on which the tests are based and numerous references to the scientific sources supporting the facts stated. Similar material on treatment modalities is included as well.

If we maintain as our standard the objective, specific, supportable methods of biomechanical assessment and treatment such as those put forward in these articles and books the discipline of musculoskeletal medicine will continue to advance as it has over recent years. ■



From The Hon. Secretary's Desk



"How is it that a self-respecting neurologist such as yourself became involved in manipulative therapy?" I asked Dr. Karel Lewit, during his recent visit to Australia to speak at a number of conferences and run courses in manipulative therapy. "I learnt it from a chiropractor in Czechoslovakia in 1952", was his surprising reply.

He told me that up to that time he had run a fairly conventional clinic in one of the State centres in Prague. One evening, as he and his wife sat huddled together feeling the cold from the snowy ground outside emanating into the house, a knock came on the door. It was a State bureaucrat. He did not, however, signal impending doom. He asked Karel whether he would be interested in taking a look at a chiropractor in Prague, who had been practising there since the mid 1920s, and was reputed to be doing some strange things to patients. The State basically wanted to know whether this form of treatment should be legitimised or not. Karel agreed to make an observation.

Consequently, the chiropractor's methods were examined by Karel. She had been trained by the original creator of chiropractic, Mr. Palmer. Karel explained to me that she treated just about everything by manipulation of the atlanto-occipital joints. Karel watched her perform and listened to her talk. He discovered that what she was doing with her hands made good sense but the rationale for performing treatment appeared thin to say the least.

Subsequently he took an avid interest in manipulative therapy and has learnt and practised it for over 30 years. In his present clinical situation he does not only act as a consultant but also as a prime treater. He has helped to develop muscle energy techniques, together with that other famous Czechoslovakian neurologist, Professor Vladimir Janda.

This is the first time we have seen Karel Lewit on our shores. Vladimir Janda has made numerous trips and more are planned. He has recently attended a conference in Manila together with our President, Dr. Conrad Winer (who apparently has arrived safely back and has not abdicated, despite the recent rash of abdications there).

It has been a great pleasure to have Karel and his wife Iris staying with us in Melbourne. He is an extremely vibrant character, especially for a man over 65 years of age. He had me up early each morning, down at the beach swimming and doing things I really never get around to doing myself. Iris was also a wonderful lady. She is English and has been living in Czechoslovakia for 40 years. Both of them speak many languages. When Karel was asked if his book, "Manipulative Therapy and Rehabilitation of the Motor System", could be translated into English from German, he said that that would be unsatisfactory, and it would be better if he just wrote it out in English. He had already written the book in Czech and German. It had been a best seller in Germany. Iris translates novels and other pieces of literature from Czech into other languages, and from other languages into Czech. She was telling my wife and me of this. My wife, who has been mentioned in the Bulletin before, has more than a passing interest in antique ceramics. She also has a fair collection of books. Iris had told us that she had translated a porcelain book and as she walked past the bookshelf, there it was: "European Porcelain, An Illustrated History". On the flyleaf was her original name, Iris Urwin, as the translator.

Karel ran a wonderful three day course, attended by 12 of us in Melbourne. He later attended Adelaide and Sydney, passing on a great deal of relevant musculoskeletal and other information to us all.

Later in the year we are to be joined by Dr Johannes Fossgreen, sometime in August, and by Professor Loren Rex for our Annual Conference in November. Hopefully these gentlemen can continue to stimulate interest in the musculoskeletal field, and provide Australian practitioners with further opportunities to update their knowledge and skills. ■



Recently, I saw an interesting patient from New South Wales. In 1984 he fell about 10 feet landing on ice, and he broke his fall with both hands. However, the ice caused the hands to slip, and he took most of the brunt of the fall on the chest. He developed chronic left sternocostal junction pain. He was referred from the general practitioner to the local orthopaedic surgeon who then referred him to a thoracic surgeon. At this stage he had had treatment with ultra-sound and steroids into the anterior chest region. He was not complaining of any interscapular ache.

The patient told me that by the time he saw the thoracic surgeon he was extremely upset by the pain which was regularly aggravated at work. The surgeon palpated vigorously over the fourth left costal cartilage, and noted that the area was tender. There were no changes present on X-ray.

He apparently deduced from the history of the clicking and the local "tenderness" that the patient had a recurrent dislocation of the chondro-sternal joint. He also deduced that this condition had stabilised but was painful.

The thoracic surgeon advised that the affected cartilage be removed and then noted that it was fortunate indeed that the patient was able to find a bed in the hospital that afternoon.

In April 1985 the medial half of the fourth left costal cartilage was removed under general anaesthetic. The surgeon made the point that the cartilage looked normal and no false joint was apparent.

After the procedure the patient's pain increased. The thoracic surgeon said that the increase in pain was out of keeping with normal and considered that the pain was functional.

Later on, the patient attended an insurance doctor. This doctor, who is an occupational medicine specialist, noted that the patient had a lot of bizarre symptoms such as a burning sensation in the windpipe and a feeling of the chest being crushed.

The patient by this stage had attended an acupuncturist and had felt some improvement. The insurance doctor made the following observation: "As far as acupuncture therapy is concerned, again my own personal opinion is that acupuncture is the greatest confidence trick of the twentieth century. This statement is also borne out by personal communication with Dr who made the official visit to China to assess the effectiveness of acupuncture. On the other hand, this form of treatment now appears to be generally accepted in this country which just goes to show how gullible people are and if patients' doctors order it I suppose it is the liability of the insurer to pay for it in exactly the same way as they would pay for physiotherapy." He went on further to say that at least in this case the treatment seemed to be keeping the patient at work and therefore he suggested that this form of treatment should be continued as long as it was ordered by the doctor.

When I saw the patient he was working as a maintenance engineer. He was a very pleasant 25 year old man. He complained of chronic pain around the site of operation.

Examination was interesting. There was little or no local tenderness in the sterno-costal region. However, on examination of the inter-scapular region I felt one of the stiffest left sided interscapular regions I have ever felt. There was considerable muscle spasm and underlying joint restriction. Palpation over the affected areas did not reproduce his sterno-costal pain, although he was extremely tender (but not in an exaggerated fashion).

Obviously I feel that his symptoms could certainly be in part derived from the interscapular region. It goes without saying that the assessment by the local G.P., orthopaedic surgeon, thoracic surgeon and an insurance doctor have all been done without any attention being paid to the joint at the other end of the ribs, i.e., in the interscapular region. The other bizarre symptoms are not infrequently associated with thoracic injuries. I have now referred this man off for some therapy to the interscapular region. Unfortunately, it may be too late to effect an improvement in his symptoms, particularly in view of the instability that has been created iatrogenically. ■



A cheerio call to someone selected at random from the membership barrel

The coo-ee goes to the Apple Isle again, in fact to Hobart where **Ron Heddle** conducts a musculoskeletal practice in the heart of the city. Born a Scot of Viking ancestry (as revealed by the Scandanavian spelling of his full Christian name, Rognvald), he graduated from the University of Glasgow and later obtained the Fellowship of the Royal College of Surgeons of Edinburgh. He has followed his career in several countries, spending his early post-graduate years in the Royal Army Medical Corps and then in hospital practice in Scotland, followed by four years in each of Zambia and Canada as a consultant surgeon before settling in Australia. His first eleven years in this country were spent as a senior lecturer in anatomy, with a special interest in neuroanatomy, at the Universities of Queensland and Tasmania. Since 1976 he has been in private practice again, combining his anatomic and surgical knowledge with a special interest in musculoskeletal problems. In 1985 he was elected as an A.A.M.M. State Representative.

Mainland members visiting Tasmania are invited to call him in Hobart for a little local information or just for a friendly chat. ■

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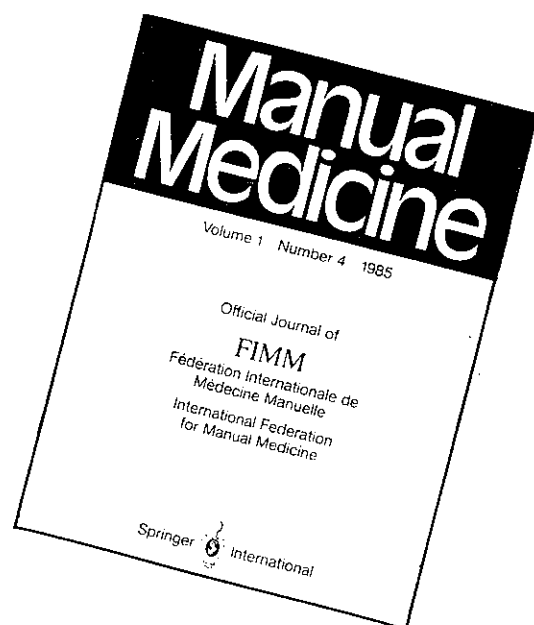


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MAIL BAG Letters to the editor

"I had written him a letter....."



The editor was inundated with letters after the publication of the membership list in the last Bulletin. Unfortunately, all were on the same topic, namely the use of the [R] symbol to designate those who are willing to accept patients on referral for musculoskeletal management.

Most were straight-forward requests to have the [R] included after the writers' names in the next list to be published. These have been passed on to the Treasurer and are not reproduced here as they were not really of general interest. The following was selected to represent them all, mainly because the writer raises other points as well.

Dear Sir,

I have been meaning to write for some time and have at last got around to it. I think that the Bulletin is a worthwhile endeavour of the Association and I should perhaps have volunteered at the last A.G.M. when you were asking for people to give a hand in its preparation. I will do so now if you feel that I might be of assistance.

In the list of members in the last issue my name did not have an [R] after it, even though I am in full-time musculoskeletal practice and most of my patients are seen on referral. This is rather sad because at the Tarnworth meeting in 1983 I think it was I who suggested that this would be a suitable method of denoting those who would be prepared to have patients referred to them. I would be most grateful for correction of the omission in the next list.

Incidentally, don't you think that if Roger Watson's name is really as it is recorded he should be moved to the top of the list and described as our patron?

Yours faithfully,
(Dr.) Jeffrey Phillips
Toowoomba, Qld., 4350

All three points are taken. The offer in the first paragraph is most welcome: other members are invited to follow suit. The second paragraph is acknowledged and the Treasurer has been notified. Members are, however, reminded that it is their individual responsibility to inform the Treasurer of the status of their practices.

The third paragraph, of course, raises an issue of considerable significance. Dr. Watson's name is correctly recorded. At the risk of offending his modesty, an approach will be made along the lines suggested. The Association may also wish to consider the addition to its title of the initial R. (or, for consistency, R.R. designating Royally Recognised), making it the R.R.A.A.M.M.

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NEWS

"heard on the bush telegraph"

The A.A.M.M. Committee, or rather 60% of it, met in Sydney on Saturday 22nd March, 1986. The three Victorian committee members were prevented from attending by an air strike (not the military kind). The Hon. Treasurer actually made it half-way to Sydney but then his vehicle developed an acute hypomobility problem and he had to have it towed home. Nonetheless, the meeting went ahead in the best tradition of persistence in the face of adversity. Those not able to be present in person contributed by telephone and although it was not the easiest way to hold a meeting a great deal was achieved.

□ □ □

Research into aspects of musculoskeletal medicine was again high on the Committee's agenda. Two positive steps were taken. A grant of \$3600 was made to the research team of Bogduk and Macintosh of the Department of Anatomy, University of Queensland, for a project on radiological correlates of symptomatic zygapophyseal joints. Also a policy on research funding was laid down for the guidance of both those seeking funds and those in the Association responsible for the way in which such funds are used.

□ □ □

The New Zealand Association of Musculoskeletal Medicine has proposed that a combined conference of the two associations be held in 1987. The New Zealanders have suggested an island venue, possibly a Queensland island resort. The A.A.M.M. Committee felt that whilst a combined meeting would be well worthwhile, the choice of venue may determine its chance of success (shades of 1985!). A Queensland island may be exotic for the New Zealanders but would not be for Australians and when the relative costs are considered a venue such as Fiji may be both cheaper and more interesting for both groups. Members are invited to submit ideas on the subject to the Hon. Sec., or to the editor for publication, to assist in the choice of a suitable location.

