

LETTER TO THE EDITOR

Chiropractic Legal Challenges to the Physical Therapy Scope of Practice: Anybody Else Taking the Ethical High Ground?

In writing a response to “the longest editorial in the history of peer-reviewed literature,” it is tempting to craft the longest response to an editorial in the history of peer-reviewed literature. Alas, Huijbregts has performed nicely in his comprehensive argument that such a lengthy repose is simply unnecessary. It was refreshing to see such an argument solidified on paper and backed by numerous literary references, moving what is a common colloquial conversation around the Physical Therapy water cooler to the status of a documented issue. In writing *Chiropractic Legal Challenges to the Physical Therapy Scope of Practice: Anybody Else Taking the Ethical High Ground*, Huijbregts has issued a real challenge to the chiropractic profession. The question now is: Are they listening?

State chapter meetings of the APTA are often boring and even more often bleak. Perhaps this is due to the repetitive nature of the business relating to legislative affairs. The Physical Therapy profession is seemingly perpetually forced to devote enormous resources to the defense of our scope of practice in response to the constant attacks upon it from chiropractors and physicians. In some cases, these debates are truly that: a legal debate taking place in the appropriate venue to answer questions about safety, qualifications, and ethics that serve to protect society from potential harm. In other cases, the question of manipulation perhaps foremost among them, these debates are disguised attempts to hoodwink legislators into ruling on behalf of one profession or another without regard to any societal benefit. This is the ethical low road that Huijbregts is arguing against in his challenge. So many times we hear about medical professions acting to protect their piece of the economic health care pie. I have to ask: Is acting simply to preserve an economic position ever considered the ethical high ground? The medical industry is one of the fastest growing segments of our economic world. It seems out of place to argue over the relative size of each profession's proverbial slice of pie at the same time that every health care provider's pie is growing so substantially.

This is a dangerous time for our health care system in the United States as reform moves once again to the forefront of the political agenda. Even while a war is being waged, headlines about health care prevail when one of the many presidential hopefuls announces their plan to fix our nation's health system. It is in times like these when the power and threat of semantic arguments and tactics of obfuscation become more real. When fast decisions are made for popular gain, all sides might not be given a chance to clarify the difference between two points of view. For example, evidence exists that is not fully supportive of Physical Therapy interventions for low back pain¹. However, when such evidence is further scrutinized, it becomes clear that a watered-down version of Physical Therapy was utilized in the research, devoid of much manual therapy and rigorous patient classification. A legislator untrained in the medical arts may miss this important distinction and, in turn, make crucial decisions without recognizing the subtleties hidden within a carefully worded bill. Frankly, arguments relying on semantics such as where mobilization ends and manipulation begins seem ridiculous. Until chiropractors can better define the conceptual basis of subluxation or define the “paraphysiologic motion”, logic supports the APTA definition of manual therapy that does not distinguish between mobilization and manipulation². Who has not, clinically, caused a cavitation of a thoracic spine while performing even the lightest of mobilizations? If such techniques were so fundamentally different as to require an entirely different doctoral level education, then I surely should not be able to perform the maneuver in question without intent!

As we are reminded, the ultimate goal of scientific pursuit is to increase our society's knowledge base. The creation of such knowledge does not imply ownership. We must hold ourselves true to this ideal when defending the many chiropractic challenges to our scope of practice. Physical Therapy has contributed greatly to the development

of manual therapy concepts, including manipulation. But, we do not own these concepts. We should never argue our ability and right to perform manipulation based on our assistance in developing the concepts of manipulation, however great that contribution might be. However, if through that development of knowledge, we have created a documented record of Physical Therapists safely and effectively performing spinal manipulation with positive clinical outcomes³⁻⁷, then these facts should be proclaimed far and wide.

Human behavior changes when there is an incentive to do so. What will be the incentive for the chiropractic group to cease their perpetual attempts to limit our scope of practice? Perhaps hoping for a journey to an ethical high ground is a case of hoping beyond hope. Instead, let Physical Therapists move forward in avenues of marketing our services to the public, the government, and businesses. Physical Therapists should progressively provide lawmakers with incentive to protect our scope of practice based on a continued pattern of excellent scientific research in the field of manual therapy. In the meantime, however, let's also be prepared with skilled lobbyists and healthy legislative budgets.

