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CLINICALEVIDENCE

Intervention in menorrhagia through Chiropractic adjustment and spondylotherapy: A case report

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Narrative: Low back pain and female reproductive problems are the source of frequent consultations to a Chiropractor. Menorrhagia, described as excessive uterine bleeding, yearly affects up to 10 million American women in their forties and fifties.

This patient indicated that her menstrual cycle had never been 'normal', and since the age of 16 her cycles were of 36-45 days duration with bleeding lasting about seven days. On her heaviest days of bleeding, days 2 and 3, she had to use a super plus tampon every 1 – 1½ hours.

The patient was treated with SOT blocking, instrument adjusting, Van Rumpt cranial technique, and Spondylotherapy. She continues care for other matters and but has had no menstrual or bleeding complaints throughout this time.

Indexing terms: Chiropractic; menorrhagia; Category 2; spondylotherapy; Van Rumpt; cranial.

Introduction

Low back pain and female reproductive problems are the source of frequent consultations to a Chiropractor. Low back pain, as one might expect, is the most common reason (1) and is generally found to have its aetiology to be of biomechanical musculoskeletal origin. However other sources of referred back pain may be uterine conditions such as endometriosis and adenomyosis. (1, 2) Although dysmenorrhea is a common female condition and Radler (3) states that 72% of patients with dysmenorrhea also have low back pain (twice as much as women without dysmenorrhea), there is little Chiropractic literature relating to this condition. (1 - 14)

Menstrual disorder is the only female reproductive condition that Chiropractors see more than rarely as reported in the National Board of

'... Since treatment the patient states her periods have become more normal, are now mostly every 28 days without very heavy bleeding and minimal cramping...'

Chiropractic Examiners' job analysis report. (2)

Literature suggests that endometriosis may be present in up to 33% of menstruating females, adenomyosis may have an incidence of up to 20% of the same population. (1) A link is suggested between early menarche (ages 11 or 12) and increased incidence and severity of dysmenorrhea. (15) Primary dysmenorrhea is observed in women as young as 15 years old. (15) '*Heavy bleeding (menorrhagia) is one of the most common problems women report to their doctors. It affects more than 10 million American women each year, approximately one out of every five women*'. (16)

A normal menstrual cycle is 21 – 35 days in duration with bleeding lasting on average five days with a total blood flow of 25-80 ml. A blood loss of more than 80 ml or lasting longer than seven days constitutes menorrhagia.

> Usually no causative abnormality can be identified, and treatment is directed at the symptom rather than at a mechanism. After a differential diagnosis is performed to rule out causes such as hypothyroidism, endometriosis, fibroids, endometrial polyps or cancer, ovarian or other endocrine disorder, (3) or coagulation defects, medical treatment may consist of prescriptive medications including hormone therapy, non-steroidal anti-inflammatories, (3) or tranexamic acid. (16) Endometrial ablation or hysterectomy are surgical options.

Menorrhagia, described as excessive uterine bleeding, yearly affects up to 10 million American women in their forties and fifties. However, according to a survey performed by Shapley, Jordan and Croft in 2002, less than a third of women over 35 suffering from heavy bleeding actually discussed the problem with their doctor. Most of them (83%) expressed that the heavy periods were just something with which they would have to live. (2)

The purpose of this case report is to describe the clinical course, treatment, and immediate response of a female patient suffering from uncontrolled uterine bleeding of over two weeks duration to the application of chiropractic adjustments and the use of spondylotherapy.

Patient history

A 5'4" 162.5cm, 164 lb 74.3kg, 37 year old, nulliparous female veterinary technician with a history of back and hip pain, headaches and asthma presented to this office on December 6, 2012 with complaints of severe pain in her left hip. She stated the pain was similar to the pain she had had prior to her back 'going out' in October 2011. She also complained of nonstop menstrual bleeding for the previous two weeks. The patient noted that she had an occurrence of prolonged menstrual bleeding the previous spring as well.