□ □ □

An unrelated suggestion is that an A.A.M.M. conference be held in the winter months, possibly in 1987 or 1988, as well as the usual annual conference in November. The proposed venue is a ski lodge. Members interested in attending such a meeting are asked to write a brief note to the editor, who is conducting a straw poll on the subject. If enough interest is shown the matter will be given serious consideration at the next Committee meeting.

□ □ □

The 1986 A.A.M.M. Annual Conference is shaping up well. It will be held over three days this year instead of the usual two: among other reasons, this is to allow more time for practical sessions, a perennial request made by members after conferences in the past. Dates are Friday 14th to Sunday 16th November, 1986 and the venue the Royal Prince Alfred Hospital, Sydney. A special guest speaker will be Professor Loren Rex of Michigan State University, East Lansing, which is known to many as the "home" of muscle energy techniques.

A one day practical introductory course on the biomechanical assessment of the patient with musculoskeletal pain will be held the day before the conference, on Thursday 13th November.

Further details will be found on the Meeting, Conferences and Courses pages.

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Members planning to attend the eighth tri-ennial congress of the international body F.I.M.M. in Madrid in June are asked to contact the Hon. Sec. so that group travel arrangements can be finalised. At this stage it seems that the success of this meeting is likely to outweigh even the legendary successes of previous congresses in Copenhagen, Baden Baden and Zurich, to name but a few.

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Australia has been visited by a number of internationally recognised authorities on musculoskeletal medicine already this year. More are to come.

Dr. Johannes Fossgreen, Chief of the Department of Rheumatology, Aarhus University Hospital, Denmark, is expected to visit Australia in August, 1986, after leading a delegation from the Danish Association of Manual Medicine to the New Zealand conference on the Spine in Action.

Professor Loren Rex, Associate Clinical Professor in the Department of Biomechanics of the College of Osteopathic Medicine, Michigan State University, is due in Australia in November, 1986. He will be addressing meetings arranged by the M.T.A.A. and the annual conference of the A.A.M.M. on his special interest, muscle energy techniques related to the spine and pelvis.

□ □ □

Whilst in Manila recently at the I.R.M.A. Congress the President took the opportunity to observe a session of "psychic surgery". He was impressed by it as a spectacle, combining the elements of skilful tissue manipulation, faith healing and autosuggestion. However, it is not considered likely to be introduced into his introductory courses in musculoskeletal medicine.

□ □ □

Many members who regularly treat referred patients were surprised to find that they did not have the referral symbol [R] after their names in the membership list published in the last issue of the Bulletin. Several wrote to the editor or the Treasurer to correct the supposed oversight (see Mailbag). What some failed to realise is that the membership list is compiled from information supplied by individual members. To put it bluntly, if you wish other members to know that you are willing to accept referred patients for musculoskeletal management, it is up to you to let the Treasurer know when you renew your subs.

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The South Australian branch is breaking new ground again this year with a twelve month course on musculoskeletal pain management. Ten local medicos have enrolled and they will be spending a considerable amount of their time this year sharpening up diagnostic and treatment skills together. The course is based at the Department of Physical Medicine at the Royal Adelaide Hospital, an institution well recognised for its contribution to musculoskeletal education.

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The issue of education in musculoskeletal medicine in Australia was high on the agenda for the recent committee meeting but was not discussed in detail because of the absence of some members, especially **Clive Kenna** who has collected information on the various courses being conducted around the country. The matter will be given precedence at the next committee meeting, which will attempt to establish guidelines for the standardisation of material presented, at least in introductory courses run by or with the support of the Association.

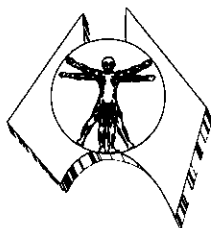
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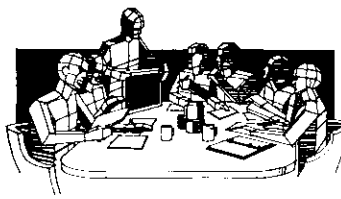
*The Association's statement on "whiplash" injuries, discussed at the last annual conference, is still in preparation under the capable hand of **Nik Bogduk**. Members wishing to contribute to it should send their ideas (urgently) to him at the Department of Anatomy, University of Queensland.*

□ □ □

Dr. Leonard Youngs, known to many for his contribution to musculoskeletal medicine in Australia over several years, has returned to the United States for family reasons. As an American-trained osteopathic physician Len had a great deal to share with Australian colleagues and his presence at A.A.M.M. meetings will be missed. Members travelling to the U.S. west coast are invited to look him up in Los Angeles, where he is now in practice.

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MEETINGS, CONFERENCES AND COURSES

In **Adelaide**, regular meetings are conducted by the South Australian branch of the Association and held at the Department of Physical Medicine, Queen Elizabeth Hospital. A locally-organised course on the management of musculoskeletal pain is planned to run throughout 1986, following a detailed syllabus. The R.A.C.G.P. course on spinal manipulation for doctors will also continue in 1986. Enquiries about these and other activities should be directed to Dr. Norm Broadhurst, telephone (08) 295 1890.

In **Melbourne** and **Geelong**, members meet at a number of places for discussions and practical sessions. Three courses are conducted each year. For details of these, contact Ann at the R.A.C.G.P. on (03) 240 8671 or Dr. David Vivian on (03) 596 7211.

In **Sydney**, meetings are held at 7.30p.m. on the third Monday of each month in the Department of Rehabilitation Medicine, Royal Prince Alfred Hospital. These meetings are designed as practical sessions for those who have attended the introductory course in spinal manipulation. Those wishing to attend are asked to telephone Dr. Conrad Winer on (02) 27 8926 during the preceding three working days to confirm the arrangement.

The next Copleston Institute introductory course in spinal manipulation will begin in August, 1986. Dates have not yet been finalised. Enquiries should be directed to Miss Licitis at the Copleston Postgraduate Medical Institute, University of Sydney, telephone (02) 692 3526.

There will be a seminar on "The Rheumatic Hand" at the Stephen Roberts Lecture Theatre, University of Sydney, on Saturday 24th May, 1986. The theme is a practical approach to the problem of the painful, disabled hand. Topics for discussion include various mechanical disorders. A programme and registration form is enclosed as an insert with this bulletin. Enquiries about the seminar should be addressed to Elizabeth Rich at the Arthritis Foundation of Australia (N.S.W. Branch), telephone (02) 29 5271.

In **Tamworth** meetings are held at 5p.m. each Thursday in the Outpatients Department of Tamworth Base Hospital. An introductory course in musculoskeletal medicine, with emphasis on biomechanical techniques of diagnosis and treatment, is being conducted over a period of twelve months. Further information can be obtained by contacting Dr. Wade King, telephone (067) 66 6166.

In **Wollongong**, introductory courses are run over a period of ten weeks. The organiser is Dr. Alex Ganora, who can be contacted on (042) 67 2811.

The Australian College of Rehabilitation Medicine will be holding its seventh annual scientific meeting in **Canberra** in March or April, 1987. The theme will be "The Assessment and Achievement of Fitness", including fitness for work, for recreation and for competitive sports. There will also be sessions on the cost of fitness and accident compensation. The organising committee is inviting interested persons to submit written papers or abstracts by 15th June, 1986 for consideration for presentation at this conference. Abstracts should not exceed two hundred words and should be forwarded to Dr. David McConachy, Convenor 1987 A.S.M., Australian College of Rehabilitation Medicine, 55 Charles Street, Ryde. N.S.W., 2112.

Dr. Lawrence Funt, of the Cranio-Facial Pain Centre, Washington D.C., will probably not be visiting Australia this year as had been hoped. However, members may be interested in a course he will be conducting in **Washington** from 26th April to 2nd May, 1986. The course will be on the diagnosis and treatment of myofascial pain, with special reference to trigger points. Speakers will include Dr. Janet Travell, well known for her work on trigger points, Dr. Robert Gerwin, a prominent neurologist, Dr. David Zohn, a specialist in rehabilitation medicine and co-author of three texts, and Dr. John Aseff, Associate Co-Director of the new National Rehabilitation Hospital of Washington. Those seeking further information should contact the Hon. Secretary.

An international conference entitled "The Spine in Action" is being arranged by a number of New Zealand organisations including the New Zealand Association of Musculoskeletal Medicine. The conference will be held in **Christchurch** in mid-August, 1986. Four separate "hands-on" courses will be staged in conjunction. Members of the A.A.M.M. are cordially invited to attend, as indeed are doctors and physiotherapists from around the world. A large contingent from the Danish Association of Manual Medicine is already expected. Air New Zealand and the Mount Cook Company, which are both sponsoring the conference are offering pre- and post-conference tours and ski packages. Further details may be obtained from Dr. Don Dalley of the Conference Organising Committee, P.O. Box 21044, Christchurch, New Zealand.

"Neuro-orthopaedics '86 and Rehabilitation" is the title of the International Danube Symposium for Neurological Sciences, to be held on 19th to 21st November, 1986 in **Prague**, Czechoslovakia. The symposium will discuss pathogenesis, treatment and rehabilitation of disorders of the locomotor system and of central motor control. It is being organised by a number of Czech medical societies under the auspices of the World Federation of Neurology, the medical section of Rehabilitation International and the International Federation of Manual Medicine (F.I.M.M.). Official languages for the meeting are English, Czech and Slovak with simultaneous translation. There will be associated social gatherings and a special ladies programme. For further information, contact Prof. J. Pfeiffer, Czechoslovak Medical Society J.E. Purkyne, "Neuro-orthopaedics '86 and Rehabilitation", P.O. Box 88, Vit unora 31, 120 26 Praha 2, Czechoslovakia.

The International Association for the Study of Pain is holding its fifth triennial World Congress in **Hamburg**, West Germany, from 2nd to 7th August, 1987. Further details can be obtained from Dr. Terry Little, Pain Clinic, Southern Memorial Hospital, Kooyong Road, Caulfield, Victoria, 3162.

see you in...

Sydney



The sixteenth annual conference of the Australian Association of Musculoskeletal Medicine will be held at the Royal Prince Alfred Hospital, Sydney, over three days instead of the usual two, from Friday 14th to Sunday 16th November, 1986.

A varied programme is in preparation, with plans for lectures, panel discussions and practical sessions to be interspersed over the three days. Professor Loren Rex of the Department of Biomechanics, Michigan State University, will give sessions of muscle energy techniques and a number of well-known Australian speakers have also agreed to contribute on subjects including spinal pathomechanics, Scheuermann's disease, occupational biomechanics, legal aspects of musculoskeletal practice, etc.

The conference will be preceded by a one day introductory course on "Clinical Assessment of the Patient with Back Pain", on Thursday 13th November, 1986 at the Queen Elizabeth II Rehabilitation Centre, adjacent to the main hospital venue. This will be a practical course with provision for ninety participants working in groups of two or three under supervision to acquire new techniques of biomechanical assessment.

There will be a number of social functions and provision will be made for accompanying spouses and offspring who may wish to visit places of interest around Sydney whilst the conference is in session.

Further details will be published in the next Bulletin. Enquiries about the conference should be addressed to the Organising Committee, A.A.M.M. Annual Conference, Department of Rehabilitation Medicine, Royal Prince Alfred Hospital, Sydney, N.S.W. 2050.



Madrid

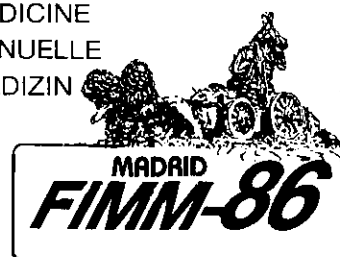
The next tri-ennial congress of the F.I.M.M. (International Federation of Manual Medicine, with which A.A.M.M. is affiliated) will be held in Madrid on 24th to 28th June, 1986. The main topics on the programme include "Pathogenesis of Back Pain", "Pain Origin, Perception and Measurement", "Chronic Back Pain", "Facet Syndromes", "Disc Disorders", "Teno-cellulo-myalgic Disorders", "New Diagnostic Methods", "Back Pain Treatment", "Analysis of Results of Treatment", "Prevention of Back Pain in Industry" and "Social Problems and Resettlement".

