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# Chronic Recurrent Back & Neck Sprains: Principles for Permanent Cure

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CHRONIC RECURRENT BACK AND NECK SPRAINS  
PRINCIPLES FOR PERMANENT CURE

Now in 1990 we no longer hesitate to proclaim five years and apparently final cures in many cases of cancer. Yet many physicians timidly shy from the notion of and declaration that an aching or "weak" back or neck can be permanently cured.

It is firmly believed that the vast majority of all chronic recurring back and neck aches and "weakness" can be cured - and permanently. In the minority are the destructive bone diseases (neoplasms, infections, etc.), wherein optimism for cure of spine discomfort is much less. Even when mild bone disease, such as spondylosis is present, in the vast majority of cases, the bone usually does not directly produce the back or neck discomfort. The actual source of most of the spinal distress is due to soft tissue alterations, i.e. tendons, muscle, fascia, and ligaments. Spinal ligamentous strains (asthenia) appear also to accompany most chronic recurrent spinal discomforts. Total and permanent cure of back and neck aches then can only be achieved by removing these abnormal soft tissue factors. Helpful and often essential to this goal is attention to the following commonest contributing factors of the soft tissue abnormalities.

1. Skeletal (boney) asymmetries (short legs, pelvic tilts, anomalies, degenerative arthrotic deformities, scolioses, lists, and malalignments). These are preferably detected by standing postural X-ray studies.
2. Varying soft tissue tensions of muscles and fascia due to scars and fibrosis, toxic or reflex contractures from local or constitutional infection or other disease. These are best detected by observation and manual palpation and testing for asymmetrical and restricted motion and hypermobility.
3. Intervertebral disc disease commonly producing pain via nerve pressure; but usually allowed by abnormal vertebral malalignment via weakened ligaments and musculo-fascial shortening and the other above mentioned factors disturbing efficient vertebral dynamics.
4. Weak, relaxed or asthenic, ligaments, intimately adherent to and supporting the vertebrae and ribs, permitting excessive vertebral and costal motion. These are due to one or more of the above conditions, or trauma, either single or repeated, either severe or so mild it may go unnoticed.

## TREATMENT

1. Bony asymmetries must first be minimized by such procedures as heel lifts, hip lifts, osteopathic manipulation and daily program of spinal rehabilitation procedures prescribed by the physician, self and home administered.
2. Musculofascial shortenings and tensions must be relieved by procedures such as manipulation, traction, and other physical medical modalities and a home spinal rehabilitation program via passive and active exercises or stretches. Medications should be used concurrently to help soften and resolve indurated fibrotic and edematous areas. Commonly overlooked, and equally important, is the visceral counterpart of the spinal somatic lesion problem. The spine frequently appears to be an area of emanation of distress in visceral disease segmentally directed. These visceral diseases must be recognized and corrected, even if exceedingly mild. One should employ the usual supplementary medical measures of surgery, medication, diet, optimum living habits, etc. (Example-treat prostatitis, cervicitis, pyelonephritis, gastritis, upper respiratory infection, myringitis, bronchitis, dental caries, cardiac problems, neoplasms, etc.)
3. It would appear through vast clinical experience that the areas of most chronic and recurrent back and neck aches centers not only in the fibrotic and shortened muscles, but also in the ligaments that have become asthenic (thin and weakened) from the excessive protracted trauma of abnormal positioning, motion, and musculofascial gravitational forces around the related vertebrae. Unscientific, injudicious, and excessive spinal manipulation likewise contributes to ligamentous weakness. Such weaknesses may allow and encourage even relatively minor daily postural stresses to cause recurrent painful osteopathic lesions, or fixations, of the costal and spinal segments. Unless these ligaments are strengthened and made more resilient by sclerotherapy, the ligaments, though commonly symptomless for months and years, are never really returned to their optimum strength. The patient consequently is "re-straining" his/her spine. Weak ligaments then again provide the susceptibility to the vicious cycle of spinal stress and painful muscular protective contractures producing spinal malalignment and lesioning. This in turn produces lowered somatico-visceral autonomic nervous system thresholds. These alternately producing their neuronal over stimulation and then exhaustion. A vasomotor imbalance results altering local organ chemistry. Suboptimum functioning, congestion, and lowered tissue resistance and immunity of the visceral organs frequently occurs encouraging and promoting visceral

disease to develop. This in turn reflexly produces somatic spinal tensions, vertebral malalignments, and scolioses, which stress, lengthen, swell and weaken the ligaments. Pain, muscle spasm, and further weakening of ligaments results.

Spinal stabilization via ligament sclerotherapy seems to be an invaluable "must" in the physician's armamentarium for permanent and total cure of most chronic recurrent back and neck aches. However, the above mentioned contributing causes of this commonest human ailment must be attended totally to eliminate a patient's "weak spine" and to prevent "re-weakening" of the ligaments after sclerotherapy.