The patient indicated that her menstrual cycle had never been 'normal', and since the age of 16 her cycles were of 36-45 days duration with bleeding lasting about seven days. On her heaviest days of bleeding, days 2 and 3, she had to use a super plus tampon every 1 – 1½ hours. A super plus tampon holds about 12 -15 ml of blood. (17) This calculates to more than 80 ml of blood on each of those two days. She stated that her periods were often accompanied with migraines and significant cramping.

Prior to her visit, she had been seen by her gynaecologist who suspected fibroids, but none were observed on ultrasound. Hormone levels were tested and they were normal. The gynaecologist recommended that the patient 'deal with it' and it was felt that this amount of

bleeding was 'normal' as she had an IUD and the prolonged bleeding wasn't substantial enough to be a medical concern. It was suggested that she use a feminine product (tampon) daily.

The patient was concerned and stated to me (WJB) that '*it is incredibly annoying to bleed for that long and I didn't think it was normal even though the gynaecologist did. Also, you fixed my back and I thought I was willing to see if maybe you could help me, since I was having no cramps since I have been seeing you*.'

Other than a menstrually associated headache, reported on September 13, 2013, this was first the patient had reported of her menstrual issues.

The patient had been seen at this office for treatment intermittently since December 2011 when she first presented with severe low back pain which began in March 2011. An MRI had been performed on March 29, 2011 and demonstrated a '*large broad-based central and left posterior para-central disc herniation at L5-S1 with posterior displacement of the traversing left S1 nerve root and contact on the traversing right S1 nerve root. Moderate sized posterocentral disc protrusion eccentric to the left with annular tear at L4-5, with a mild impression on the traversing L5 nerve root bilaterally, left greater than right, and mild left lateral stenosis*'. She received an epidural injection in March 2011 which helped and a second epidural in October 2011 which did not help. Physical therapy had been prescribed which she continued until October 2011. Prescribed by her gynaecologist were medications that included Percoset and Advil.

She presented to this office for the first time on December 21, 2011 when she reported severe low back pain, numbness in her left leg, pain on coughing or sneezing. She had difficulty in sitting, dressing herself, and having sexual relations with her husband. Examination revealed positive bilateral sitting straight leg raise, reduced and painful lumbar ROM, dermatomal loss of sensation, and indications of Sacro Occipital Technique's Category II (sacroiliac joint sprain or hypermobility syndrome) and Category III (lumbosacral sprain and discopathy syndromes).

The patient received 18 treatments between December 21, 2011 and May 29, 2012 with her pain initially resolving by January 11, 2012, but returning briefly in February. She received treatment on two consecutive days in July 2012 after being hospitalised for an asthma attack the previous day. She returned again on September 13, 2012 hoping treatment would resolve a menstrual related headache as she was going on vacation in two days.

The patient was not seen again until November 6, 2012, at which time she shared information about her menorrhagia and other menstrual related complaints. After taking her history, a limited examination was performed. Positive findings on examination that day revealed: Trendelenburg (positive on the right), Sitting Straight Leg Raise (positive on the left), and Category II (positive on the left side) with inguinal ligament sensitivity on left side.

Methods & intervention

Three treatments were performed to care for this patient's specific menorrhagic condition.

On November 6, 2012: Sacro Occipital Technique Category II supine block placement to reduce pelvic torsion and improve sacroiliac joint juxtaposition Figure 1); with patient in standing posture (Figure 2) and assuming postures of flexion, extension, lateral flexion, and rotation adjustments were made to the lumbar spine (L1-5) with an Activator™ instrument; and adjustments to femoral heads bilaterally.