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LETTER TO THE EDITOR

Chiropractic Legal Challenges to the Physical Therapy Scope of Practice: Anybody Else Taking the Ethical High Ground?

I would like to thank the editor for providing such a thorough history and comparison of physical therapy (PT) and chiropractic in his recent editorial "Chiropractic Legal Challenges to the Physical Therapy Scope of Practice: Anybody Else Taking the Ethical High Ground?" In this editorial, he clearly differentiated the public policy issues from the economic issues behind the chiropractors' seemingly organized attempts to restrain the PT scope of practice. Like the editor, I am tired of battling the chiropractors in the legislatures of our country when we should be competing on price, quality, value, and outcomes. Or rather, we should be joining forces to promote the benefits of manipulation in response to recent negative articles such as in the April issue of *Self Magazine* about the dangers of chiropractic manipulation.

As the editor so competently pointed out, physical therapists have led the efforts to validate the benefits of manipulation in evidence-based medicine and there is absolutely no evidence of potential public harm from manipulation by a physical therapist. Therefore, the fear of losing market share can be the only driving force behind the chiropractors' advocacy agenda. Such unfair and deceptive acts affecting commerce would be characterized as a restraint of trade if it were not in the context of lobbying the government.

The Federal Trade Commission Act¹ was passed in 1914 for the purpose of regulating unfair competition. Section 5 of the Act states, "Unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, are declared unlawful." Unfair methods of competition include violations of the Sherman Act², which involve conspiracies to monopolize or attempt to monopolize trade or commerce. It seems that both of these laws would prevent chiropractors from attempting to gain a monopoly on manipulation services, but unfortunately they have not.

The First Amendment³ guarantees freedom of speech, of assembly, and “to petition the government for a redress of grievances.” In an effort to balance constitutional rights against antitrust liability, the Supreme Court, through a line of cases that have become known as the Noerr-Pennington doctrine, has limited the enforcement of antitrust laws for private acts that involve attempts to influence legislation⁴. Although petitioning is lawful, the Court has acknowledged that there may be situations where the petitioning, although “ostensibly directed toward influencing governmental action, is a mere sham to cover what is actually nothing more than an attempt to interfere directly with the business relationships of a competitor.”⁵

The recent editorial references voluminous evidence that contradicts what legislators are being told by chiropractors that petition the government to restrict the PT scope of practice. Therefore, are the chiropractors advocacy efforts a “mere sham”? Unfortunately, the courts have yet to define conduct that constitutes a “mere sham” with regard to petitioning the government. So for now, it is up to responsible legislators to see the facts through all the dogma.

I have faith in the wisdom of our elected officials, but less faith in the physical therapists’ ability to identify the relevant arguments. The chiropractors are very skilled at articulating “sham” arguments against the therapists, resulting in the latter having to defend themselves against positions that are irrelevant to public protection concerns. A few of these positions are discussed in the recent editorial. For instance, the argument that “chiropractic predates the PT profession” is irrelevant to the question of whether the public needs government protection against manipulation by physical therapists. Manipulation techniques are not protected under any trade secret, patent, or copyright laws. Physical therapists don’t need to spend any more energy rebutting this mute point. Even if therapists learned manipulation yesterday, it is not relevant to the issue of public protection where there is no evidence that the public has been harmed.

The argument that the PT education is not the same as chiropractic education is an equally irrelevant argument. Medical doctors do not take as many pharmacology classes as pharmacists. Should we restrict physicians from prescribing drugs? The only relevant scope of practice question is what education is necessary to ensure adequate competence for public protection, not whether our education is identical. The editor did an excellent job of comparing chiropractic and PT education in the recent editorial, proving that PT education is certainly equitable and adequate in absence of evidence of public harm.

Physical therapists need to shift the debate to the real evidence of public harm instead of spending so much energy on defending our education. The credible references in this editorial provide proof that physical therapists do not harm the public. If our education were not adequate, there would be more evidence of public harm in those states where therapists use manipulation. In fact, if the legislatures are truly concerned about public harm from manipulation, they should take a close look at the evidence of harm done at the hands of chiropractors.

The editor discussed the problem of creating scope of practice restraints around political constructs, such as distinguishing mobilization from manipulation by defining physiological barriers and the “paraphysiological space” and that the paraphysiological space has never been measured. Legislators should be aware of the problems that are created when the line between lawful and unlawful conduct is defined by something immeasurable. When unlawful conduct can only be described in philosophical terms versus identified by reliable objective evidence, it can have a chilling effect on the rights of licensees to lawfully practice their profession.