Further information can be obtained from the Secretary-General of the Organizing Committee, Dr. A. Ferrero, Secretariat 8th F.I.M.M. International Congress, Servicio de Rehabilitacion, Centro Ramon y Cajal, Carr. Colmenar, Km. 9. 100, 28034 Madrid, Spain.

8º CONGRESO DE LA FEDERACION INTERNACIONAL DE MEDICINA MANUAL
8th CONGRESS OF THE INTERNATIONAL FEDERATION FOR MANUAL MEDICINE
8eme CONGRES DE LA FEDERATION INTERNATIONALE DE MEDECINE MANUELLE
8. KONGRESS DER FEDERATION INTERNATIONALER FUR MANUELLE MEDIZIN

FIMM Fédération Internationale de Médecine Manuelle

Madrid 24.-28.6.1986



8th CONGRESS OF THE INTERNATIONAL FEDERATION FOR MANUAL MEDICINE PROVISIONAL FRAME PROGRAM SCIENTIFIC AND SOCIAL EVENTS

	MARTES TUES-24 June	MIERCOLES WEDN-24 June	JUEVES THURS-26 June	VIERNES FRID-27 June	SABADO SAT-28 June
10.00	Información e Inscripciones Information and Registration	Medicina Manual Manual Medicine Presid: Lewit and Mennell	Síndrome de charnela dorso lumbar Thoraco lumbar junction syndrom Presid: Maigne and Schwartz	Dolor vertebral evaluación y diagnóstico Vertebral pain-evaluation Presid: Neumann and Rageot	EXCURSION AUSFLUG «FIESTA CAMPERA» Bus in hotels
11.00	Information et Enregistrement	Communications	Communications	Communications	Chinchon castle visit and lord major reception
12.00	Kongres-Registration	Algodistrafia Presid: Simon and Bonica	Traumatología Deportiva Sport-traumatology and manual medicine Presid: Greenman and Janda	Dolor vertebral - Terapéutica Vertebral pain - Therapeutic technics Presid: Gurman, and Larrea	Aperitif and horse exhibition
13.00		Com. libres Free papers	Com. libres Free papers	Com. libres Free papers	Flamenco music
14.00		Comunicaciones	Communications	Communications	Lunch in wine cellars
		LUNCH TIME-DEJEUNER-MITTAGESSEN-COMIDA			
15.00		Spine Biomechanics and Back-pain Part. I Prof. Panjabi	Spine Biomechanics and back-pain Part. II Prof. Panjabi	Spine Biomechanics and back-pain Part. III Prof. Panjabi	Fiesta campera with Flamenco and bullfight imitation with small cows
16.00	Expomedica	Myofascial syndroms Part. I. Prof. Bonica Frozen shoulder Dr. Madrid	Myofascial syndroms Part. II Prof. Bonica Cervical Brachialgy Dr. Madrid	Myofascial Syndroms - Part. III. Prof. Bonica Meralgia Parestesica Dr. Madrid	
	Back-pain expo	Orthomanual medicine Dr. Keizer, colls.	Cervical Instability Part I D'Dvorak	Cervical Instability Part II-III Dr. Dvorak	
18.00		Free papers Freie Mitteilungen	Free papers Exposés libres	Free papers Freie Mitteilungen	Return to hotels
			Pannel: Nordgreen and Brodin	Pannell: Burn and Colombo	
		DEMOSTRACIONES PRACTICAS Y SEMINARIOS WORKSHOPS, SEMINARS AND PRACTICAL DEMONSTRATIONS			
19.00	Inauguración oficial Opening ceremony Seance d'ouverture Kongress-Eröffnung	Concierto en los Jerónimos ofrecido por el Presidente de la Comunidad	Recepción en los Jardines del Retiro ofrecido por el alcalde Town hall reception	Gala dinner dance and show Cena de gala con espectáculo y danza	
20.00		Community concert	Reception aux jardins du Retiro	Galla dinner mit Tanz und Flamenco	
21.00	Cocktail Reception	Concert classic	Empfängungsund durch Kanton und Stadt Madrid	Dinner de gala dansant avec spectacle	
22.00		Classic Konzert			

CONFIRMED SPEAKERS (as January 86)

Astegiano
Arkuszewski
Banga
Barrachero
Bonica
Bongartz
Borg
Bottani
Brodin
Brzuseck

Burn
Chila
Denayer
Depassio
Deramondt
De Vries
Dvorak
Dumont
Drevet
Fahlstrom

Faucon
Forte
Fosgreen
Fraser
Gatto
Gonzales-Mas
Gourjon
Goussara
Greenmann
Guttmann

Howell
Jajic
Janda
Juvin
Kappler
Keizer
Keditsch
Koch
Korpi
Kuthan

Kraeff
Laser
Lecorre
Lesage
Levin
Madrid
Maigne
Maltinskins
Marguery
Meas

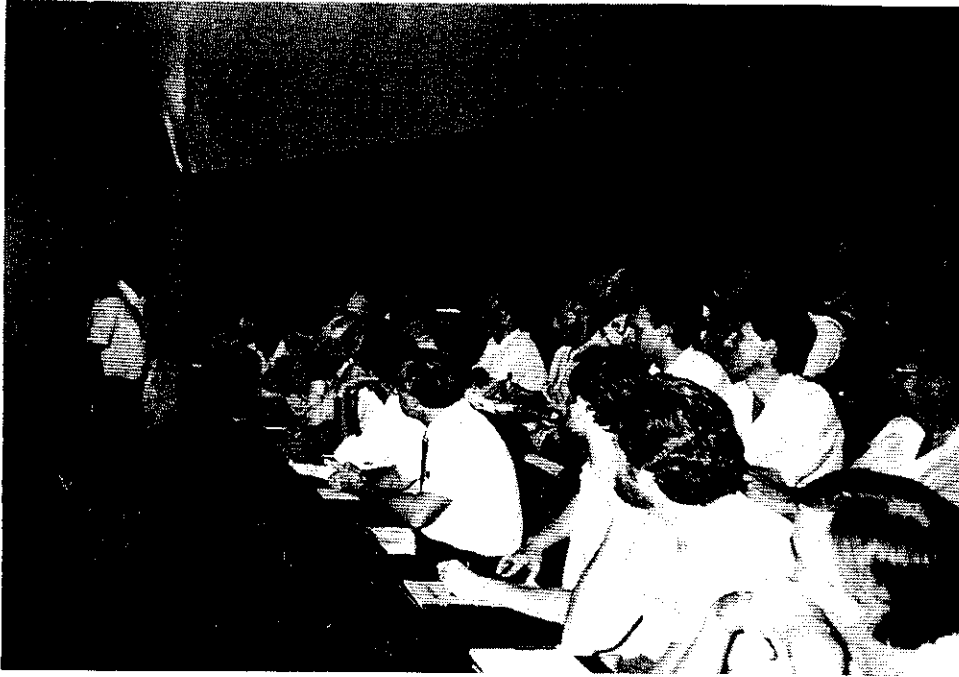
Mennell
Meyer
Milne
Natchev
Nordgreen
Ornano
Palacios
Panjabi
Parriquin
Paterson

Paugam
Rageot
Rekola
Riese
Rodriguez
Schmidt
Schnciaer
Sickesz
Simon
Stevens

Talluri
Tritscheer
Teyssandier
Toussaint
Veys
Van Delft
Zicha
Zimmerman

VISIT OF DR. KAREL LEWIT

Many Australian doctors will be using additional techniques of diagnosis and treatment after the recent visit of the Czechoslovakian neurologist and musculoskeletal physician, Dr. Karel Lewit.



Dr. Lewit spoke at the Pain Society annual conference in Melbourne and gave a day of lectures at a special meeting arranged by the A.A.M.M. in Sydney. He also conducted courses in his diagnostic and treatment methods for groups of A.A.M.M. members in Adelaide, Melbourne and Sydney.



His emphases throughout were on specificity in the assessment of dysfunctional states and the use of non-invasive, biomechanical treatment modalities. In particular, his techniques of post-isometric relaxation for treatment and self-treatment appealed to many because of the significant advantages of relaxation rather than stretching of hypertonic muscles and the extreme gentleness of the procedures.

Once again we are indebted to a man of great learning for making a long trip to Australia to allow us to share some of his wisdom.

WHICH NSAID? WHY IT MATTER

In the past 30 years non-steroidal anti-inflammatory drugs have become the mainstay of rheumatological therapy. Generally speaking, the newer compounds now in widespread use are more effective and better tolerated than their predecessors – as is reflected in the increasing availability of well-established drugs “over the counter”. But variations in individual response can still pose problems, of efficacy as well as tolerability. The basis for such variability was exhaustively discussed both at a two-day pre-congress Satellite Symposium in the Blue Mountains, chaired by

VARIABILITY IN CLINICAL RESPONSE

Many factors contribute, in greater or lesser degree, to the overall outcome of any form of drug therapy.

Where that outcome must be assessed largely on subjective criteria – such as relief of pain, tenderness, and stiffness – “soft” information on influences like mood and social circumstances needs to be considered alongside “hard” factual data, such as the diagnosis, effect of the individual patient's genetic constitution on drug handling, the modes of action of the particular NSAID given, and the time-curve of its concentrations in synovial joints (Day, Australia).

Moreover, the expectations of both doctor and patient may each influence the actual outcome and/or their assessment of it. Individual patient preferences for particular drugs must represent the contributions of all such variables (Bellamy, Canada). Perhaps the individual patient's view of a certain drug is coloured most of all by the relationship between his or her prior expectations and subsequent perceptions of its effect – because these

may reinforce or contradict each other (Edwards, New Zealand). The papers on variability of response clearly demonstrated the need to establish firm criteria for its assessment, and the difficulty in doing so. Clinical judgment analysis can reveal why the clinicians' assessment of response to treatment varies and can make this assessment more consistent by showing individual doctors how they reach decisions (Kirwan, UK).

THE RIGHT DRUG FOR THE PATIENT – SELECTING NSAIDS BY THEIR MECHANISMS OF ACTION

Ideally it should be possible to select an appropriate NSAID in advance to suit each arthritic patient. That ideal is coming closer to clinical reality as a result of recent work, reported in Sydney, which shows how much NSAIDs differ in their pharmacokinetics and mechanisms of action. No longer should these anti-inflammatory and analgesic drugs be regarded as an amorphous group sharing much the same actions and side effects. The reality is very different. Each NSAID has particular strengths and weaknesses which could be exploited to optimise



Dr D. Champion and Professor P. Brooks (Australia) chairing the first session of the Satellite Symposium on NSAIDs.

benefit and minimise the risk of side effects in individual patients.

Comparing diclofenac sodium (Voltaren) with indomethacin and piroxicam, Brune (FRG) drew attention to several contrasting pharmacokinetic features likely to influence clinical response. The half-life of diclofenac, for instance, is very reliable at 1–2 hours, compared with 1.5–16 hours for indomethacin and 14–158 hours for piroxicam. These major differences are largely accounted for by the high first-pass metabolism of diclofenac, mainly into inactive forms, whereas indomethacin and piroxicam are conjugated in the liver, reabsorbed, and broken down into active forms again during enterohepatic recirculation. This might explain their enhanced effects on

the gastrointestinal tract and could lead to cumulation in elderly patients.

Brune also raised the question of their suitability in patients with liver disease. By contrast, he said that, although diclofenac may be less reliably effective in the short term, it is well tolerated – and not contraindicated in the presence of kidney dysfunction or liver disease, or in elderly patients.

Any fear that the short half-life of diclofenac might result in its anti-inflammatory activity being poorly sustained was fully answered by Liauw (USA) on the basis of remarkably intensive synovial fluid studies in patients with rheumatoid arthritis. She showed that effective concentrations (higher than those in plasma) are well maintained in the inflamed synovium, particularly after the first week of therapy.

