



# Some clinical pearls to enhance your X-ray practice: A Clinical Huddle.

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## Transferring your Nervoscope/Delta T findings to a X-ray

**I**n central Iowa we have a great group of doctors and students that meet the second Monday of the month at different doctors' offices and review difficult cases. The person presenting typically reviews the patient's case history, ortho/neuro findings, EMG and Thermal scans, gait analysis, visualization, static and motion palpation, single and dual probe analysis and X-rays.

For the last several years we have encouraged the doctors to put lead markers (.30 caliber lead shot or #5 lead split shot fishing weights work the best) on the patient prior to taking the X-rays where they find the nervoscope/Delta T dual probe readings. We do this to improve the doctor's chiropractic examination skills leading to finding the subluxation on the patient PRIOR to taking the X-ray. In Dr. Gonstead's *Pit Class* years ago he used to talk about how he would find the subluxation on the patient and then take the X-ray to see if it agreed with the subluxation he found on the patient.

I enjoy listening to the doctors as they present their cases as to what they found, what they were adjusting and the results. While discussing the cervical, thoracic and lumbar ranges of motion, the ortho/neuro examination, the EMG and Thermograph findings and gait analysis tell about how the patient presented and how they may be improving clinically.

*... the beauty of over 40 years of practice is having the ability to call it like it is. Here is a new landmark for you, the COB, or 'Crack of Butt'. Its relevance is that your Nervoscope scan must always include the sacrum, to the COB.'*



However it is the Nervoscope/Delta T dual probe needle reading 'break' that tells the most about the location of the subluxation when it is marked on the X-ray with a lead marker and evaluated on the lateral full spine X-ray. Visualization, static and motion palpation help confirm the location and listing of the vertebra.

The easiest way I know of to show the location of the nerve pressure reading location on X-ray is to scotch tape a lead marker on the patient prior to taking the X-ray at the location of the 'break' found with your Nervoscope/ Delta T. When I examine my patients I list where I found the 'break'/subluxation on my examination form. Most of the time, where I listed the subluxation on the form is where I find the lead marker on the lateral X-ray. It is extremely satisfying when where I found the subluxation on the patient is where the lead marker is on the lateral X-ray. Do I always find the lead marker where I noted it on my examination form. 'NO', but I am still working on developing my Gonstead chiropractic examination skills after 42 years in practice. It is a journey, not a destination. Try it, a lot of the time where I thought I found nerve pressure on L5, it is on the second sacral tubercle.

I have learned over the years that people with excess/loose skin, excessive lordosis, large buttocks, very obese, or have a significant scoliosis may not correlate with marking the level of the 'break' with a lead marker on the lateral X-ray. For the vast majority of the patients, putting a lead marker at the level of the 'break will greatly improve your chiropractic palpation skills and further your examination skills. This will further improve the specificity of your adjustment which is what I hope everyone reading this is doing on a daily basis.

### **The vertebra that looks the worst on X-ray is usually NOT the location of the subluxation**

The last several years in our central Iowa Gonstead study group we have encouraged members to put lead markers on the X-ray marking the location of the nerve pressure PRIOR to taking the X-ray and most members do. After the doctor/student has done their presentation of the case history, ortho/neuro findings, EMG and Thermal scan finding, gait analysis, visualization and motion and static palpation findings we review the X-rays and the listings. The doctor/student relates what has been adjusted and the results of the adjustments. Sometimes the doctor/student relates what is being adjusted it is not the same vertebra that is noted by the lead marker on the X-ray as to the location of the 'break'. When asked 'why' the vertebra at the level of the 'break' isn't being adjusted the answer is '*When I looked at the X-ray, the vertebra I adjusted looked a lot worse than the vertebra that I marked with the lead marker so I adjusted this one*'. This concept is 'WRONG'.

Frequently the level of compensation looks worse than the subluxated vertebra due to it having to move a lot more than the subluxated one that has lost its normal range of motion. Often the doctor/student is told to go back and adjust the vertebra that correlates to the initial 'break' and report back. Most of the time the doctor/student reports back that the patient responded favorably to the adjustment where the initial 'break' was.

Remember, Dr. Gonstead said '*take all the time necessary to examine the patient, find the subluxation, ACCEPT it where you FIND it, fix it and leave it alone*'. I would like to add, I try to take new X-rays of the patient when the subluxation is corrected so I have some idea of how the patient looks when they are doing well so I have a reference set of films for when the patient has problems in the future. Otherwise the only films of the doctor has on file are the ones taken when the patient is messed up.

Another frequent situation is that the doctor/student reports that they adjusted the lead marked vertebra once and the patient didn't show any improvement so they went to another vertebra and when that didn't show an immediate response, they adjusted another vertebra and the patient has gotten marked worse. Again this is 'WRONG'.

