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system of medicine and its graduates will usually immerse themselves in this, while medical manipulation is simply one method of treatment among many others.

Medical manipulation should be given only a few times—once may be sufficient. The aim is to hasten recovery, usually by a few days, allowing patients to go back to work or normal activity sooner. There is no expectation of “cure” or the prevention of recurrences or any alteration in the long term prognosis. The reaction to a session of manipulation may be an immediate and sustained improvement in pain or range of movement, or both, sometimes after a transient increase in soreness due to the treatment. A relapse may occur in a day or two, but this often responds to one or more further sessions of manipulation. Some patients are not helped, and a very few are made temporarily worse.

There are risks to manipulation, as with any interventional treatment.^{18,20} Manipulation under general anaesthesia should be avoided,¹⁸ and patients with clear contraindications should be left alone.²¹ Careful attention to contraindications⁹ and a high index of diagnostic suspicion with radiography and blood tests where appropriate before treatment will ensure that these simple and effective procedures retain their great safety.

Manipulation for backache rests on an established case and provides for back sufferers “a clinically worthwhile hastening of relief” (J A Mathews, MD thesis, 1985, University of Cambridge).

I thank Dr John Mathews for lending me a copy of his MD thesis and the late Dr James Cyriax, who taught me to manipulate.

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Osteopathy in back trouble

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Osteopathy is practised in many countries throughout the world, yet (with the notable exception of the United States), it is rarely included in the orthodox medical services. The lack of scientific research which has kept the discipline among the ranks of “alternative” medicine has been discussed elsewhere, but this categorisation may well be inappropriate for osteopathy where back trouble is concerned.¹ Heterodox disciplines are usually based on belief in an alternative explanation for illness, but the osteopathic management of back trouble asks for no such belief—at least as practised in Britain by members of the Register of Osteopaths.

The lack of scientific evidence for the efficacy of osteopathy as a treatment for back pain should be seen in the light of similar deficiencies for other conservative treatments. The multiplicity of treatments highlights our inability to offer patients managements which have predictable results on the clinical course of their condition. Osteopathy may be considered as one of several manipulative treatments on offer to such patients, though some believe it should really be regarded a system of diagnosis and treatment laying emphasis on structural integrity.²

A retrospective study of the practice of members of the Register of Osteopaths in Britain showed that over half of their patients presented with low back pain and that their patterns of age, sex, and occupation were similar to those reported in orthodox practice.³

Diagnostic labels could not be assigned, though half the patients reported associated symptoms in their legs. Some 40% presented within one month of the onset of back pain, but a third had had their complaint for over a year. The conditions treated seemed to cover the range seen in general practice,⁴ and some 6% of patients were rejected as being “unsuitable for treatment,” though the criteria for rejection were not recorded. The study showed that the osteopaths carried out a detailed structural and functional assessment (similar to that described by Stoddard⁵) together with conventional orthopaedic and neurological tests. Radiographic examination and biochemical tests were used infrequently, but as about two thirds of patients had previously consulted a doctor⁶ some preliminary screening seems likely already to have been carried out.

The treatment given by osteopaths is largely manual, consisting of a wide range of soft tissue stretching and relaxation techniques as well as manipulative thrusts to spinal joints.⁷ They exercise considerable discretion in the use of manipulative thrust techniques, and they make little use of adjunctive treatments such as exercises, traction, and corsets.³

The evidence shows that osteopathic management of back trouble as practised by registered practitioners in Britain consists of a method of assessment and manual treatment which is used largely on patients with “mechanical” back ailments. These treatments seem likely to be safe in view of the practitioners’ use of orthodox diagnostic procedures and of most patients’ prior medical contact. Their efficacy, however, remains in doubt. The only reported controlled trial of osteopathic treatment for back pain showed its results to be no better than those of short wave diathermy or placebo.⁸ A recent review of the physiology of joint dysfunction,

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however, supported the probable effectiveness of passive movement but stated that further research was required to determine therapeutic indications.⁹ The direction for future research into conservative management of back trouble was discussed at an international back pain congress in 1985. The consensus of opinion suggested that efforts should be made to define clinically identifiable syndromes with a known clinical course, which would increase the validity of controlled therapeutic trials ("Back pain: current concepts and recent advances," November 1985, Vienna). Osteopathy should be able to contribute to this process by subjecting its specialised clinical diagnostic procedures to scientific scrutiny to establish their discriminatory value.

At present it is probably correct to describe osteopaths primarily as therapists.¹⁰ Nevertheless, many would claim to be musculo-skeletal specialists capable of offering a complete diagnostic and assessment service in addition to the treatment, but there is little evidence to confirm this view. The future place of osteopathy will be determined through scientific research procedures, but these will probably have to be directed to establishing not simply its value as a

treatment but also its potential as a specialty. Meanwhile, it will probably remain one of the frequently used treatments for back trouble which is no worse—if no better—than other conservative approaches and may be of benefit in some patients.

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Lesson of the Week

Chronic urological problems in neurological patients

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Urological problems are common in neurological disorders, particularly in those that become chronic—for example, stroke and multiple sclerosis. Patients with stroke whose consciousness is altered are incontinent, and some may need long term catheterisation during rehabilitation. In such patients the maximum urinary disability usually occurs at the beginning of the illness.

The most common associated problems in nearly all patients with established multiple sclerosis—that is, those with clinical neurological deficit—are failure to empty the bladder, leading to retention of urine, and failure to store urine, leading to incontinence. Unlike in patients with stroke, urinary problems in patients with multiple sclerosis tend to deteriorate rather than improve over time.

We describe two patients whose urological complaints were wrongly attributed to their neurological problem.

Case 1

A 74 year old woman was admitted for investigation of urinary problems. Multiple sclerosis had been diagnosed in 1958. She had had further admissions to hospital because of multiple sclerosis, and her condition had gradually deteriorated. In May 1984 she was admitted to hospital with a stroke in the right cerebral hemisphere. She recovered well within a month and was discharged to a warden controlled flat, where she lived an

Urinary problems are common in chronic neurological disorders, but knowledge of the clinical course of the disease should help in selecting those patients who need further investigations

independent life with some help from her daughter—for example, with shopping and bathing.

She had had no urinary problems apart from the occasional urinary tract infection, which was treated by her general practitioner, but she noticed increasing frequency of micturition over time though paid no attention to it. On admission in May 1984 her frequency of micturition became worse, and she was incontinent of urine. This was treated with brief catheterisation and frequent visits to the toilet. Her urinary problems worsened after discharge, and she again became incontinent of urine, with associated pelvic discomfort and pain. Because of her neurological disability from multiple sclerosis she was unable to walk to the toilet quickly enough to avoid incontinence. When seen as a new referral to the neurology clinic in August 1985, she was incontinent at night and had to empty her bladder more than 20 times during the day to stay dry. Before this her worsening urological symptoms had been put down to her longstanding multiple sclerosis.

The results of physical examination showed a spastic gait and cerebellar incoordination of her arms. There was sustained nystagmus on lateral gaze bilaterally but no residual neurological signs from her stroke. The results of the rest of the examination were normal. A midstream sample of urine showed evidence of urinary tract infection. Plain x ray film of the abdomen, an intravenous urogram, and the results of cystoscopic examination showed a large bladder calculus formed around a catheter tip (fig 1). Four diverticuli in the bladder wall indicated outlet obstruction. The stone was crushed and removed cystoscopically. Postoperatively, her urinary symptoms improved considerably. Unfortunately, she died suddenly from a myocardial infarction just before being discharged home three weeks later.

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