

EDITORIAL

## Chiropractic and Visceral Disorders

DANIEL REDWOOD, D.C.

Few aspects of chiropractic are as controversial as manual adjustment (spinal manipulation) for visceral disorders. Its possible efficacy for a variety of conditions including asthma, dysmenorrhea, hypertension, infantile colic, nocturnal enuresis, and otitis media has been the subject of randomized controlled trials (RCTs). A broader range of nonmusculoskeletal (non-MS) conditions has been addressed in case studies, case series, and various experimental approaches. That the spine and nervous system affect visceral organs is not in dispute; the controversy centers on the extent to which chiropractic and other manual therapies, presumably mediated by the nervous system, influence the viscera.

In this issue of the *Journal* (pp. 491–512), Cheryl Hawk and colleagues present a systematic review of the literature on chiropractic care for non-MS conditions. There has long been a need for an academically sound paper on this topic, and the authors have performed a conventional systematic review well, utilizing SIGN and Jadad checklists as well as a “modified CONSORT” checklist.

What makes their paper even more noteworthy is that they have also performed a parallel analysis, systematically reviewing the literature using the emergent principles of Whole Systems Research (WSR). This is a crucial step in the development and utilization of analytic methods that recognize and respect the fullness of the doctor–patient interaction and also address fundamental differences between physical medicine (e.g., chiropractic, massage, acupuncture, and physical therapy) and delivery systems involving neutrally packaged pills (e.g., homeopathy, some forms of herbal therapy, and pharmaceuticals).

In the WSR portion of Hawk et al.’s review, points were deducted from the scores of studies in which (1) there was no assessment of treatment preference or expectations; (2) the practitioner could not exercise clinical judgment to modify number of visits or duration of care; (3) procedures and

protocols were not based on usual practice, as documented by case reports or other published studies; (4) there was no assessment of patient satisfaction; and (5) comparison groups did not reflect real-life practice, often using a treatment used in practice as a sham or placebo.

Although all of these factors are significant, the final one is critical. As I have written previously in this journal,<sup>1,2</sup> RCTs on chiropractic that use so-called placebos or shams that overlap significantly with methods that some practitioners use as actual therapies (e.g., manual massage or gentle joint movement) are severely compromised and frequently lead to unduly pessimistic conclusions. The importance of this methodological challenge is huge and has been remarkably resistant to widely accepted solutions. The current paper by Hawk et al. is an encouraging sign that progress is possible.

The qualifications of the review’s authors are worthy of mention because they lend credibility to the study’s conclusions and embody the important role played by dual-degreed chiropractors in the profession’s advancement. Cheryl Hawk and Will Evans are D.C.-Ph.D.s at chiropractic college research departments, and Randy Ferrance is a D.C.-M.D. who works as a hospital-based physician. Along with perhaps several dozen others in the profession who hold two advanced degrees and a few who hold three (D.C.-M.D.-Ph.D.), these scholars serve as an invaluable bridge to other health professions and set high standards of scholarship within the chiropractic community.

Chiropractic care for visceral disorders has been part of the profession’s mission since its inception. The first chiropractic adjustment, in 1895, was delivered to a patient seeking care for deafness. Though the vast majority of chiropractic cases involve musculoskeletal conditions (chiefly back pain, neck pain, and headaches), virtually all chiropractors (myself included) have seen cases in which a patient with visceral symptoms appeared to respond dramati-

cally to chiropractic care. However, for most visceral conditions these cases seem to be the exception rather than the rule.

How do evidence-respecting practitioners handle such a situation? RCTs are structured to yield positive results only when a strong majority of patients are helped. What do we do when only a minority (and perhaps just a small minority) of patients with a particular named condition are likely to experience a meaningfully positive response to treatment?

Consider this case, from my first year in practice. Briefly summarized, my patient was a male young adult whose motorcycle was hit by a truck. He survived, with several broken bones and, initially, a great deal of pain. After a few months of apparently helpful treatment by an orthopedist and a physical therapist, his bones had healed and his pain was gone. There a problem, though—he was constantly nauseous. During the next year, he was seen by an internist, nutritionist, neurologist, psychiatrist, and at a fasting clinic, to no avail. His last stop before coming to me was at the office of a classical homeopathic medical physician in the town where I practiced. When homeopathy did not help, this M.D. did something that was then quite rare—he referred his patient to a chiropractor. After a single adjustment to the upper cervical area, the nausea vanished. As of 5 years later, it had not returned.

I am reasonably confident that no RCT will ever show that a majority of cases of nausea respond so positively to chiropractic adjustments. This was an unusual case, and yet I think it entirely likely that if this patient had not gone to

a chiropractor, he would still be nauseous today, 25 years later.

The moral of the story, I think, is that all health professionals must be permitted to use unproven methods (as long as they are reasonably safe), and that we must never make overly broad or inaccurate claims about these methods. At the same time, we must become comfortable operating within the broad zones of uncertainty common to all healing arts.

The Hawk et al. paper (pp. 491–512) will not solve all of these conundrums, but it is a major step forward in more fully understanding and more fairly evaluating the effects of chiropractic care for visceral disorders.

## REFERENCES

1. Redwood D. Same data, different interpretation. *J Altern Complement Med* 1999;5:89–91.
2. Redwood D. Methodological changes in the evaluation of complementary and alternative medicine: Issues raised by Sherman et al. and Hawk et al. *J Altern Complement Med* 2002;8:5–6.

Address reprint requests to:

*Daniel Redwood, D.C.  
Cleveland Chiropractic College  
6401 Rockhill Road  
Kansas City, MO 64101*

*E-mail: dan.redwood@cleveland.edu*