Despite how mobilization and manipulation are statutorily defined, chiropractors tend to rely on an audible “pop” as the only evidence that a legal line was crossed even if a “pop” is not part of the statutory definition. Scientific evidence does not support an audible “pop” as being the distinction between these techniques. I can think of no political construct that could produce reliable evidence to distinguish between a mobilization and a manipulation when it is only the patient and the provider in the room. Therefore, legislators should not pass legislation that could result in fines, criminal charges, or disciplinary action against one’s license unless the unlawful conduct can be distinguished from lawful conduct with reliable and valid evidence.

The Federal Trade Commission has opined that the consumer “deserves a right to evaluate all elements of the bargain” in choosing which provider of services to use in the “absence of compelling evidence” of potential harm to consumers. In *Improving Health Care: A Dose of Competition*,⁶ the FTC makes it clear that competition is in the public’s best interest to control overall health care costs and that unnecessary licensure restraints serve no purpose. The benefit of the statutory restraints does not provide additional public protection where the PT Licensure Board already regulates standards of care and competency.

There is always a risk with manipulation or any other medical treatment, including one as common as taking aspirin. This is why clinicians obtain informed consent before any medical procedure. The consumer should be the one, who chooses their treatment and their provider after being informed of all their options. Harm done by medical professionals who do not meet the standard of care is remedied by a malpractice action, not by a disciplinary action by a licensure board. Thus the need proposed by chiropractors to protect the public from physical therapists who manipulate is an illusory political argument. Responsible legislators who weigh the actual harm to the public from a PT manipulation against the harm to the public that is created by cutting off access to care and restraining competition will come down on the side of the physical therapists and the public.

In summary, I would like to echo the editor's call to chiropractors to seek higher ethical ground and not be afraid of PT competition. If chiropractors cannot maintain their market share through their own skill and reputation, they most certainly do not deserve to have a monopoly on manipulation legislated to them!

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LETTER TO THE EDITOR

Chiropractic Legal Challenges to the Physical Therapy Scope of Practice: Anybody Else Taking the Ethical High Ground?

The extensively researched editorial¹ in V15N2 of the *Journal of Manual and Manipulative Therapy* provides a historical and theoretical context for my recent experience in Tennessee that I would like to share with you all. As perhaps most of you, I think of myself as politically active. I follow the major national and international issues and vote regularly. But likely again as most of you, up until recently I had rarely written to, never spoken with, let alone met anyone who represented me at any level of government. Despite many disappointments on Election Day, my day-to-day life remained pretty much the same. The big change for me came at the end of the 2006 Tennessee legislative session when I received an email from the Tennessee Physical Therapy Association (TPTA) informing me that they were abandoning proposed legislation that essentially would have resulted in trading away the right to manipulate the spine in order to secure direct access. I was struck by a feeling of déjà vu. The situation was reminiscent of what happened in Washington State in the late 1980's. There, 16 years after trading direct access for the right to manipulate the spine, physical therapists still are not legally allowed to manipulate the spine. This is made all the more ironic given that state's remarkable number of therapists with postgraduate training in orthopaedic manipulative physical therapy (OMPT). After moving from Washington to Tennessee, I was pleased to finally be able to practice using all of the techniques in which I was extensively trained.

The 2007 Tennessee legislative session returned to the issue of direct access and manipulation. Never had a pending political decision had such an impact on my life. Having spent the previous 8 years pursuing advanced clinical and academic training in OMPT, I had planned to set up an OMPT fellowship program in Tennessee. So I was inspired to act in any way I could. My initial delusion was that I would write a letter, make some calls, and that thereby the perceived injustices could be averted. Determined to make my voice heard, I contacted my legislator, the TPTA, and informed dozens of my patients. I cancelled a day of clinic to attend a legislative session in support of our bill and against the manipulative amendment, petitioned a representative, and experienced the political machine first-hand. The astounding complexity of the politics of state government took me by surprise.

