herself is perhaps just as useful as the form of treatment she gives, and quite often if you have doubts about the patient's mental background your psychiatric consultant will be very helpful in advising whether one or other particular substance such as Nardil or Tofranil will help in this particular case. But, to finish, one must emphasize that in a chronic painful condition some time must initially be spent in telling the patient what disorder she suffers from and what she should and should not do about it.

## III

## The Scope of Manipulative Treatment

**D. R. L. Newton,** M.R.C.P., D.PHYS.MED. (*Middlesborough*)

Many medical practitioners assume an attitude of healthy scepticism whenever the term " manipulation " is mentioned. They may not be averse to ordering " passive stretching " or " passive movements " as part of their prescription to a physiotherapist, yet would strongly deny any suggestion that they were thereby employing manipulative methods of treatment. If these methods were not on the whole successful when applied to suitable cases, a large number of lay practitioners and a rather lesser number of medically qualified men would be unemployed, because inevitably any form of treatment will fall into disrepute if it produces a sufficient number of poor, or frankly bad, results and this has not happened in the case of manipulation. The consideration of manipulative methods of treatment may engender distaste in the minds of many of us for several reasons. This is something we were not taught anything about as students, and since qualification we have met it only secondhand from those of our patients who admit that they have been to a lay manipulator and have returned to us either cured, which can be very aggravating after our failure to help them in the past, or worse than they were and asking for our forgiveness and further help.

When discussing this subject dispassionately, we must have a good working definition, and I would suggest that manipulation be regarded as the production by the operator of a movement at a joint which is not attainable by natural active means on the part of the patient himself at the material time. In terms of pathological

anatomy, contracted joint capsules and ligaments can be stretched and displaced structures can be moved or replaced. In this latter sense, manipulative methods are used every day in orthopaedic and fracture clinics up and down the country and I do not suppose anyone will wish to argue about the value of reducing fractures and dislocations, though many of us, and orthopaedic surgeons in particular, would make a plea for wisdom and forbearance in the manipulation of a joint, particularly the knee, elbow and temporomandibular joint, which is the site of an internal derangement due to a meniscus lesion or the impaction of a loose body. Likewise, some of the stiff and painful feet resulting from the damage caused by rheumatoid arthritis can often be helped considerably by manipulation under an anaesthetic, but this should only be part of an overall planned routine of management. Opinions are more divided about the use of manipulation in the treatment of soft tissue lesions. Most of us who see many cases of periarthritis (or capsulitis) of the shoulder are aware of the damage which may result from attempts to force movement too early during the course of the natural history of the condition. On the other hand, a manoeuvre such as Mills' manipulation is certainly worth trying in the treatment of a tennis elbow which has failed to respond to other methods of treatment, including an accurately placed injection of steroid or local anaesthetic.

It is when we come to the spine that the controversy really begins to rage. This is because, in the present state of our knowledge, all manipulative treatment to the spine is necessarily empirical, thus allowing people who so wish to make the most extravagant claims which, whatever we may suspect, we cannot readily disprove. Any one of us can carry out a simple postero-anterior thrust on someone's lumbar spine and produce an audible click and probably quite a pleasant feeling akin to that which we get after a good stretch. This is quite a normal manifestation, but who can blame a patient for believing the statement which has been made to him that " the misplaced bone has been put back ", particularly when the tale is well garnished with high sounding, if quite meaningless jargon and he is at the same time relieved of an impressive number of guineas?

There can be no doubt that a large number of man's aches and pains are referred, and sometimes widely, from lesions in the spinal or paraspinal structures, and Professor Kellgren's studies in this field should have done much to clarify our thinking on the diagnostic difficulties set by referred pain mechanisms. Our present methods of examination are comparatively coarse because largely indirect, and it is usually impossible accurately to implicate a particular structure. From our knowledge of well authenticated spinal pathology, we may infer, for instance, that there is a disc lesion or

alternatively suspect the presence of a derangement in a facet joint, but in most cases we cannot prove it. With experience we may learn that a patient presenting with a certain history and exhibiting certain physical signs may be greatly helped by a particular, and often relatively simple, manipulative movement. While being thankful that this is so, we should not necessarily delude ourselves that we have replaced a protruding disc or shifted an impacted loose body in a facet joint: it may be so, but for the present we would be well advised to keep an open mind and be prepared to admit that we do not really know what we have done, whilst at the same time searching for clues which might fit together to lead to a better understanding of the fundamental problem.