Figure 1: Sacro Occipital Technique Category Two Blocking

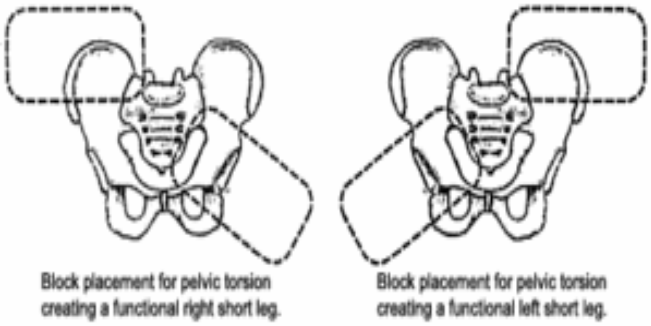


Figure 2: Standing instrument adjustment in Lumbar Flexion

Spondylotherapy (19 - 21) was administered to C7 (4 minutes), L3 (2 minutes) and L5 (2 minutes) at a percussive rate of 200 beats per minute. (22)

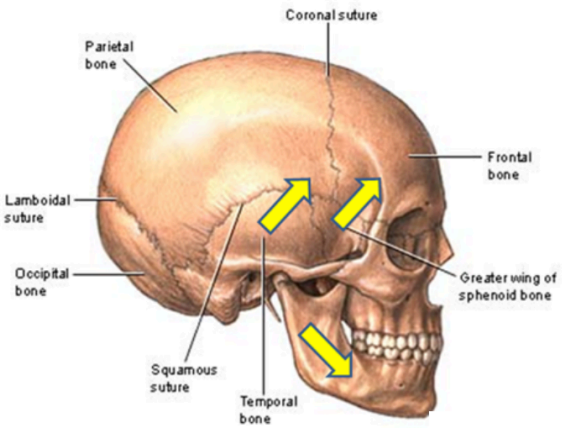
Figure 3: Spondylotherapy to C7

On November 13, 2012: Patient reported that the bleeding had stopped by 11/7/2012. Adjustments were made to T3, 5, 7, 9 vertebrae levels and their discs. Disc adjustments were

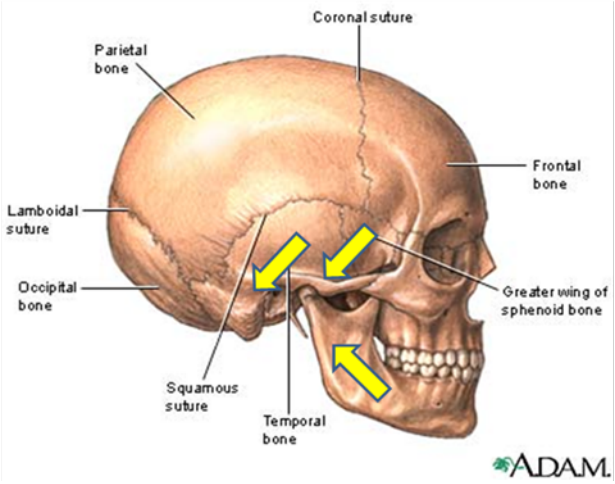
performed utilising a disc plexor according to Van Rumpt protocol. Spondylotherapy was administered to C7 (4 minutes), L3 (2 minutes) and L5 (2 minutes) at a percussive rate of 200 beats per minute. (22)

On November 16, 2012: Adjustment to lumbar spine, discs and associated muscles and adjustment to the cranium utilising anterior cranial pattern according to Van Rumpt protocol. (23)

Van Rumpt's cranial analysis involves subluxation listings on the temporal, sphenoid and mandibular bones. The anterior pattern consists of anterior/superior listings found of the sphenoid, temporal, and mastoid bones. The mandible is found to have an anterior/inferior subluxation listing. Corrective double thumb toggle adjustments are made to both sides of the skull.



Anterior pattern



Correcting anterior pattern

The patient has returned to my office on 8 other occasions (last visit February 19, 2014) for various reasons (mostly for hip pain), but has had no menstrual or bleeding complaints throughout this time.