In the senate our bill's sponsor was a physical therapist and his key role helped in its unanimous passage. In contrast the House Bill was burdened early on in subcommittee with an amendment prohibiting manipulation of the spine as this intervention was defined in the chiropractic practice act. The newly elected House majority leadership was taking its opportunity to flex their legislative muscle. One of the majority leaders was a representative with strong ties to the chiropractic association. He was a vocal opponent of our bill. With his leadership position giving him the ability to appoint individuals to leading committees, he also had many legislators indebted to him. To add to our challenges our House Bill sponsor was now from the minority party and partisan allegiances were expected. As I came to understand, in politics legislators "trade" votes back and forth. One will vote for the other's pet project. They call this compromise. Compromise was a key word that the legislators used often in regards to our conflict. They wanted all parties to "come away with something." As an orthopaedic manual physical therapist the position of having to choose between manipulation and direct access felt like choosing which one of one's

children you were going to abandon. A detailed and rational discussion of the issues was not welcomed. Arguments were reduced to sound bites. Citing national and international precedent did little to influence the legislators. More than once we heard, “we are in Tennessee and we don’t care what they do elsewhere.”

Much to my surprise, I learned the manipulation-prohibitive language was already in Tennessee law, stating that only a chiropractor or osteopathic or medical physician may manipulate the spine. This language had been made part of the chiropractic practice act in 1997, when the TPTA political machinery was not in place to stop, or perhaps even know about, this. As a practicing therapist, I was familiar with my own practice act allowing manual therapy as defined in the Guide for Physical Therapy². I was not, however, aware that I should be familiar with other health professions’ practice acts. Why would I? I am a physical therapist, not a chiropractor. Still, did this mean my practice of OMPT could be in violation of a Tennessee law? Most frustratingly, I found no one able to definitively answer that question. Running through my mind were the stories told by therapists with postgraduate OMPT training in Washington State of being “set up” by the chiropractic board to catch them “practicing chiropractic” by manipulating the spine. Recently, a physical therapist colleague in Arkansas had faced a similar situation.

Add to this that TPTA was caught in a compromising position. Over the previous 2 years, they had leveraged a great deal of political energy. Many representatives were eager to see the bill finally resolved. If the TPTA pulled the bill for the second year because of the manipulation issue, it was likely that it would not be well received by the state legislators the next year. In the end, the TPTA pushed the legislation through figuring that if the amendment language meant the loss of manipulation, then the battle had already been lost 10 years earlier. Conceding to the chiropractic lobbying efforts the TPTA decided not to oppose the amendment on manipulation if the Tennessee Chiropractic Association’s powerful political interests allowed the bill on direct access to pass.

So, as of July 1 of 2007, physical therapists in the state of Tennessee are allowed direct access. The direct access is limited to 45 days with a notification requirement for the patient’s licensed doctor of medicine, dentistry, podiatry, osteopathy, or *chiropractic* [italics mine]. If the patient chooses not to allow notification, the limit is 30 days. The limit is further shortened to 15 calendar days or 6 visits, unless reasonable evidence demonstrates that progress has been made. In short, direct access in Tennessee is limited and convoluted and our “legislative victory” is at best partial. Whether third-party payers will reimburse for direct access physical therapy services is as of yet unclear. Again, if prior experience in Washington State applies, only a small fraction of payers will reimburse without a referral. The full impact of the language that prohibits spinal manipulation is also not clear. The physical therapy practice act remains inconsistent and insufficiently specific making future legal challenges appear inevitable.

The conflict between the professions of physical therapy and chiropractic is generations old. In 1930, therapists relinquished direct access to gain professional support from the medical profession due in part to economic challenges from chiropractors and other professions claiming to provide physical therapy³. Physical therapy has recently defended its scope of practice from chiropractic challenges in 30 of 50 states⁴. Neither of our professions is going to just pack up and go away. Like it or not: money equals influence. Physical therapists have failed to embrace this political reality to the extent that the chiropractors have. Despite our greater numbers, the state laws are often not written in our favor. Chiropractic resources are focused at the state level where health care practice laws are defined. At the national level, the allocation of resources is far different. The national resources of the APTA are disproportionately larger than the chiropractic association ACA⁵. Yet at the state level, we have a fraction of their resources. In 2006, money contributed to the Tennessee legislature by the TCA were 12-fold of what the TPTA contributed. In lobbying, the TCA spent between 2 to 5 times as much money as the TPTA⁵.