Diclofenac only needs to be given in twice-daily doses of 75 mg to produce this continuous effect. In other words, rapid clearance of each dose from the rest of the body should minimise the risk of side effects, while anti-inflammatory activity continues unabated. reported direct evidence of this, in the form of marked suppression of synovial prostaglandin E₂ levels throughout a 24-hour period after a week of twice-daily diclofenac treatment. Detailing some of the different mechanisms by which NSAIDs exert their anti-inflammatory action, Ku (USA) showed that diclofenac very strongly inhibits the enzyme cyclooxygenase, concerned in prostaglandin synthesis. Indomethacin and naproxen are slightly less potent, and all the other NSAIDs very much less potent, inhibitors of cyclooxygenase. This is clearly the sort of difference that could be related to the needs of different patients for suppression of particular mediators of inflammation. As regards other possible mechanisms of anti-inflammatory activity, diclofenac is relatively ineffective against 5-lipoxygenase, but acts strongly to inhibit 5-HETE and LTC₄ formation, as shown in leucocyte studies

S TO THE INDIVIDUAL PATIENT.

Richard Day (Australia), and at many sessions of the Sydney congress. This intensive activity went well beyond a conventional defining of indications for NSAID therapy in terms of particular diagnoses. Its ultimate aim was to help clinicians decide which drug would be most appropriately prescribed for each individual patient. Further progress in NSAID treatment – no obvious successor is yet in sight – could well depend on finding a sound basis for making such decisions.

It also inhibits the release of arachidonic acid, the precursor of prostaglandin, prostacyclin, leucotriene, and thromboxane, and it increases the uptake of this precursor. These effects combine to redistribute arachidonic acid intracellularly, from the phospholipid to the triglyceride pool, and to reduce the free arachidonic acid available for conversion into prostaglandins and leucotrienes – thus limiting production of these mediators of inflammation.

WHAT CAN NSAID PHARMACOKINETICS TELL US ABOUT VARIABILITY OF DOSE/RESPONSE, DURATION OF ACTION, AND SIDE EFFECTS?

Most clinicians seem to regard pharmacokinetics as an abstruse basic science that need not concern them much in practice. Yet most of the key clinical questions raised in Sydney about the variability of response to NSAID therapy can be answered only by reference to pharmacokinetic studies. It is good to be able to report that many such answers were in fact forthcoming at the Congress – about the factors governing drug absorption, distribution, and plasma binding, for

example. **Also, studies of synovial kinetics showed how it is that a drug like diclofenac with a relatively short half-life in plasma produces more prolonged relief of joint symptoms. The synovial concentration is higher and more sustained, especially in inflamed joints (Furst, USA).** Increasing attention is being paid to the clinical significance of the various forms in which an NSAID may be administered and/or present in the body – with particular reference to prodrugs, active metabolites, and enantiomers. Williams (Australia), for example, stressed the evidence that the extent to which the R-isomer of ibuprofen is converted into the S-isomer (thought to be the pharmacologically active form) may lead to a variability in response. And several speakers at Sydney reported new work on NSAID kinetics and excretion in the elderly – which goes some way to explain how renal and other side effects arise (Eriksson, Sweden). Where renal function is impaired, notably in the elderly, cumulation can be prevented by modifying the dosage.



Dr R. Day (Australia) delivering his paper at the NSAID symposium in the Blue Mountains.

All in all, advances in these fields are pointing towards more precise prescribing of NSAIDs, which should maximise benefit and minimise side effects.

TOXICITY AND INTERACTIONS

Among acknowledged side effects of NSAID therapy, gastrointestinal haemorrhage is perhaps the most widely recognised risk. Yet, as Henry (Australia) pointed out, the likelihood of an NSAID damaging the gastric mucosa is probably less than with unbuffered aspirin. Precise figures are hard to obtain, however, and it is always difficult to demonstrate that a widely prevalent condition is drug-related. Other undesired effects of NSAID therapy discussed at Sydney – by Wing (Australia) and Eriksson (Sweden) among others – included inter-

action with antihypertensive drugs (their efficacy is impaired) and differing degrees of interference with renal function (naproxen significantly reduces the excretion of water, sodium, and chloride, for instance, but sulindac does not).

TWO FUNDAMENTAL QUESTIONS OF EFFICACY

NSAID therapy is generally described as "symptomatic" – in the sense that each dose relieves inflammation and pain but does not cure the underlying disease. So far as it goes, that is certainly true. But there is an intermediate possibility: that an NSAID could modify the disease process at some intermediate point (Dixon, UK). In this case, pathological changes might be slowed and permanent damage deferred. It is still not fully clear whether any NSAID currently available can delay the advance of rheumatoid arthritis in this way, but some suggestive evidence was presented at the Sydney Congress. For instance, Sanda (USA) reported that etodolac, a new NSAID, in a dosage of 300 mg/day "arrested" radiographic signs of rheumatoid arthritis. And it certainly seems not unreasonable to expect that inhibiting inflammatory

changes that are known to produce joint-damaging effects would in the long run ameliorate the severity of the damage produced. The second fundamental question concerns cartilage deterioration, mainly in OA. Here, there is experimental evidence that NSAIDs may differ materially in their effect. Some appear to have no influence on the natural course of cartilage degeneration characteristic of OA. Certain others seem to be associated with accelerated cartilage breakdown, whereas NSAIDs in a third group have been shown to exert a chondroprotective (or cartilage-sparing) effect, at least in animal studies.

FUNCTIONAL PATHOLOGY OF THE LOCOMOTOR SYSTEM

Karel Lewit

Central Railway Health Institute,
Prague, Czechoslovakia.

ABSTRACT

Theories of musculoskeletal pain aetiology are considered. Restricted joint movement and increased muscle tone are put forward as important features of many common painful conditions. The role of increased tension in producing clinical manifestations is explained. Functional pathology of the locomotor system is described as disturbances of function and associated reflex changes. Practical considerations are discussed, with examples. Understanding of the functional pathology is shown to be of fundamental significance in the clinical diagnosis and management of musculoskeletal disorders.

THEORIES OF MUSCULOSKELETAL PAIN AETIOLOGY

In the opinion of the experts, there is no generally accepted theory as to the cause of common back pain. Jayson (3) therefore talks of "non-specific back pain", which covers by far the most numerous group of patients and now constitutes one of the most urgent problems of day-to-day medical practice.

The theoretical dilemma started when the old and widely accepted theory of the inflammatory origin of the condition had to be dropped, simply for lack of positive pathological evidence. How difficult and almost painful this process was can be seen to this day in the innumerable terms ending in "-itis" which are still with us. The tendency to use the term "rheumatic disease" is further evidence of this situation, the word "rheumatic" in this context being almost meaningless.

Pathological anatomy, having thus forced the medical profession to abandon the inflammatory theory, then generously provided us with a wealth of degenerative changes, which can be found not only at autopsy but most easily on X-ray examination. So we came to the term "degenerative disease or diseases" and instead of names ending in "-itis" we now have those ending in "-osis". The difficulty we now face lies not in proving these changes but in assessing the relevance. We know that these changes increase with age and can be "severe" in old persons without symptoms and lacking in young patients with severe symptoms. Even in the same person the site of symptoms frequently does not correspond to the site of degenerative changes and the painful condition usually improves while the degenerative changes go on deteriorating. In fact, common back pain affects the oldest age groups less than younger ones. The worst of it is that the term "degenerative", which in itself is a perjorative statement or interpretation, is used for widely different

conditions: destructive arthrosis, common wear and tear, adaptive changes due to trauma and healing. Frequently what is true of destructive arthrosis occurring exclusively in weight-bearing joints of the lower extremity is applied uncritically to other structures including the spinal column.

We are confronted almost daily with the unfortunate consequences of this "ideology" if we have to deal with patients who have only slight clinical changes but have been told about their "dreadful" spinal columns.

Pathomorphology has yet another mechanism to offer to explain painful lesions: nerve compression, by the disc, by stenosis and by nerve entrapment, giving the surgeon his chance. That such conditions exist cannot be doubted. What seems doubtful, however, is that common back pain, or most of the other common painful conditions of the motor system, have this origin. This is also borne out by physiological thinking, one might even say by common sense. What use would the nervous system, and the nociceptive system in particular, be if it signalled pain only when it was damaged itself and not when the innervated tissues were harmed? Clinical evidence is also supportive: nerve compression causes numbness (dysaesthesia) and weakness, but not necessarily pain and certainly not pain alone. In the typical carpal tunnel syndrome, and in other compression syndromes too, there is at first only numbness; painful dysaesthesia sets in later. In true radicular compression syndromes there are both dysaesthesia and weakness in addition to pain and the pain mechanism itself is not due so much to compression of the nerve tissue as to impingement on the meningeal sheath [7], i.e. to irritation of nociceptors by the disc. There are, however, no signs of root compression in common back pain, cervical headache, thoracic pain, most types of shoulder pain, etc.

RESTRICTED JOINT MOVEMENT

It was experience with manipulative therapy which showed us the way out of this dilemma but only once we understood the mechanisms involved. As long as anyone thought they were "adjusting subluxations", as chiropractors seem to think to this day, the effect of manipulation was also explained by the nerve root being freed. However, once we had learned to diagnose movement restriction in individual motor segments of the spinal column [8] and therefore learned that the effect of manipulation is due to restoration of lost joint movement, we had a fundamental discovery literally in our hands: that normalisation of function goes hand in hand with relief of pain. This experience — or experiment — was soon repeated hundreds and even thousands of times with similar results: if we achieve normal joint function, pain subsides or at least improves. This is particularly true where no pathomorphological changes (co-) exist: in children and adolescents.

INCREASED MUSCLE TONE

After having recognised reversible movement restriction or "blockage" of a joint as the model of disturbed function, causing pain, it was logical to look for other such changes. Hand in hand with joint dysfunction we usually find painful muscle tension, most characteristically trigger points as defined by Travell and Simons [6]. They too are reversible changes of function and can be abolished by local anaesthetics, needling, or even better by spray and stretch and simplest of all by post-isometric relaxation [5] (Fig. 1); sometimes the symptoms subside after joint manipulation, if they are secondary to joint dysfunction. There are also



Fig. 1. Post isometric relaxation of the upper trapezius: First the operator resists side bending of the patient's head (looking to the left) followed by relaxation with increased side bending to the right

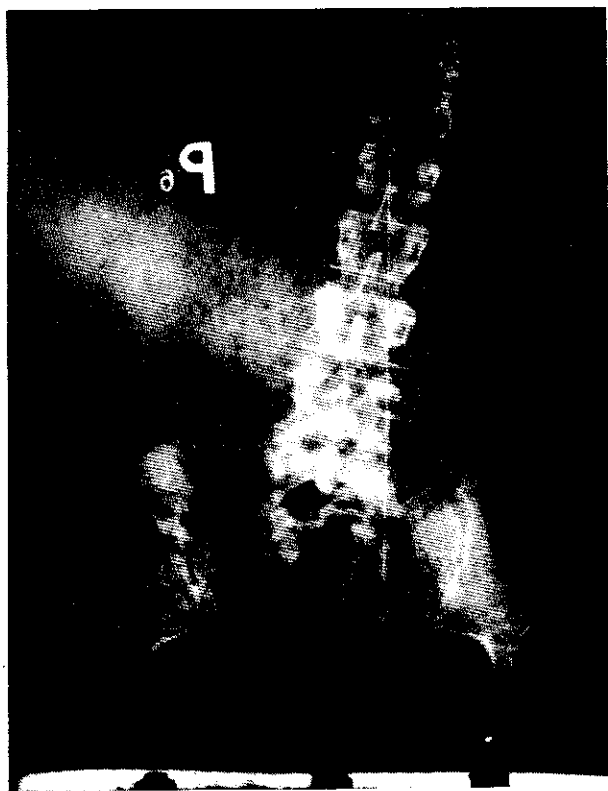


Fig. 2 X-ray. Deviation of the lumbar spine to the left (without scoliosis) causing static strain.

more complex changes of function, e.g. disturbances of body statics producing static overstrain [4] (Fig. 2). This can be due to uncompensated pelvic obliquity but also to exogenic static overstrain, e.g. the result of an uncomfortable position standing or sitting. It is sufficient to correct such positions and pain subsides. Another important cause of pain is faulty or over strenuous movement, again, either due to exogenic overstrain or to faulty movement patterns [2]. If the cause of pain is excessive work, pain subsides after sufficient rest. Faulty movement patterns, e.g. breathing (Fig. 3), weight lifting (Fig. 4 a. and b.) and weight carrying have to be corrected.