Discussion

Chiropractic care can offer conservative therapeutics with the goal of improving neurology and physiology to facilitate the maintenance of normal homeostasis of all systems.

Several studies have been written describing the use of Sacro Occipital Technique in the management of female reproductive problems such as secondary amenorrhea, (24) uterine fibroids, (25) and dysmenorrhea. (26) Through use of Chiropractic Manipulative Reflex Therapy (CMRT), with or without combination of acupuncture methods, there was successful resolution of symptoms.

Both afferent and efferent nerve supply to female reproductive organs involve lower thoracic, upper lumbar, and mid-sacral segments. The efferent supply consists of sympathetic fibres originating mostly from the T12 - L2 levels, and parasympathetic fibres originating from sacral three, four and occasionally five. The sensory fibres enter the cord at vertebral segments T12-L2, and S2 - 4. '*The close relationship between afferent and efferent cord levels suggests the importance*

of viscero-visceral, viscero-somatic and somato-visceral reflexes… Thus … there is great potential for interference and modification of this (genital tract) activity by aberrant somato-visceral activity. For instance, vasomotor disturbance to the uterus can occur, and will differ depending on the physiologic state of the uterus'. (14)

There is a concern regarding the differentiation of primary dysmenorrhea from secondary dysmenorrhea (includes factors such as endometriosis, infection, leiomyomas or adenomyosis). Assuming no obvious organic disease, conservative options can be considered. The mechanism of primary dysmenorrhea is unknown, but presumed to involve persistent, hyperactive sympathetic or parasympathetic stimulation. Chiropractic interventions might consider assessing whether either T11-L2 or the sacrum may be involved. (14)

Altered mobility or fixation of spinal segments has been hypothesised to cause abnormal somato-somato and somato-autonomic reflexes. Liebl et al (5) point out that areas of primary fixation were at L1, 2 and 5, sacrum and sacroiliac joints.

Various hypotheses are offered in the literature as to why non-medical approaches to dysmenorrhea help. (6, 21, 27) Various Chiropractic hypotheses include '*the removal of mechanical joint fixations correct aberrant motion and elicits a sympathetic response to inhibit uterine contraction*' (12) or that the adjustment '*interferes with pain reflexes that link the mental interpretation in the cerebral cortex to the physical manifestation of pain in the uterus*', (15) or how the psoas muscle may be involved in pain referral from the uterus.

Primary dysmenorrhea is associated with an increase in uterine vasculature throughout the menstrual cycle. '*A dense vascular endometrium establishes the environment and opportunity for producing greater pain when sloughed from the uterine walls. The increased vasculature suggests a propensity for developing dysmenorrhea due to the inherent structural composition of the uterus*'. (15) I propose that one of the reasons for the successful treatment with spondylotherapy is its effect on returning tone to the uterine muscle and vasculature (19 - 21) and thereby reducing the amount of blood flow and loss from the uterine lining both during the cycle and at menstruation. If that tone is maintained in future cycles, then it may be considered that the lining maintains better tone throughout the cycle and therefore the patient experiences less discomfort and bleeding in future cycles.

Spondylotherapy

Spondylotherapy was developed by Albert Abrams around 1903. His interest in spinal therapeutics developed deeply after investigating various visceral reflexes that he discovered bearing his name. (28 - 30) From simple yet astute observational beginnings, '*he ascertained that a number of pathological conditions could be more easily and certainly controlled by spondylotherapeutic means, than by the conventional measures*'. (19)

'*Visceral reflexes may be evoked not only by cutaneous irritation but likewise by concussion and the application of sinusoidal current to the spinous processes of the vertebra. Reflexes elicited from the spinous process have been specified by the author as VERTEBRAL REFLEXES … to excite the vertebral reflexes for therapeutic purposes, concussion by means of an apparatus is employed. For simple concussion the author employs a pleximeter and plexor … In the therapeutic elicitation of the vertebral reflexes, the only kind of vibratory apparatus which is effective is one giving the PERCUSSION STROKE*'. (20)