For correction of a subluxation, you must on the correct bone, moving it in the correct direction of correction and adjust it as many times as it takes to remove the nerve pressure. It takes TIME and Repetition to make a correction of a vertebral subluxation. Follow your Nervoscope/Delta T readings as well as your motion and static palpation findings to determine how the patient is progressing.

The scope will tell you more about HOW the patient is doing versus what the patient may be relating verbally to you. I read more out of a person's body language than what comes out of their mouth.

### **Why I put lead markers on my X-rays where I find my 'break'**

I have been putting lead markers on my X-rays where I find the 'break' for at least three decades, probably more. When I look at my lateral X-ray I expect to see my lead marker at the same vertebral level where I listed my 'break' on my examination form.

Years ago, I was scoping a former employee who returned with a low back condition. After I finished scoping her spine I was doing my motion palpation of her sacroiliac joints and my little finger brushed across the lower part of her sacrum about 2 inches below where I had made my mark at her L5 vertebra. When I touched that point, she jumped and related that was the focus of her lower back pain. I picked up my Delta T, ran my Delta T lower on her pelvis and there was a three point 'break' that was much lower on her spine than I had ever found any evidence of nerve pressure. I put a lead marker there and after taking her new X-rays found that the lead marker was right across from the 3rd sacral tubercle on her lateral X-ray. Lesson learned!!

Note to self, on EVERY patient make sure I run the scope up and down the spine from the occiput to the coccyx. After I found that 3rd sacral tubercle, I adjusted it and the patient reported back the next day that she was markedly better and didn't have to go to bed with her three friends (the pillows she put between her legs, in front and behind her when she was in bed).

When I was first in practice, when I ran my Nervoscope/Delta T I often found evidence of nerve pressure at L5 or at one of the sacroiliac joints. Since the incident listed above, I make sure that I run my dual probe instrument from the patient's occiput to their coccyx or COB [crack of the butt]. I still find a lot of L5 and sacroiliac readings of nerve pressure, but I also find a lot of sacral tubercle and coccyx nerve pressure readings. In a nut shell, specificity lies in being EXTREMELY thorough in your examination.

### **My Thots, My Opinion**

Over the years I have had many patients come to me after having had spinal surgery. In most cases, the patient had spinal surgery based on the evidence of disc herniation or bulge on a MRI scan. While those scans are very beneficial in detecting tumors and the like, I have heard that patients who have no S/S may have a positive MRI scan for a herniated disc. While the spinal surgery may have been successful in reducing the disc herniation or protrusion, the patient still has S/S that range from moderate to severe pain despite doing PT, taking NSAIDS and/or other pain or muscle relaxing medications.

I have always wondered how this could happen after the offending lesion has been removed. My opinion is that while the offending lesion has been removed the subluxation has not and is still causing nerve interference. Hence, pardon me to all neurologists reading this article, remember these words '*Spinal Biomechanics ALWAYS trumps neurology*'. In short, my opinion is that the subluxation of the spine or pelvis disrupts the spinal or pelvic biomechanics causing the herniation or protrusion. The neurologist may be correct in their evaluation of the patient's neurological problem. It is my contention that the subluxation of the lumbar spine, sacrum or pelvis may be the cause of the patient's health problems, not necessarily a disc herniation or protrusion.

When I evaluate a post-surgical patient, I typically find a subluxation of the lumbar spine, sacrum or pelvis after an extremely thorough examination (yes, the patient may still have a subluxation where the protruding disc has been removed). When I adjust these patients, I find I have to be very specific when I give them a Gonstead adjustment in my LOC (Line of Correction).

That being said, the adjustment does not require a lot of force, but the thrust must be very specific. Focus in this order of correction:

- ▶ Inferior to superior
- ▶ posterior to anterior
- ▶ right to left or left to right to correct rotation of the vertebra
- ▶ and then close the wedge if it is present.

The adjustment frequently is noiseless, and I may or may not feel any movement or the movement is minimal. The patient frequently says they didn't hear a 'crack' or feel any movement. I tell them I have put the amount of force in the adjustment necessary to move the bone in the direction of correction to correct your subluxation. Then I tell them to go home and ice the area I adjusted and I'll see them the next time.

I remember Dr. Gonstead saying in his Pit Class, '*Youse boys adjust too many bones too hard*'. Take all the time necessary to find the subluxation on the patient, ACCEPT it where you find it, adjust/fix it, and leave it alone.

I like to take a new set of X-rays when the patient is as good as I can get them or the patient is happy with the care, to see what they look like when they are as good as I can get them. Then you have a reference point when the patient goofs themselves up again



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In July 24 2021, the Gonstead Clinical Studies Society and Gonstead Methodology presented Dr. Rick Elbert the C.S. Gonstead Lifetime Achievement award for his work promoting Chiropractic and the Gonstead method of Chiropractic adjusting. Dr. Elbert has been in Chiropractic practice for 43 years, the last 9 in Ogden.

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