Fig. 3. Inspiration by lifting of the thorax: exaggerated tension of the sternocleidomastoids etc., causing overstrain of the cervical spine

ROLE OF INCREASED TENSION

The common mechanism causing pain in all these types of faulty function is increased tension, which can be found clinically. This stands to reason. Increased tension is the result of all types of overstrain which may cause tissue damage: this increased tension, i.e. the sign of impending danger, initiates a warning signal by causing pain. Indeed nociceptors can be found at those sites where increased tension is most likely to occur: attachments of tendons and ligaments, joint capsules and muscles.

This type of pain seems to be the one the human organism suffers from most frequently [4]. This is not a mere co-incidence. Not only does the motor system represent by far the largest part of the human organism, it is also under our voluntary control and has no other way of defending itself against our whims but by producing pain.

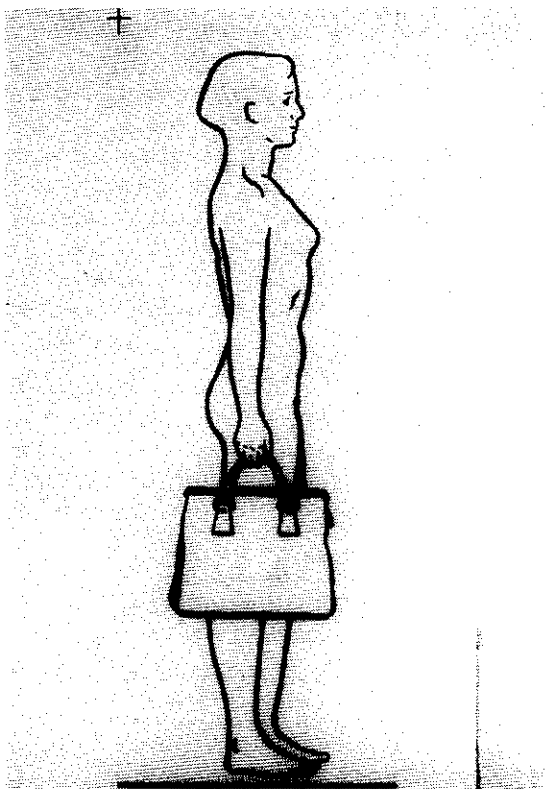


Fig. 4a. Correct weight bearing.

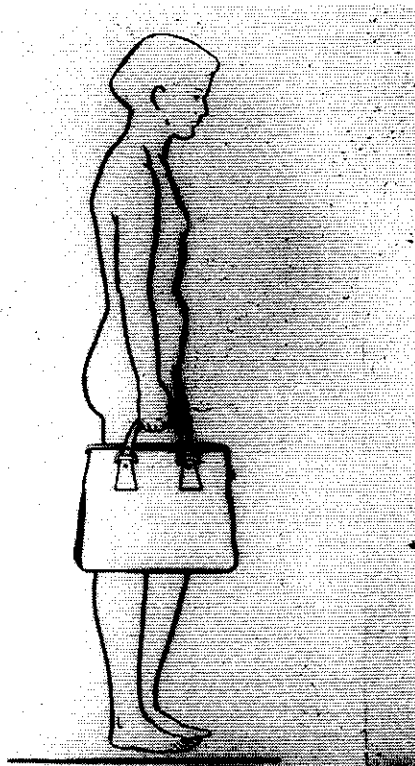


Fig. 4b. Faulty weight bearing. The shoulders thrust forward causing overstrain of the cervical spine.

Pain due to impaired function thus plays its natural role as a warning signal to protect the motor system from permanent structural damage.

Impaired function plays the role of nociceptive stimulus which is not identical with its result, i.e. pain. As a stimulus it produces reflex changes, which are most characteristic in the segment corresponding to the stimulus. We find a hyperalgesic skin zone, muscle spasm with trigger points,

pain points at the periosteum and joint dysfunction. At all these sites there are signs of increased tension, which can be palpated. In this way pain, or rather nociceptive stimulation, can be objectivised.

FUNCTIONAL PATHOLOGY

Disturbed function with its reflex changes constitutes what we call "the functional pathology of the locomotor system". It is so closely related to pain in general that even visceral pain is usually accompanied by changes in the motor system and is referred to parts of it, i.e. to the most frequent source of pain, which then also shows the typical changes.

PRACTICAL SIGNIFICANCE

All this may sound pretty straight forward. What is more, each type of change described here can be treated effectively and specifically: joint dysfunction by manipulation, muscular trigger points and painful attachment points by post-isometric relaxation (Fig. 5), other periosteal points by needling, hyperalgesic skin zones by various types of reflex massage or skin stretching. The difficulty lies in diagnosis and analysis. Doctors are not taught to diagnose dysfunction or blockage of a single motor segment of the spinal column, they are not familiar with important trigger points, which although very painful on palpation are not felt by the patients, and worst of all, they are not familiar with tissue palpation, the source of first

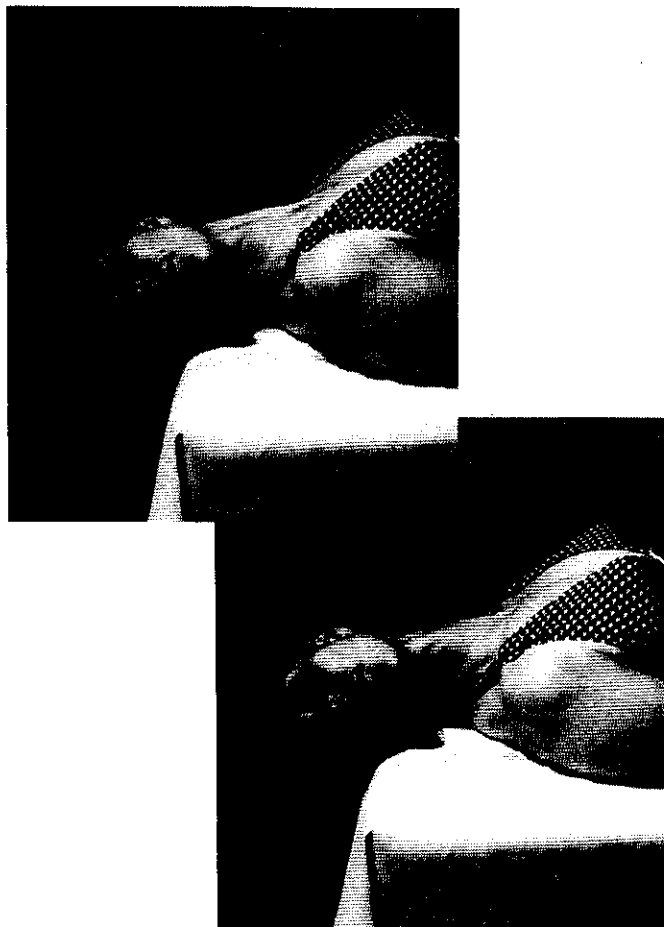


Fig. 5. Gravity induced post-isometric relaxation of the sternocleidomastoid muscle. Upper: During inspiration the muscle automatically contracts and lifts the head. Lower: During expiration the muscle relaxes and the head is lowered (producing also mobilisation of the occiput against the atlas).

hand information about changes producing pain. The same applies to the diagnosis of the even more complex disturbances of body statics and faulty movement patterns (Fig. 6 a. and b.).



Fig. 6a. Stooping with the abdomen bulging due to insufficient contraction of abdominal muscles.



Fig. 6b. Good contraction of abdominal muscles after treatment.

This, however, is mere "symptomatology". To establish a clinical diagnosis with a view to rational therapy, we have to know typical syndromes. Symptoms do not appear in a haphazard way but follow certain rules resulting in characteristic "chains". These chains correspond to certain basic functions like breathing, prehension, intake and mastication of food, body statics and gait. Knowledge of them enables the examiner to orientate himself in the confusing plethora of symptoms and gives him the opportunity to establish a hierarchy of basic and secondary lesions. The importance of such an approach may be highlighted by some examples.

In cases of the scalenus syndrome [4], operation is sometimes performed without proper diagnosis of scalenus spasm (Fig. 7) let alone of its possible causes: dysfunction of the cervico-thoracic spine, the first ribs, faulty respiration, faulty movement pattern of arm lifting and weight carrying (prehension). It is little known that in the early stages the carpal tunnel syndrome is caused by (slight) movement restriction between the carpal bones so that the walls of the tunnel do not adapt sufficiently to its content during work [4]. Meralgia paraesthetica, caused by compression of the lateral cutaneous nerve of the thigh in the lacuna musculorum, is due to psoas spasm which can be treated as such but is usually the result of movement restriction at the thoraco-lumbar junction. Therapeutic failure in headache patients whose pain arises in the motor system (the most frequent type of headache) is often due to misunderstanding of the complex interplay of the structures of the craniocervical junction with the muscles of the shoulder girdle, faulty respiration and masticatory dysfunction, forming chains which may be triggered from any of these sources at any time. Conditions of the pelvis,



Fig. 7. Examination of increased tension of the scaleni: restriction of back bending with the head rotated.

the sacroiliac joints and the pelvic muscles are so complex and confusing that all specialists including experts in manipulative therapy are at loggerheads.

In all these instances treatment at or of the site of pain by whatever means is useless as a rule. We have to restore correct functioning which is possible only if we have first understood the mechanism of the disorder.

It was necessary to make all these points in order to show that functional pathology of the motor system is most complex. This is borne out by the fact that the greatest part of the nervous system has to subserve it. There is no medical speciality at present wholly devoted to it: that explains the necessity felt by many to establish "Orthopaedic Medicine" [1] or better "Neuro-orthopaedics". Obviously, no single method of therapy can be adequate. Only the aim is clear: to re-establish normal function by the most adequate means. Only thorough clinical knowledge, so sadly lacking in this field, can solve the problem. I have tried to show the importance and also the difficulty of the task. ■

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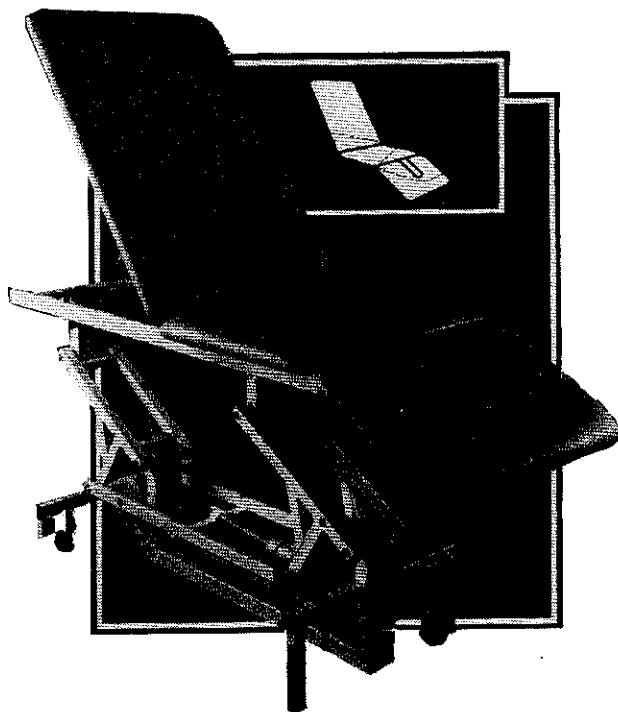
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THE UPPER LIMB TENSION TEST

Helen Rubenach

Postgraduate School of Manipulative Therapy,
South Australian Institute of Technology, Adelaide.

ABSTRACT

Clinical diagnosis of the cause of arm pain is sometimes a difficult task. The differential diagnosis includes problems in and around the shoulder and elbow joints and referred pain from cervical joints and nerve roots.