Abrams described his early experiences with female reproductive problems:

'*Painful menstruation is subdued in conventional practice by treatment of the cause and the use of some analgesic during paroxysm of pain. The author has thus far examined about fifty patients*

who suffer from painful menstruation and has noted points of tenderness located either to the right or left side or both sides of one or more of the spines of the first four lumbar vertebrae. Firm pressure with the end of the thumb over one or more sensitive areas will abolish the pain for several hours or during the entire period of menstruation'. (19)

Many contemporaries of Abrams studied and embraced his ideas. Alva Emory Gregory MD, DC, in his text 'Spondylotherapy Simplified' stated: ' … *spinal adjustment and spinal concussion, are excellent, but that a combination of the two methods is the most rational and efficient procedure, and experience has convinced us of this fact, since many cases recover from the use of both methods, which have failed to respond to either of these methods alone*'. (21)

Although there has been little current research (31) into the use or effectiveness of spondylotherapy, in the 1940s it was part of the curriculum at National College of Chiropractic including a chapter in one their required textbooks. (32)

Abrams explained its physiological application as follows: '*The capacity of an organ to execute its functions is determined by the tone of its musculature … Unlike the skeletal, the visceral muscle receives its stimuli not directly but indirectly through the intermediation of ganglion cells. The visceral musculature shows elasticity, tonicity, irritability and conductivity. There is distinct periodicity in the movements of visceral muscle characterised by contraction and relaxation of the muscle fibres*'. (33)

The vertebrae chosen for the application of spondylotherapy in the treatment of this patient were guided by recommendations from Alva Gregory and Richard Van Rumpt. Gregory states: '*The seventh cervical segment contains a very important spinal centre which … contains the cells of origin of the second pair of thoracic nerves, which have a very potent influence over the heart and vasomotor tone of the vessels for the general circulation … Stimulation of … the seventh cervical vertebra will induce … a very decided and general vasoconstriction*'.

Concussion of the upper three lumbar segments is claimed to produce the results as follows:

- excite uterine contraction
- overcome atonic constipation
- overcome uterine haemorrhage
- excite contraction of the liver
- excite contraction of the spleen
- excite contraction of the stomach
- excite contraction of the intestines
- increase the tone of the colon and intestines. (21)

It is recommended that if, after a trial of conservative treatment, one finds the treatment outcome is less than expected or desired, that a referral be made to a medical specialist and further diagnostics be performed.

Inconsistent results as reported in Chiropractic studies may be due to small sample sizes and the paucity of studies or the inherent problems of performing controlled randomised studies of interventions that make use of hands-on therapies. The positive changes may also be a result of the normal progression of the condition. Regardless, the lack of conclusive evidence does not mean these interventions do not work and are not worthy of consideration. (1)

Since many reports show hysterectomy to be the most 'cost effective' treatment (approximately US$30,000 - $40,000), (34) a handful of Chiropractic visits including spondylotherapy (significantly less for a series of treatments) makes this treatment approach worthy of investigation if only for the potential of reduced medical costs, not to mention the reduced human costs of pain and suffering.

Although studies have been performed showing that menstrual pain associated with primary dysmenorrhea may be alleviated by treating motion segment restrictions of the lumbosacral spine, (9, 11) the strength of relationship between neuro-mechanical dysfunction of the lumbosacral spine and symptoms of primary dysmenorrhea need to be more conclusively established.

> Since the patient has been treated at this office (December 2011), she states her periods have become more normal, are now mostly every 28 days without very heavy bleeding and minimal cramping.

While reviewing the literature it became apparent that the levels of spondylotherapy application might have been more appropriate at L1, 2, 3 instead of L5. However, since the somato-visceral and viscero-somatic reflexes are diffuse and not discrete, it is possible that the exact site of percussion may vary amongst individuals as it did with this patient.