The APTA plays an important role for our profession, including working toward Medicare reimbursement without physician referral, an issue that is critical to direct access. However, despite its powerful influence, we often lose legislative ground at the state level in issues such as manipulation. The only thing that will change the reality of our state practice laws is action—our action—at the state level. Our quest for professional autonomy in Tennessee cannot end with limited direct access and a prohibition of spinal manipulation. We require a more effective grass roots state effort to raise resources to defend our scope of practice. In Tennessee we need to narrow the 12-fold gap in funds devoted to state politics. We need to get to know our politicians by lobbying them, volunteering in their campaigns, and educating them about our profession. Some of us even need to be politicians. One of the difficulties in defending manipulation in Washington State was that, for more than a decade, the respective chairs of the health care committees in the House and Senate were chiropractors. If we cannot raise the needed resources at the state level then we must divert more from the national level. What good is Medicare reimbursement for direct access if you do not have meaningful direct access in your state?

Ultimately, our respective professions engage in this *quid pro quo* conflict, due to our focus on our differences. Yet both of our professions believe that manual and mechanical forces can help the body heal itself. Further, our respective substantial bodies of research support the effectiveness of manual and manipulative treatments. Despite these important commonalities, we squander the opportunity to expand the role of manual and manipulative techniques in healthcare. The US healthcare system is not dealing well with the impact of problems such as low back pain. Waddell calls the problem “overmedicalized”⁶. In

the common diagnosis of lumbar degenerative disc disease the increasingly prevalent treatment of spinal fusion has indications which are unclear^{7,8}. The economic impact of low back pain is growing and “grave”⁹. We need more than a truce with the chiropractors; we need an alliance. If our collective resources were focused on educating the public, government, medical community, and third-party payers about the benefits of manual and mechanical treatments, then there would be more than enough patients for both professions. In the US, where the healthcare system is generally agreed upon as broken, manual and manipulative treatments are underutilized and undervalued. This is to the detriment of Americans and our economy. It is the mutual ethical responsibility of the physical therapy and chiropractic professions to reframe our adversarial relationship into one of mutual respect and collaboration.

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LETTER TO THE EDITOR

Low Back Pain and Myofascial Trigger Points

This letter is concerning the article in Vol. 15#2 starting on page 111 by Pinto et al on “Management of Low Back Pain.” Their discussion started with the statement, “The origin of low back pain (LBP) is difficult to establish.” That is so true if you do as they did and base thinking only on symptoms with no regard or concern for the literature that clearly identifies its treatable cause, i.e., myofascial trigger points. I am referring here to the clear and rather complete presentation of the cause of LBP on pages 804–809 of the 1999 edition of the *Trigger Point Manual*¹ and the seven references of published articles provided below²⁻⁸ that describe its successful treatment by addressing skillfully the myofascial trigger point cause of the pain and dysfunction. Patients deserve and need to be examined for myofascial trigger points that are common and likely to be causing their LBP. How to identify those muscles and treat them is fully explained in the *Trigger Point Manuals*, volume 1 & 2^{1,9}.

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Authors' Response to Dr. Simons

We would like to thank Dr. Simons for his letter to the editor on our case series titled “Management of low back pain: A case series illustrating the pragmatic combination of treatment- and mechanism-based classification systems”. Recent literature has clearly identified the importance of classifying patients with low back pain (LBP) into subgroups^{1,2}. Classification provides a means of breaking down a larger entity into more homogenous subgroups of patients based on examination data³. The most common methods of classifying patients with musculoskeletal conditions are based on identifying the underlying pathology causing the condition⁴, however the pathology underlying the complaints of LBP is often difficult to identify⁵. Even if identified, the pathology is often of limited usefulness in selecting the most beneficial interventions⁶. Moreover, classification is most helpful for physical therapists when it is based on signs and symptoms that match interventions to the subgroup of patients most likely to benefit from them (i.e. treatment-based classification)^{7,8}. The goal of treatment-based classification is to improve decision-making in the determination of an individual patient’s diagnosis, prognosis, and intervention strategy.

Dr. Simons seems to ignore the importance of sub-grouping patients when he states that myofascial trigger points are the “treatable cause” of LBP. We disagree with this as it has been reported that in 90% of patients with LBP a patho-anatomical cause cannot be identified⁵. Additionally, reviewing the references that Dr. Simons provided it appears that Kovacs et al⁹ also contradict Dr. Simons with the following statement, “Low back pain often is believed to be the result of degenerative disk syndrome, protrusion of intervertebral disks, strains, sprains, and other disorders associated with the position or movement of the spine, such as those caused by scoliosis or spondylolisthesis. In most cases, however, it is not possible to establish an organic cause.” In another reference provided by Dr. Simons we find that the first randomized controlled trial performed to evaluate the effectiveness of myofascial therapy clearly demonstrated that no significant differences existed for pain or activity between patients receiving myofascial therapy, joint manipulation, and back school in the management of sub-acute LBP¹⁰. We would argue that the lack of statistical significance may have been related to the failure of the authors to classify patients to receive interventions from which they are most likely to benefit. Nonetheless this provides no data to support the use of incorporating the treatment of myofascial trigger points into the management of LBP.