The upper limb tension test (U.L.T.T.) has been developed to assess the mobility of the mid and lower cervical nerve roots. Information gained from the test helps in the assessment of nerve root and meningeal contribution to symptoms in the same way as the straight leg raising test helps in the assessment of lower limb pain.

The test procedure is described and responses are discussed in the light of relevant studies.

INTRODUCTION

Differential diagnosis of the source of arm pain is a difficult clinical task. It is often hard to determine if the origin of the symptom is in the intra- or peri-articular structures of the shoulder or elbow or if it is referred from the cervical joints or from the cervical nerve roots or their pain sensitive coverings.

Differential diagnosis is difficult as you cannot rely on the 'area' of the symptoms to lead to their source. This is due to the shared dermatomes, sclerotomes and myotomes of the cervical area and the upper limb.

Also, there are close biomechanical links between the cervical spine and arm. Their movements are interdependent. For example, any movement of the arm results in contraction of the muscles of the cervical spine as they stabilise the scapula.

Therefore, arm movements will not only irritate an intrinsic shoulder or elbow lesion but also a painful cervical lesion. In fact, arm movements often seem a more potent irritant to a cervical lesion than do neck movements.

Furthermore, physical examination of a patient presenting with cervical and/or arm pain commonly reveals signs in more than one joint or pain sensitive tissue. For example, on objective examination of someone with shoulder pain there are commonly shoulder and appropriate cervical joint signs. Rarely are signs localised to one joint or structure.

Clearly there is a need for examination techniques of the cervical spine and upper limb which test the various pain sensitive tissues specifically.



DEVELOPMENT OF THE U.L.T.T.

The Upper Limb Tension Test (U.L.T.T.) was recently developed by a Western Australian manipulative therapist, Mr. Robert Elvey, specifically to assess the mobility of the mid and low cervical nerve roots and hence to assess their contribution to symptoms. This is analogous to the use of the straight leg raise (S.L.R.) to assess the contribution of the lower lumbar nerve roots to lower limb symptoms.

The U.L.T.T. involves glenohumeral abduction, extension and external rotation, forearm supination and elbow, wrist and finger extension and can include cervical lateral flexion towards and away from the test arm. Passively doing this combination of joint movements on a subject is thought to produce movement and stretch of the peripheral nerves of the upper limb, particularly the median nerve, and the resulting tension to be transmitted via the brachial plexus to the cervical nerve roots.

RESPONSES

The earliest study on the test was published by Elvey (1979) [4]. Elvey performed the test on a cadaver and showed the resulting movement of the nerve roots, mainly mid cervical, peripherally in the nerve root canal.

Mark Kenneally, South Australian manipulative therapist in 1983 performed the U.L.T.T. on 100 asymptomatic subjects to determine what is the 'normal' response to the test [5]. He recorded the subjects' responses and then individually tested all the joints and muscles involved in the manoeuvre to see if their stretch could account for the U.L.T.T. response. In no case was this reported.

The most consistent response amongst the 'normal' subjects was a deep stretch or ache sensation in the cubital fossa, extending down the anterior and radial aspects of the forearm, and into the radial side of the hand. A definite tingling sensation was also common in the thumb and first three fingers.

From this distribution Kenneally (1983) proposed that the C5-7 nerve roots were maximally stressed. A response which correlates with the C5-7 dermatomes was reported by close to 80% of the subjects studied.

These results were supported in 1984 by a study done by this author on 116 normal subjects. Approximately 75% subjects also reported this response.

This 'normal' response is of clinical importance:- care must be taken in interpreting the patient's response to the U.L.T.T., as it is 'normal' to have quite a 'painful' arm when the stretch is applied.

In 1984 I undertook a further study into the U.L.T.T. If as previous studies suggest the U.L.T.T. stresses the pain sensitive nerve roots then the pain response would be able to be affected by other movements known to alter the tension or position of the spinal cord and nerve roots. Adams and Logue (1971) [1] and Breig (1978) [2] showed that cervical movements affect cord and nerve root position and tension as does straight leg raise (Breig, 1979) [3] and the slump test (Maitland, 1978) (Massey, 1982) [6,7].

Sunderland (1974) [10] observed in his cadaveric studies that traction on a cervical spinal nerve, such as is proposed to occur during the U.L.T.T., caused movement of the spinal cord laterally in the canal towards the spinal nerve. The position of the spinal nerves on the contra-lateral side of the canal should be affected by this cord movement. If spinal nerve tension is transmitted across the cervical spinal canal the U.L.T.T. response in one arm may be altered by movement of the other arm. It was the effect of the position and movement of the contra-lateral arm that I decided to look at in my study.

I am not going into details of the study but the interested reader is referred to Rubenach (1984) (1985) [8,9].

The main finding in this study was that a change in the intensity and area of the subject's response to the U.L.T.T., when the U.L.T.T. was then also performed on the contra-lateral arm was reported by 77% subjects (left arm) and 79% subjects (right).

This change further implicates the nerve roots and spinal nerves in the U.L.T.T. response. If the response to the U.L.T.T. was due to stretch of other musculoskeletal structures in the arm, it would not change with movement of the other arm.

Clinical experience thus far has shown the U.L.T.T. to be a valuable diagnostic clinical tool, which can be used in the cervical examination in a comparable way as is the straight leg raise in examination of lumbar problems.

U.L.T.T. PROCEDURE

The test is described for the left arm and as being able to be taken to full range. If any component of the test reproduces or increases the patient's symptoms, the range at which pain is produced is noted and then the joint taken back into a painfree range. This is very important if the test is to differentiate pain from joint and nerve root.

Patient's position

- supine with left glenohumeral joint clear of plinth
- no pillow (cervical spine or knees)
- patient looking up to the ceiling

Operator's position

- standing facing towards the patient's head.

Method

1. Assess resting symptoms
2. Operator abducts patient's glenohumeral joint to 100 — 120° and extends joint 10 — 20°
 - assess available range and response
3. Operator laterally rotates the patient's glenohumeral joint to the end of range without joint overpressure
 - assess available range and response



4. Operator supinates patient's forearm to the end of range
 - assess available range and response
5. Operator extends patient's elbow to end of range without overpressure
 - assess available range and response
6. Ask patient to extend ('straighten') their fingers
 - assess available range and response

N.B. Give overpressure to wrist and finger extension if necessary to produce a response.

7. Ask patient to laterally flex his/her cervical spine to right; give overpressure if you have an assistant
- Repeat to left

- in both positions assess available range and response
8. Compare the range and the pain response on the other arm.

The U.L.T.T. can be considered positive if it reproduces the patient's pain or if the 'normal' pain response is much more intense on the symptomatic arm.

The test is more positive if:

- there is restriction of movement e.g. elbow E (L) U.L.T.T. < (R) U.L.T.T.
- release of one component e.g. wrist and finger extension alters the response

- movement of the unaffected arm alters the symptoms.

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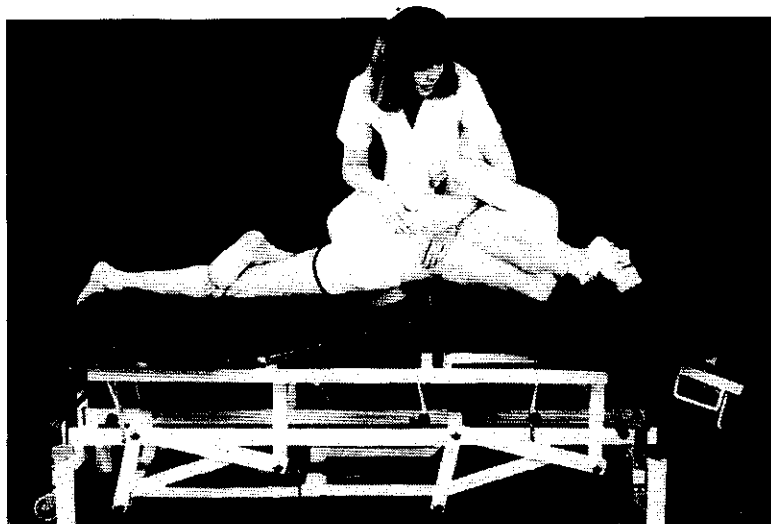
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BOOK REVIEW

Myofascial Pain and Dysfunction. The Trigger Point Manual

by Janet Travell, M.D., and David Simons, M.D.

Williams & Wilkins, Baltimore 1983

For many of us, the "Textbook of Orthopaedic Medicine" by James Cyriax was the catalyst for a lifelong interest in the diagnosis and treatment of soft tissue pain. The limitation of that excellent textbook was, in my opinion, the narrow focus of treatment, being confined principally to manipulation and cortisone injection.

Janet Travell and David Simons deserve the accolades of their colleagues in having pursued the scientific basis of muscle trigger points, and having produced an excellent "workshop manual" as a detailed guide to treatment.

The book is over 700 pages long and is divided into two sections. The first gives an extensively referenced background to the principles of the treatment of muscle trigger points. There is a chapter on perpetuating factors, and the treatment recommendations contained in this chapter will not be readily accepted by all. The authors advocate routine serum vitamin levels screening with supplementation of vitamins B1, B6, B12, folic acid and vitamin C. They claim that low normal levels of these vitamins may be responsible for perpetuating myofascial pain. The evidence given for this recommendation is not entirely convincing. However, on the credit side, other factors referred to are mechanical stresses, metabolic and endocrine inadequacies, psychological factors and chronic infection. The authors go to considerable lengths to emphasise the importance of perpetuating factors and the point is well taken. One should not assume that, armed with this book and a syringe of 0.5% Procaine, one will achieve instant cure of every chronic pain syndrome that

enters the surgery.

The major part of the book is devoted to a beautifully illustrated guide to the diagnosis and treatment of pain in the head and neck, upper back, shoulder, arm and torso.

In their introduction, the authors promise a second volume devoted to the lower half of the body.

In his foreword, Rene Cailliet compliments the authors on compiling a documentary which will be a classic for years to come. I strongly concur with this sentiment, and believe that this book deserves a place beside the examination couch of every practitioner who is involved in the treatment of soft tissue pain.

As a guide to the treatment of "whiplash injury", the anatomical drawings are excellent, and the syndrome descriptions exact. Explanations to the patient based upon the rationale contained in this book have proven to be successful in treatment.

"The Trigger Point Manual" is highly recommended to general practitioners, rehabilitation physicians, orthopaedic surgeons and physiotherapists.

Few books have the capacity to improve both one's clinical diagnostic skills and treatment skills. This book has both, as well as a splendid layout. Buy it.

713 pages. Price about \$140.00.

B.M. Kinloch.

Manipulation Therapy in Rehabilitation of the Motor System

by Karel Lewit: formerly Assistant Professor, Neurological Clinic, Prague; Consultant to the Central Railway Health Institute, Prague.

Butterworths, London and Sydney, 1985

This long-awaited book, which covers every aspect of the diagnosis and treatment of motor system disorders, is not merely a manual of manipulative therapy but a compendium of Dr. Lewit's work and ideas. Until now we have not had the opportunity to see much of this information in print, so it will be doubly welcome.

Dr. Lewit stresses the importance of thorough examination and accurate diagnosis. He concludes that morphological changes themselves cannot explain much of the pain arising in the locomotor system. Although changes of mechanical function alone may not cause clinical symptoms, they act as the stimuli for reflex changes which, if sufficiently intense, will eventually cause pain.

The influence of respiration and of eye movements on facilitation and inhibition of muscles is discussed, as is the connection between motor system and visceral symptoms. Dr. Lewit comments that pain which eludes a definite diagnosis most commonly arises from impairment of motor function; his views are reflected in the finding of a recent study by the College of General Practitioners which showed that musculoskeletal problems constitute the most common cause of disability in the population.

The chapter on Functional Anatomy and Radiology is most interesting and reveals aspects of x-ray investigation that I feel are not generally known or used in this country.

There is much in the book that will be of assistance in the management of the current epidemic of upper extremity pain, for which there is yet no suitable name. Faulty statics are dealt with, as well as mobility disorders. Chain reaction patterns are described and this is an interesting helpful concept that can be used as a path leading from one abnormal finding to another in a logical way.

