A Presentation of a New Approach to Correction of Disc Lesions

By George J. Goodheart, Jr., D. C., Detroit, Michigan
Member, National Chiropractic Association

DISC LESIONS are difficult to diagnose, difficult to treat, and apparently difficult to keep from appearing more and more on the scene. A relative increase in disc lesions, which has required surgical intervention, has definitely occurred in our practice in the last fifteen years, and in the opinion of those conservative surgeons who do the surgery, even though they now operate less,[1] they still continue to see relatively more of these cases. Cyriax[2] says that one out of eight disc cases requires operative removal of the displaced or bulged fragment.

The total number of disc cases is steadily rising, many practitioners observe, and it is our conclusion also. Why the relative increase? Why the need for surgery in one out of eight? Our experience with disc lesions has been favorable but arduous, in that a favorable outcome from chiropractic management is sometimes difficult to achieve. Time-worn measures of heat, rest, traction—all have been resorted to, in addition to carefully applied technic including basic, specific, sacroiliac, and lumbar adjustment, upper cervical specific, reflex, eliminative, dehydration and nutritional balancing on precision analysis.

A middle-aged, overweight male was referred to us for consultation and treatment by a D. C. who had done his best to relieve the unilateral sciatic and back pain of this patient. Examination revealed a plumb-line alignment of the buttocks with a definite break to the right at the fourth lumbar segment. Compensatory reverse scoliosis was present above in the dorsal spine, with vertical alignment of the head with the sacrum. Pain was present on standing, disappearing after a few minutes on sitting, absent when prone or supine, exaggerated by coughing or sneezing, exaggerated by jugular compression[3] and leg raising[3] and heel drop on toe walking on affected side.

A carefully laid out manipulative approach based on AP and lateral standing films was begun and the patient was seen daily. Some relief of the myositis was seen but sciatic pain continued unrelieved and grew steadily greater in intensity. Various combinations of therapies were tried with little success until finally surgery was decided upon. A prolapsed disc at the fourth lumbar segment was found on myelographic X-rays, and when surgery was scheduled, we decided one of us would observe the exact details of this case at operative disclosure. Standing directly beside and behind the surgeon gave a vantage view, and the most unusual thing noted was the flaccidity of the posterior spinal ligaments and the ligamentum flavum with the patient in slight flexion in a prone position. This flaccidity remained in our mind an interesting feature of this case which went on to good recovery.

A young male, sixteen years of age, was next seen by us for a recurring sprain of the right ankle; balancing of the pelvis was effective but only reduced the frequency of sprain from several times weekly to two or three times monthly. Recalling the veterinary problem of perosis in chickens, the so-called slipped tendon disease of fowl and the recovery gained by feeding manganese to the affected chickens, we gave trace organic minerals* containing 140 mg. of manganese glycerophosphate six times daily with a phenomenal recovery in the sprained ankle syndrome; no recurrence has presented itself now for over a year. Using this unusual response as a guide, we begin to use manganese glycerophosphate in trace mineral form routinely on all ligamentous cases which showed a lack of ligamentous tone, including discs.

Since the annulous ligament acts as a circular retaining ring for the disc, we postulated the theory that a bulging or extrusion of the disc was due to the laxity of this ligament. A total of twenty-two cases has been seen at this date, all having a typical history of previous back injury, pain in low back, later intractable sciatic pain, which was unrelieved by traction adjustments and even opiates. Cases of sciatic neuritis, fibrositis, reflex sciatic neuralgia, femoral head bursitis, unilateral and bilateral pronation of feet with referred pain, were all excluded from this series in an effort to accumulate data on true disc lesions.

The manipulative approach we use is plumb-line analysis, occipital investigation, sacral contacts, specific adjustments when proved by X-ray and reflex areas and some lifts. This specific specialized technic, to say the least, prevents aggravation of the lesion and, when com-

*Allorganic Trace Minerals [redacted]

bined with dehydration, rest, postural traction and hot baths in acute cases, previously gave a fair average of results in disc cases, but, with the addition of manganese therapy and the previously mentioned routine, we have practically doubled our average recovery rate. Only one in twenty-two has required surgery at this date, two are still under therapy, but recovering. The remainder are symptom-free, plumb-line aligned, and reflex free. We push manganese glycerophosphate in acute cases to one hourly with reduction in the level when headache, digestive distress, or aggravation of fungus lesions occur.

Precision manipulation, encouragement, postural therapy, plus manganese, give very good results in our hands and by informal interrogation of other practitioners who were told of this therapy, we feel they also have benefited from its use. The addition of manganese is not a cure-all, the patients still require the most precise adjustment and management; but they do avoid surgery; they do stay adjusted better and longer; they do achieve pain relief, and they do refer patients. The trace mineral compound we used did contain B-12 as a source of cobalt, but on feeding a high manganese diet and excluding the B-12, we got comparable results, although with an office practice such testing is not at laboratory level. We have also used placebo therapy to attempt to exclude the suggestive element, and here too the patient showed a failure to respond or relapsed, thus proving the point, although again there is a limit to this type of testing in a busy office.

Many of these disc patients have attempted self-imposed weight reduction regimes or show a poor state of nutrition which shows the possible etiology. Recently McCormick[4] has treated his cases with natural C complex with good results. So use care, precision adjustment, postural traction, rest (one week should do it) and use trace mineral compounds containing high manganese components and watch your results increase from progressive chiropractic.

References

1. Personal Communication.
2. Rheumatism and Soft Tissue Diseases, Cyriax, 1952.
3. Intervertebral Disc, Bradford and Spurling, 1950.
4. Clinical Medicine, McCormick, July, 1954.

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