Conclusion

Caution about generalising these results to other patients is advised since without control groups or comparative sham interventions positive findings may relate to the placebo or ideomotor effect.

Of interest is that the patient had the menstrual condition for years. Her response to care suggests a temporal relationship between the intervention and her positive response. That her condition has improved and has sustained itself is suggestive of this relationship, though it might also be considered to be coincidental or a regression to the mean.

Further research is needed to determine if the care rendered in this case study might offer a low risk alternative for menorrhagia for a subset of patients that may be responsive to this novel chiropractic intervention.

Evidence context

This descriptive study is an observational design and is limited as an n of 1 report, lacking controls. The effect of potential confounding factors, including comorbidities, cannot be excluded. We recognise that subluxation identification and correction is the art of the individual Chiropractor.

The findings could support the clinically relevant hypothesis that the identification and correction of spinal subluxation, pelvic subluxation, and cranial dysfunction are modifiable contributors to the effective management of the clinical presentation of menorrhagia in the adult patient.

This report is eligible for inclusion as 'expertise' bringing clinical insights into the JBI FAME evidential ring (35) to inform evidence-based healthcare in general and the science of Chiropractic in particular.

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References

1. Jensen, AM, Bewketu B, Sanford D. Intermittent low back pain referred from a uterine adenomyosis: a case report. J Chiropr Med.10.1 (2011): 64-69.
2. Livdans-Forret AB, Harvey PJ, Larkin-Thier SM. Menorrhagia: a synopsis of management focusing on herbal and nutritional supplements, and chiropractic. J Can Chiropr Assoc. 2007 Dec;51(4):235-46.
3. Radler M. Dysmenorrhea: chiropractic application. Am Chiropr: Mar/Apr 1984(:) 29, 31-32.
4. Arnold-Frochot S. Investigation of the effect of chiropractic adjustments on a specific gynecological symptom: dysmenorrhea. J Aust Chiro Assoc, 1981; 10:14-16.
5. Liebl NA, Butler LM. A chiropractic approach to the treatment of dysmenorrhea. J Manipulative Physiol Ther. 1990 Feb;13(2):101-6.
6. Dobrik I. Disorders of the iliopsoas muscle and its role in gynaecological diseases. Journal of Manual Medicine. 1989; 4: 120-2.
7. Bull PW, Genders WG, Hopkins SS, Lean EK. Dysmenorrhea and pelvic dysfunction: a possible clinical relationship. Chiropr J Aust. Mar 2003(33:1) 23-9.
8. Henry SJ, Polus BI, Walsh MJ. Dysmenorrhea: to treat or not to treat? Chiropr J Aust. Mar 1996(26:1) 21-4.
9. Holtzman DA, Petrocco-Napuli KL, Burke JR. Prospective case series on the effects of lumbosacral manipulation on dysmenorrhea [case report]. J Manipulative Physiol Ther. Mar 2008(31:3) 237.-246.
10. Kokjohn K, Shmid DM, Triano JJ, Brennan PC. The effect of spinal manipulation on pain and prostaglandin levels in women with primary dysmenorrhoea. J Manipulative Physiol Ther. Jun 1992(15:5) 279-85.
11. Proctor ML, Hing W, Johnson TC, Murphy PA. Spinal manipulation for primary and secondary dysmenorrhoea. Cochrane Database of Systematic Reviews. 2006 Jul 19;(3):CD002119.
12. Smith D. Chiropractic care of a patient with low back pain and primary dysmenorrhoea [case report]. Chiropr J Aust. Dec 2007(37:4) 141-4.
13. Thomason PR, Fisher BL, Carpenter PA, Fike GL. Effectiveness of spinal manipulative therapy in treatment of primary dysmenorrhoea: a pilot study. J Manipulative Physiol Ther. 1979: 2: 140-5.