The author's views on the diagnosis and treatment of disorders affecting or arising from the pelvis may seem revolutionary to many. For instance, blockage at the cranio-cervical junction is cited as the most frequent cause of pelvic distortion.

Dr. Lewit's aim is not to promote one kind of therapy but to improve function and to relieve symptoms by the most adequate and efficient methods available. This means the re-evaluation of every patient on every occasion, to decide which form of therapy may be the most effective on that particular day.

The final chapters cover important subjects rarely dealt with in depth. On prophylaxis: all aspects of the patients' activities at home and at work are important; early intervention is essential and manipulation can be used to prevent chronic sequelae, which too often are seen too late by those with manipulative skills. The need for patients to develop motivation and to take responsibility for their own treatment and progress is emphasised. The chapter on problems of expertise and the role of trauma should be mandatory reading for the legal profession and for those specialists who are called for their expert opinions but who are not involved in treating people along lines similar to those put forward in Dr. Lewit's book. Here are the sword and buckler with which to back up opinions when beset about with tortuous legality and the rigidity of experts.

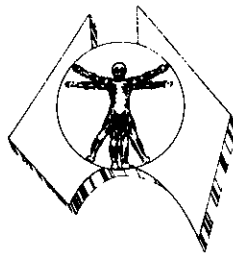
Illustrations and photographs are mainly clear and helpful (although I cannot agree with Fig. 4.60(b) on page 165 as being a correct lifting method, the object being held out too far from the body). There is an extensive list of references and the index seems adequate.

"Manipulative Therapy in Rehabilitation of the Motor System" will appeal to those who wish to develop their skills in examination and treatment of musculoskeletal disorders, which are so commonly encountered and so often neglected. I can recommend it to general practitioners who have this special interest, as well as physiotherapists, rehabilitation physicians, orthopaedic surgeons and osteopaths.

388 pages. Price about \$140.

G.T. Nelson

FOOTNOTE: This review is reprinted (with corrections) from the December issue of the Bulletin. The garbled version that appeared in that issue somehow slipped through the proof-reading system and sneaked into print in an unintelligible form. The editor wishes to apologise to the author and the reviewer and hopes the publication of this corrected version will help to make amends.



CONSTITUTION OF THE AUSTRALIAN ASSOCIATION OF MUSCULOSKELETAL MEDICINE

(Incorporating the Australian Association of Manipulative Medicine)

1. NAME

The name of the association shall be The Australian Association of Musculoskeletal Medicine, incorporating the Australian Association of Manipulative Medicine.

2. OBJECTS

- (a) To promote the science and study of the medical management of mechanical disorders of the musculoskeletal system.
- (b) To promote the teaching of manipulative therapy.
- (c) To promote treatment of musculoskeletal disorders by all methods consistent with scientific principles, but favouring the least invasive method appropriate to each individual patient.
- (d) To promote research into manipulative medicine and all other aspects of musculoskeletal medicine.
- (e) To constitute the Australian branch of the International Federation of Manual Medicine.
- (f) To further these objects by holding meetings, both professional and social; by co-operation and, where possible, close association, with other Associations both national and international; by arranging demonstrations of manipulative medicine; by encouraging articles and papers to be written by members and circulating copies thereof to all members and to other interested persons.

3. MEMBERSHIP

- (a) Membership of the Association is limited to Medical Practitioners registered in Australia.
- (b) Medical Practitioners with adequate qualifications but not registered in Australia, and medical students, shall be eligible at the discretion of the Committee for election as Associate Members. Associate Membership shall confer all privileges of membership except voting rights.
- (c) Notwithstanding anything contained in paragraphs 3 (a) and 3 (b) above, the Committee may, at its discretion offer to, or confer upon deserving persons Honorary Membership, Life Membership or Honorary Life Membership of the Association.

4. SUBSCRIPTION

- (a) Every Member (except an Honorary Member) shall pay an annual subscription which shall become payable on the first day of November in each year. A Member whose subscription is in arrears more than one year shall not be entitled to vote at any meeting.
- (b) Notwithstanding the provisions of paragraph (a) above, it is provided that when the spouse of a Member who pays the usual subscription is or becomes a Member, such spouse shall pay an annual subscription equal to one half of the usual Member's subscription.

5. ELECTION OF MEMBERS

- (a) Applications for membership shall be sent to the Secretary and will be decided by the Committee, who may refuse any such application without assigning any reason therefore.
- (b) A Member may be deprived of his membership by a Special Resolution passed by a two-thirds majority of those present and voting at a meeting of the Committee duly convened for that purpose. Such Member shall be entitled to be heard at such meeting.

6. COMMITTEE

- (a) The Committee shall consist of the Executive Officers of the Association, who shall be a President, a Treasurer and a Secretary, and Committee Members to constitute a Committee of up to ten persons.
- (b) The Committee shall be elected at the Annual General Meeting of the Association and shall hold office until the next Annual General Meeting after their election. They may offer themselves for re-election.
- (c) The Committee shall meet as often as the business of the Association shall require, and in any event at least once in each six months. Four Members of the Committee shall constitute a quorum.
- (d) The Committee shall have power to co-opt Members to be additional Members of the Committee or any sub-committee.

7. STATE REPRESENTATIVES

- (a) The Association may nominate at the Annual General Meeting one or two Members from each State of Australia to act as the Association's representatives in that State. Nomination as a State Representative shall not per se confer ex-officio membership of the Committee.
- (b) The State Representatives shall refer to the Committee for its information and advice matters in which they may become involved as Representatives of the Association.

8. PROCEEDINGS AT MEETINGS

- (a) At all meetings of the Association and of the Committee every Member of the Association or of the Executive Committee as the case may be, who is present in person, and who is not disqualified by being in arrears of subscription, shall be entitled to one vote. In the case of an equality of votes the Chairman of the meeting shall be entitled to a second or casting vote.
- (b) The Committee shall convene an Annual General Meeting of the Association once in every year, and the First Annual General Meeting after the Inaugural Meeting shall be held in 1972.
- (c) At every General Meeting of the Association, ten Members personally present, or one quarter of the total membership (whichever number is the less) shall be a quorum.
- (d) The Committee may at any time convene an Extraordinary General Meeting upon receipt of a resolution signed by at least seven Members specifying the nature of the business for which the meeting is to be called.
- (e) At least four weeks' notice of all General Meetings shall be given to all Members who have notified an address in Australia to the Secretary; such notice shall specify the date, time and place of the meeting and in the case of an Extraordinary General Meeting, the nature of the business to be transacted thereat.

9. ACCOUNTS

- (a) Cheques drawn on the Association's account shall be signed by two officers of the Association.
- (b) The Committee shall cause proper accounts to be kept of all assets of the Association including proper records of all receipts and expenditure. Such accounts shall be audited in every year and an audited income and expenditure accounts shall be presented to each Annual General Meeting. The accounts shall, subject to any reasonable restrictions imposed by the Committee, be available for inspection by Members.

10. POSTAL VOTING

Postal votes received by the Hon. Secretary will be accepted at all General Meetings. Proxy votes shall not be accepted.

11. AMENDMENT TO CONSTITUTION

A three-quarters majority of Members voting at a specially convened Extraordinary General Meeting shall be required to add to, abrogate, vary or modify the Constitution. ■



**THE OSTEOPATHIC LESION
— AND ALL THAT**

Roderic MacDonald MRCP MLCOM, the honorary secretary of the British Osteopathic Association, has sent me a good natured but very thorough rebuttal of the rather scathing attack made by Loic Burn and John Paterson in their first book on the osteopathic concept of the facilitated cord segment and the contention that somatico-visceral reflexes spread malfunction in spinal facet joints to produce malfunction in viscera. It seems that JKP has not read the very careful research on the first point by Professor Irwin Korr, nor that by Neuwirth (Neuwirth, E (1952): 'Headaches and Facial Pains in Cervical Discopathy. Annals of Internal Medicine 37.75 on the question of autonomic afferent fibres and their connection with spinal malfunction.

We print his letter in full since some basic points are raised and there was no way to shorten his contribution. The Newsletter will be pleased to publish replies by JKB or LB or by anyone else on this interesting topic (or any other topic).

**CONVENTIONAL MEDICINE AND
COMPLEMENTARY THERAPIES**

A response to John Paterson's letter of last month.

In his letter John raises several issues worthy of comment and also draws attention to the lack of any factual challenge to the criticisms of osteopathy in 'Medical Manipulation' which he and Loic Burn published last year. As a practising medical osteopath, I would like to respond to both letter and book.

John's position is difficult: he wishes to take most of his diagnostic and therapeutic repertoire from osteopathic sources without damaging his credibility by going too far beyond the pale. To this end osteopathic theory is renounced hastily without the careful analysis which characterises other aspects of John's writings and thought. He ascribes to osteopaths faith in 'fundamental truths' for which there is no validation, and recommends instead that we champion 'logic in deduction' and put each theory to the test.

The background to this argument is relevant — is this really a conflict between science and hard data on the one hand, and unvalidated theory and gullible belief on the other? The majority of pain of spinal origin that occurs defies an orthodox diagnosis hence the terms "mechanical" and "non-specific". Both anatomical origins and mechanisms often defy the investigators, and yet patients have to be managed as best we can. We are in the area of the "best guess" and "the working hypothesis" — there is no orthodox hard data which osteopathic theory is challenging.

In such uncharted seas science progresses in three stages: i) the investigator observes phenomena and attempts to construct conceptual models which fit the observations; ii) hypotheses are derived which can be tested in reality; iii) that testing takes place. When testing appears to confirm the hypotheses, then further related hypotheses are formulated and tested to extend the body of knowledge. When hypotheses are not confirmed the process should return not only to stage ii), but also to i); it is not science to continue endlessly and unsuccessfully to test hypotheses based on the same conceptual model without seriously considering whether alternative models have been neglected. In mechanical spinal pain, orthodoxy has applied the conceptual model of pain deriving from tissues damaged by trauma or morbid pathological process. Numerous hypotheses have stemmed therefrom — that this or that structural pathological change will be found associated causally with the experience of spinal pain. The testing of these hypotheses has taken many decades of radiological surveys, postmortem studies, etc, but has drawn a blank for the majority of spinal pain presentations. Unfortunately, with a few notable exceptions, orthodox medical investigators have not behaved like true scientists and considered other conceptual models. On the other hand for more than a century, osteopathy has addressed itself to a different conceptual model which promises the breakthrough in understanding which is now needed.

The concept is of reversible dysfunction of the musculoskeletal system as a primary entity, arising in response to mechanical stress, and producing pain and disability without the necessary presence of structural pathological change. The scientific investigation of this conceptual model requires the testing of hypotheses derived from it, and obviously this has not been done on anything like the scale that it has for the structural pathological model. This does not damn the approach as unscientific, merely it shows that this direction of investigation is at a different stage of evolution (due to the formidable difficulties in collecting useful data when excluded from the academic teahouses). One could say however that the numerous investigations seeking to confirm the association of this or that structural pathology with clinical spinal pain syndromes have in effect served to confirm one hypothesis derived from the primary dysfunction model ie that groups of patients will be found in whom pain and disability will not depend on the extent of any structural pathology discovered. These negative proofs however are always vulnerable to those who say that the structural change, which they presume is present, must be inaccessible to the diagnostic methods used (a good excuse to spend even more money on higher technology to search for the supposed needle in the haystack).

THE ORIGINAL

NECK ROLL
DESIGNED BY
DR. ROBIN MCKENZIE

NECK ROLL
DESIGNED BY
DR. ROBIN MCKENZIE

THE ORIGINAL MCKENZIE CERVICAL ROLL DESIGNED BY M.D. PHYSIOTHERAPIST ROBIN MCKENZIE

- This roll have been developed over many years and is designed, when used correctly, to prevent the onset of pain. It must be used with a pillow containing feathers, kapok, rubber chips or foam chips. Moulded rubber or foam pillows should never be used if you have neck problems.
- Place the roll between the pillow and the pillow case, so that it will be in a position to give added support to your neck. This position is usually found where the edge of the pillow comes in contact with your shoulder. (See illustration.)
- Initially the roll may feel a little uncomfortable and you may have to adjust your position slightly. After two or three nights use you should be accustomed to the roll and will feel uncomfortable without the extra support.