One thing is abundantly clear: in the musculoskeletal disorders, as in any other field of medicine, there is absolutely no excuse for not taking an adequate history and for not carrying out a thorough physical examination followed by whatever investigations seem indicated in order to reach as accurate an anatomical and pathological diagnosis as possible before considering the application of any form of treatment. In other words, to answer the questions Where? What? and, if possible, Why? is as much the essence of good medical practice in this field as in any other. We should never lose sight of the fact that serious systemic disorders may present as apparently innocuous musculoskeletal lesions, and that the apparently trivial may really be quite serious. How many of us were somewhat shaken a few years ago when we read those case histories of patients from a neurosurgical unit who had been operated on for spinal tumours? How many of the stories were surprisingly mundane and of the sort we could so easily dismiss as being due to a " touch of lumbago ". This is one reason why we must be careful to avoid meaningless terms and refrain from blowing them up to the status of a diagnosis. For example, how can one usefully compare the treatment of two series of cases labelled as " brachalgia " or " lumbago "? If we cannot define exactly what we mean we had better not begin. One should never hesitate to re-examine and carefully re-assess cases of apparently trivial musculoskeletal disorder. In some circles the diagnosis of " psychogenic rheumatism" is held all too frequently to account for the majority of aches and pains seen in everyday practice. The patient's psychological reactions to symptoms which may be associated with the effects of musculoskeletal degeneration are certainly important, but the symptoms should never be dismissed out of hand without the most careful consideration of their possible physical basis. The use of manipulative methods as a means of psychotherapy will not be any more successful in the long run than any other form of placebo and may be a great deal more harmful.

In relation to manipulation of the spine, I think certain basic rules should be observed. Most manipulative procedures are simple and can be easily learned, but preferably not from books. Practical instruction is invaluable, but beware the teacher who is so glib that he will not discuss anatomical, physiological, or pathological principles, or who, in the defence of his own cherished beliefs, will not accept or even discuss authentic work carried out elsewhere. Because of the possibility of spinal cord damage, most people prefer to manipulate the cervical and dorsal spine and the upper lumbar spine under traction. The spine should never be manipulated under an anaesthetic by anyone who has not the facilities and personal ability to carry out an immediate laminectomy in order to retrieve an error of judgment. It should go without saying that no part of the spine should ever be manipulated in the presence of symptoms or physical signs suggestive of spinal cord disturbance, and on the whole it is unwise to manipulate the cervical or lumbar spine in the presence of symptoms suggestive of nerve root irritation or physical signs indicative of root involvement. In those cases of this type where a presumptive diagnosis of a disc lesion has been made, simple traction in the line of the spine, so-called long traction, may be useful, but usually should be combined with some means of adequate immobilization. Any suspicion of bone disease, whether metabolic, infective, or neoplastic, either primary or secondary, absolutely contra-indicates manipulative treatment to the spine. The golden rule is " when in doubt leave well alone ".

After careful consideration, therefore, we are left with a small aetiological group of spinal lesions which may well be helped by a simple manipulative treatment. However, this group is numerically very great and consists of many cases of painful stiff neck and stiff back, usually of sudden onset and apparently of mechanical origin. Following proper elucidation of the cause so far as possible, the method used to manipulate these cases may vary from one operator to another. It is largely a hit and miss affair, and knowledge of which manoeuvre is likely to work in a particular patient is largely a matter of experience and not, as some seem to think, of a magic touch or a sixth sense. In the neck, for example, simple manual traction on the head of a supine patient, with counter-traction applied to the feet by an assistant, will often suffice. In cases of acute stiff neck apparently associated with some minor articular derangement, it may be found that the degree of active movement can be successively increased following each pull, and a little gentle rotation or circumduction movement may usefully be added with the traction. In the lower lumbar spine immediate and remarkable relief may be obtained from what can best be described as a " catch in the back "

by the application of thrusting movements with the whole of the operator's body weight applied to the centre of the prone spine. One practitioner of my acquaintance successfully advocates the utilization of a relative or friend of suitable proportions to walk down the back of the patient lying prone on the floor.

So far as I am aware, only one attempt has yet been made to perform a properly controlled trial on the benefits of manipulation, though a multi-centre trial is at the moment being carried out on the treatment of cervical spondylosis by neck traction. Only by remaining open-minded and by being logically critical can we hope to determine the proper scope of manipulative treatment in musculoskeletal disorders. Even if we have no control over the laity who practise manipulation, we can at least attempt to put our own house in order. Unfortunately, however, progress is likely to be slow in a field where ignorance is so often financial bliss.

## DISCUSSION

***Question:*** How can one get hold of these little yellow booklets that you give to your patients?

**Dr Hart:** Write to Mr Andrews of the Empire Rheumatism Council, Faraday House, 10 Charing Cross Road, London, W.C.2. They are free and he will send you as many as you like.

***Question:*** What is the suggested dosage of phenylbutazone for osteoarthritis? How long may the treatment be given?

**Dr Hart:** Not more than 400 mg. a day of phenylbutazone should be given in divided dosage, taken with food, and not more than 500 mg. of oxyphenbutazone, that is, Tanderil, in the day. I think it is wise to take the drug with food on each occasion. If there is no relief in four days at top level dosage, stop it. I prefer to start with the low dosage end and see if 100 or 200 mg. will do the trick; very commonly it does. Although blood levels are not high, small doses are tolerated well and very often make just that difference because of the smooth even action over the 24 hours; simple analgesics can still be taken in addition for more painful episodes. Patients have taught me that if small regular dosage does not work, graduated