In our case series therapists categorized patients into subgroups and then delivered interventions that provided patients with the highest likelihood of recovery. In addition to the utilization of a treatment-based classification therapists also treated individual impairments. At this point in our case series it would have been appropriate for the clinicians to treat trigger points that they found, however none of the clinicians chose to do so. Despite not treating any trigger points, our patients’ exhibited clinically meaningful improvements in all outcomes. Additionally, a number of trials^{1,2, 8,11-14} demonstrating the effectiveness of conservative interventions for the management of LBP have shown statistically significant improvements in pain and disability despite none of the patients receiving any treatments directed at myofascial trigger points. We agree with Dr. Simons that his textbook provides a detailed description on how to treat myofascial trigger points. However, the aforementioned references challenge the need to do so.

We have found little support for the use of soft tissue mobilization and treatment of trigger points in the (sub) acute LBP population^{15,16}. Within the limitations imposed by current best evidence for the (sub) acute LBP population it is our opinion that if clinicians choose to incorporate any soft tissue or trigger point techniques that these should be used within the context of a treatment-based classification system that is supported in the literature.

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LETTER TO THE EDITOR

Low Back Pain and Leg Symptoms: Another Differential Diagnostic Possibility

This letter is in response to the recent article by Pinto et al¹. The authors are to be congratulated on a very successful presentation of a case series. My comments are directed at some of the symptoms of patients 1 and 2, because they apply to other clients seen in a typical PT clinic. Patient 1 had chief complaints of low back and groin pain, whereas patient 2 reported left buttock pain and pins and needles down the left medial leg. The examination addressed many things, including testing for altered sensation to pinprick in the lower extremity dermatomes. However, I would like to suggest that for these and similar patients the inclusion of the lower abdominal wall in the sensory screen might be of value because of the possibility of a para-inguinal neuropathy.

A recent male patient had experienced painful traumatically induced neuropathies of 33 years duration involving the accessory obturator, ilioinguinal, and iliohypogastric nerves and the genital portion of the genitofemoral and vesicular portion of the hypogastric nerves. All these nerves are involved in the sensory innervation of the lower abdominal wall and genito-urinary region, but may also cause hypersensitivity in the groin and paraesthesiae and/or dysaesthesia in the medial calf (saphenous portion of femoral sensory nerve). Sensory alterations in the saphenous distribution of the medial leg are at times misinterpreted due to its overlap with the S1 dermatome. In this patient a reduced sensation to pin prick was not present but rather sensory hyperaesthesia and allodynia were noted in the lower abdominal and lower extremity dermatomes.

Of differential diagnostic importance is that the ilioinguinal and iliohypogastric nerves and the genital portion of the genitofemoral nerve can be palpated proximal to and/or within the inguinal canal. All three nerves take a primary origin from the T12-L2 nerve roots. The ilioinguinal nerve innervates the inguinal ligament, the anterior inner wall of the inguinal canal, and the spermatic cord and can be palpated within and outside the inguinal canal. The iliohypogastric nerve supplies the roof of the inguinal canal and innervates superficial skin. The genital portion of the genitofemoral nerve—despite its very small diameter—can be screened by applying pressure onto the floor of the inguinal canal, located at the top of the pubic bone just medial to the spermatic cord. There is however, considerable variation in the pathway of this nerve. These palpatory tests have

not been described in the literature. In the case of my recent patient, these intra-inguinal palpatory tests proved to be diagnostic: after failing previous conservative care including PT and interventional pain management, a triple neurectomy was successful in relieving long-standing complaints and in allowing a return to exercise.

Although these comments do not directly seem to apply to the case series in which all patient had a very successful outcome, I present this differential diagnostic possibility and the associated palpatory tests for the benefit of the small percentage of clients who present with similar findings but who do not make significant gains with PT.

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