As described on page 38 of the Book "Treat Your Own Neck"

If you suffer from neck pain, you should use a cervical roll while sleeping.

- If you suffer from frequent episodes of neck pain, you may be perpetuating the problems because of poor lying and sleeping postures. Should you have neck problems that cause you to wake during the night, or if you sometimes wake in the morning with a stiff or painful neck, your sleeping positions may be faulty.



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In summary then I would say that orthodoxy is beginning to realise the need to return to stage i) in the process outlined above, while osteopathy is progressing slowly from ii) to iii). Neither situation is satisfactory as is the nature of the haphazard way that the human race makes its progress, but, if accusations of lack of science are being levelled, it would be difficult for an unbiased observer to know where they should be directed.

In the meantime we all get on managing patients on our "best guess/working hypothesis" basis; no harm in that, it was ever thus, — provided no group forgets the provisional nature of the ideas on which their management is based. If one elevates hypothesis to fact (by process of faith), one may be lured into unjustifiable and harmful action. Proponents of the structural pathological model, often prescribed NSAID drugs in non-specific musculoskeletal pain, in the expectation that these agents will mitigate the process of tissue damage leading to nociceptor excitation which they believe must be present. This unscientific assumption must kill, from the side effects of these drugs, an appreciable number of people who would have survived a course of simple analgesic. For non-specific low back pain Wiesel et al (Spine 1980 5:4 324—30) have shown NSAIDs to have no advantage over the safer simple analgesics.

John will rightly protest at this point that he should not be lumped with those doctors who eschew proper scientific thought in their blind faith in structural pathology as a source of all pain and disability, and he and Loic point out clearly the harm done to patients by the common orthodox practice of ascribing their spinal pain to any pathological change, such as facet OA, which happens to show up on an X-ray. But their position, as stated in their book, is open to criticism.

In an effort to bring manipulation within the orbit of scientific medicine, they describe the gate theory of pain modulation by mechanoreceptor inputs, and state "it seems clear that manipulation operates the same mechanism". So far so good, but they then appear to make a quite unwarranted assertion that this is the sole mechanism by which manipulation works, and that therefore any manipulation which generates "a healthy mechanoreceptor input" should be effective: a few simple techniques which can easily be taught to general practitioners will suffice — the osteopaths' complex repertoire is unnecessary. This sequence of thought is unsound; closing (or narrowing) the gate might well be included in the possible mechanisms of action of manipulation, but there is no reason to cite it as a comprehensive explanation; to do so is to close an intellectual gate on the possibility of other mechanisms, and to justify a limited therapeutic repertoire on such a basis risks discarding useful measures before they have had a chance to be evaluated properly.

The authors have a strangely ambivalent attitude to the osteopathic concept of dysfunction of a spinal segment. They seek to debunk it by quoting Barry Wyke's assertion that the spinal nerves have plurisegmental ramifications and that therefore any idea of a single dysfunctioning segment is untenable. However in the remainder of the book it is stressed that diagnostic and therapeutic attention should be directed at the "painful segmental disorder". Either you can have abnormal function of a single segment or not: the authors cannot have it both ways. This point is

perhaps the only important departure between Prof Wyke and modern osteopathic theory. He argues from the neurophysiology that a single segment cannot dysfunction, whereas osteopaths clearly feel bands of "skin drag" or increased muscle tension which correspond to a single segment. However the difference is probably not of fundamental importance, as it is not an osteopathic tenet that the abnormality is totally confined to one segment, simply that often clinical signs seem so confined — that which is actually palpable is obviously only the tip of the iceberg of neurophysiological abnormality. Group lesions, ie of several adjacent segments, are also recognised, and Irvin Korr in his original demonstration of "the facilitated segment" showed that this facilitation overlapped onto nearby segments (Denslow, Korr, and Krems. American Journal of Physiology 1947, 150: 2 229—37).

Perhaps the greatest effort John and Loic make, to separate the osteopathic methodology they wish to employ from its conceptual basis which they reject, is reserved for any claim that osteopathy "is a system of healing with effects far beyond the relief of pain". This claim they say "has been shown to be invalid". I find it sad that they need to exaggerate the importance which current osteopathy gives to this general application of the therapy; they have first to erect the "Aunt Sally" themselves before attempting to knock it down (a debating technique used mostly by politicians — let us remember that we aspire to higher standards).

When Andrew Still proposed his principles of osteopathy in 1874 he did so against the background of an orthodox medicine (no doubt as stoutly defended then as is that of today) which we can now see was either useless or dangerous — he proposed that it be abandoned en masse and offered his form of management as a complete alternative, although he accepted surgery as sometimes necessary and it was practiced in the osteopathic hospitals which arose. For how long was his alternative management superior to orthodoxy? One could argue for half a century at least solely on the basis of avoiding the iatrogenic harm of the conventional pharmacopeia, but positive benefits there must have been aplenty even if one only accepts benefits to the musculoskeletal system. Osteopaths of course claimed much more; for example postoperative atelectasis in osteopathic hospitals was claimed to be dramatically lower than elsewhere. However this claim to a complete alternative therapy was retracted as soon as orthodoxy had some useful remedies to offer — little more than fifty years ago. In the U.S.A. subsequent orthodox developments have been incorporated into osteopathic practice (so that the D.O. degree is officially in all respects equivalent to an M.D.); this has risked the submerging of their osteopathic origins, but recent developments suggest a healthy resurgence of osteopathic concepts there. Medical osteopaths in the U.K. are probably more akin to the U.S. (having been augmented by transatlantic D.O.s up to the end of the forties) than those who are non-medical and U.K. trained, but even these have in the main come to confine themselves to musculoskeletal maladies and consider appropriate referral of patients back to their orthodox doctors as an important part of their function. Stoddard in his Textbook of Osteopathic Practice (which John and Loic quote from as an authority on current osteopathic thinking) says "no one in the osteopathic

profession now claim that lesions in the spinal column are the sole cause of disease", "the influence of mechanical faults on body function still remains incompletely understood, there must be room for conjecture".

Current osteopathy therefore does not retain Still's claims for the comprehensive application of his ideas to both diagnosis and treatment, but what of John and Loic's claim in their book that such a general application has been "shown to be invalid"? Contrast this with Alan Stoddard's "there must be room for conjecture"; are the ideas debunked by the critical scrutiny of science or are they 'not proven' as Stoddard says? I would suggest the latter, and to suggest otherwise is to shut the door on a fascinating field of enquiry which could yield a rich vein of benefit for patients.

In a letter such as this (no matter how kind the editor is) one can only touch on the wealth of data concerning the relationship between somatic and visceral dysfunction: the links between Musculoskeletal Medicine and what used to be called Internal Medicine. Korr certainly showed that the neurophysiological abnormalities that he demonstrated in the clinical 'osteopathic spinal lesion' also extended into the sympathetic outflows from those regions. Reports abound correlating patterns of spinal dysfunction with specific visceral disorders; the most recent, although not perhaps the best executed, reached the BMJ columns last Summer (Nicholas, DeBias et al. BMJ 1985, 291 : 13-17). In this study patterns of left upper thoracic joint dysfunction correlating with myocardial infarction were demonstrated. Whether this is a causal relationship and whether any useful treatment can be derived from it has yet to be subjected to clinical trial.

Another intriguing insight into the relationship of spinal dysfunction and visceral disease is the work of Speransky (American Review of Soviet Medicine (1947) 2 : 22-7) on lobar pneumonia. I remember my teachers in medical school contrasting lobar and broncho-pneumonia; the latter a predictable occurrence in the weak and immobile, the latter striking randomly at fit strong people and unaccountably affecting only a minority of those in whom the causative organism could be found. Protective antibodies are not the cause of variation in susceptibility and various mechanisms have been suggested to explain the sporadic breakdown of host resistance leading to consolidation and multiplication of pneumococci in the lung, but none have provided more than a speculative

answer. Speransky's contribution was to report the work which he and his colleagues performed on soldiers developing lobar pneumonia at the fronts of the Russo-Finnish war and World War Two. Experience of 250 cases were reported, treated by intracutaneous infiltration of novocaine over an area of the posterior neck and back from C3 — T5; improvement in X-ray appearance followed by drop in temperature was seen and complication rates were reduced. The results were superior to groups treated by sulphonamide (where the X-ray did not improve until after the temperature had settled) or conservatively. This mode of treatment had been suggested by their work on animals where irritation of the upper thoracic sympathetic ganglia or the medulla oblongata was shown to produce lobar consolidations. Of course the advent of penicillin would have curtailed this work, but it did serve to demonstrate that the variability in occurrence of a disease might be mediated by factors within the neurophysiological as much as the bacteriological orbits. When one thinks of the cardiovascular and gastrointestinal systems where the causative factors we have identified account for only a small proportion of the incidence of the various diseases eg. myocardial infarction, it is clear that to conclude that the possibility of reflex influences from spinal dysfunction should be ignored as "invalid" would be quite illogical until much more data has been sought.

This letter is a plea for a scientific approach which is open to new interpretations not shackled to, and prejudiced towards, those which, no matter how successful they have been in explaining many diseases in the past, may not be appropriate to some of the maladies which we still cannot explain or treat satisfactorily. True science needs to spend time looking for new concepts, not just collecting data to test those which have already attained respectability. A flat earth at the hub of the universe was once the thinking of "sound" men; thank goodness a few were prepared to risk ridicule and worse to suggest alternatives.

Sorry John to contradict you on so many fronts, but you did poke your head over the ramparts, and you can't expect to take what you want from osteopathy and rubbish the rest, without a few faint cries of protest at a somewhat cavalier attitude to logic and evidence.

Roderic MacDonald, Honorary Secretary, British Osteopathic Association. ■

PROCEEDINGS OF MEETINGS PUBLISHED:

A.A.M.M. Back Pain 1984 Conference

available from the Hon. Sec., A.A.M.M., 441 Bay Street, Brighton, Victoria, 3186; Cost \$20, including postage.

Back Pains and Other Strains - Seminar 1983

available from the Education Co-ordinator, Arthritis Foundation of Australia (N.S.W.), 12th Floor, 291 George Street, Sydney, N.S.W., 2000; Cost \$10

Repetition Strain Injuries - Seminar 1983

available from the Arthritis Foundation, address as above; cost \$10.

Footcare Symposium 1984

also available from the Arthritis Foundation; cost \$10

Repetitive Strain Injury - Symposium 1984

sponsored by the Australian College of Rehabilitation Medicine and available from Dr. P. Colville, 616 Riversdale Road, Camberwell, Victoria. 3124; cost \$14.

Bulletin

Picture Quiz

Members are invited to answer the questions based on the picture, below, which is taken from the Association's family album. A little background may be of assistance. The four men hail from different states and were meeting on neutral ground in a fifth state to discuss a subject of great controversy. The meal depicted was taken half-way through the discussion, at a point when all parties had given up trying to convince one another and were trying to remember and understand their own opinions instead.



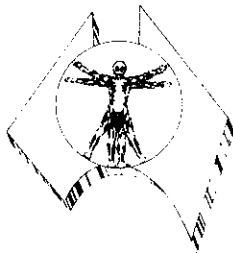
1. The man on the extreme left is:
 - a) semi conscious
 - b) intoxicated
 - c) suppressing a yawn
 - d) all of the above
 - e) none of the above
2. The man second from left is:
 - a) blowing a raspberry
 - b) eating humble pie
 - c) just trying to keep a low profile
 - d) checking his dentures prior to eating
 - e) none of the above
3. The man third from left is:
 - a) struggling to understand
 - b) holding an empty wine bottle in his lap
 - c) wondering who to punch
 - d) all of the above
 - e) none of the above
4. The man on the extreme right is:
 - a) ignoring the others
 - b) being ignored by the others
 - c) saying grace
 - d) praying for deliverance
 - e) none of the above

The neatest correct entry will be awarded the prize of first class air travel for two to the F.I.M.M. Congress in Madrid, generously donated by Qantas. The winner's name will be announced in the June issue. ■

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