14. Wiles M. Gynecology and obstetrics in chiropractic. J Can Chiropr Assoc. 1980 Dec; 24(4): 163–6.

15. Spears LG. A narrative review of medical, chiropractic, and alternative health practices in the treatment of primary dysmenorrhea. Journal of Chiropractic Medicine. J Chiropr Med: Spr 2005(4:2) 76-88.

16. Heavy Menstrual Bleeding [Internet] [cited 2014 March 17]. Available from: http://www.cdc.gov/ncbddd/blooddisorders/women/menorrhagia.html

17. What Do Tampon Absorbency Ratings Mean? [Internet] [cited 2014 March 12]. Available from: http://pms.about.com/od/hygiene/f/tampon_absorben.htm

18. DeJarnette MB. The History of Sacro Occipital Technic. Nebraska City, NE. 1952.

19. Abrams, A. Spondylotherapy. San Francisco, CA: Philopolis Press, 1910.

20. Abrams, A. Spondylotherapy. San Francisco, CA: Philopolis Press, 1914.

21. Gregory, AE. Spondylotherapy simplified; a compendium of the science of spinal concussion and sinusoidalization and the technique of their administration; the specific centers of nerve origin through which we control the function of various viscera; the results of stimulation of the different spinal centers of nerve origin, what affected and how, and directions for the correct application of those methods in the treatment of diseases amenable to them. Oklahoma City, OK: A. E. Gregory, 1922.

22. VanRumpt R. Personal Correspondence. Should be in text of document only, EX: According to R. Van Rumpt, DC (written communication, November 1989).

23. Boro WJ. Treatment of low back pain by cranial adjustment: a case report. 4th Annual Sacro Occipital Technique Research Conference Proceedings; May 2012; Atlanta, GA. P. 27-33.

24. Courtis G, Young M. Chiropractic management of idiopathic secondary amenorrhoea: a review of two cases. Br J Chiropractic. Apr 1998; 2(1):12-4.

25. Cook K, Rasmussen S. Visceral manipulation and the treatment of uterine fibroids: a case report. ACA Journal of Chiropractic. Dec 1992; 29(12): 39-41.

26. Benner CD, Blum CL. CMRT and acupuncture in the treatment of dysmenorrhea (oligomenorhea) and low back pain: a case report. World Congress on Low Back & Pelvic Pain Conference. Dubai, Oct. 2013.

27. Lin JA, Wong CS, Lee MS, Ko SC, Chan SM, Chen JJ, Chen TL. Successful treatment of primary dysmenorrhea by collateral meridian acupressure therapy [case report]. J Manipulative Physiol Ther. 2010 Jan;33(1):70-5.

28. Abrams, A. The cardiac reflex of Abrams. Lancet. 10 Oct 1903; 162(4180):1052.

29. Auld, AG. The lung reflex of Abrams. Lancet. 19 Dec 1903; 162(4190):1118.

30. Buck, AH, Stedman, TL. Reference handbook of the medical sciences embracing the entire range of scientific practical medicine and allied science. 3rd ed. New York, NY; W. Wood; 1917:910-915.

31. Warren, K, Walton, D. The effects of spondylotherapy on the hypertensive patient. [DC Thesis]. Logan College of Chiropractic, Missouri, 1995.

32. Janse J, Houser RH, Wells BF. Chiropractic Principles and Technic. National College of Chiropractic: Chicago; 1947.

33. Abrams, A. Progressive spondylotherapy. Philopolis Press: San Francisco, CA; 1913.

34. So how much does a hysterectomy cost? [Internet] 2012 Aug 12 [cited 2014 Mar 17]. Available from: http://www.hystersisters.com/vb2/showthread.php?t=490988.

35. 7.2.2. Descriptive study designs. JBI Manual for Evidence Synthesis. 2024e. At https://jbi-global-wiki.refined.site/space/MANUAL/355598734/7.2.2.+Descriptive+study+designs

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