

# Chiropractic Management of a Patient With Chronic Pain in a Federally Qualified Health Center: A Case Report

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## ABSTRACT

**Objective:** The aim of this case report is to describe the response of a patient with chronic pain who received chiropractic care in a federally qualified health center.

**Clinical Features:** A 61-year-old female patient with neck and back pain after a traumatic motor vehicle accident 3 years prior was referred for chiropractic care. She had neck pain, low back pain, knee pain, and pain associated with over 20 surgeries, as well as depression, opioid dependence, and low quality of life.

**Interventions and Outcomes:** The patient was treated with chiropractic manipulation for her low back and neck pain and was counseled on nutrition and exercise. After 6 months, she reported improvements in pain, improved quality of life, and discontinuation of opioid pain medication.

**Conclusion:** This patient improved after a course of chiropractic care that was integrated into a federally qualified health center. (J Chiropr Med 2018;17:117-120)

**Key Indexing Terms:** *Chiropractic; Analgesics, Opioid; Medically Underserved Area*

## INTRODUCTION

Chronic pain continues to be one of the primary reasons for medical consultations worldwide.<sup>1</sup> In 2008, the United States estimated that nearly 100 million people were affected by chronic pain with an associated economic cost ranging from \$560 billion to \$635 billion annually in medical care and decreased productivity.<sup>2</sup>

The American Academy of Pain Medicine outlines the management of nonmalignant chronic pain and recommends combination therapy, including analgesics, nonsteroidal anti-inflammatory drugs, opioids, antidepressants, and anticonvulsants.<sup>3</sup> Prescription pain killers are an enormous cost to the United States, with an annual bill of \$17.8 billion, of which \$12.3 billion is attributed to opioids. As the public health issue of substance abuse grows, there is a strong correlation between opioid sales and opioid-related deaths. Opioid sales quadrupled from 1999 to 2015, while opioid-related deaths quadrupled during the same time period.<sup>4</sup> Chiropractic care has been shown to help in

managing or alleviating chronic pain without the use of drugs or surgery as well as being cost effective, considered safe, and satisfactory to a high number of patients.<sup>5</sup>

Federally Qualified Health Centers (FQHCs) are federally funded community health centers that provide primary care and preventive health services in communities made up mostly of medically underserved people, such as the homeless or low-income individuals, migrant workers, or marginalized groups. These centers provide multidisciplinary and interdisciplinary healthcare. These organizations are critical for the care of urban communities where the consumers have little to no insurance or spare income, while reducing the burden on hospitals and cost of treating the underserved.<sup>6</sup> There is little literature that describes the inclusion of chiropractic care within FQHC. Therefore, the purpose of this study was to present a case of chiropractic management of a patient who had previously reached a plateau in progress in regaining overall function and pain control within a FQHC.

## CASE REPORT

A 61-year-old female patient presented for chiropractic evaluation with widespread pain since a motor vehicle accident (MVA) 3 years prior. Although she experienced pain in numerous regions, she was referred within an FQHC from her primary care provider for chiropractic treatment of low back pain (LBP) and low functional capacity. In the MVA, her right lower leg was partially severed but was later reattached with multiple surgeries and skin grafts. She

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had multiple fractured bones, mostly in the lower extremities. She reported over 20 surgeries since the MVA. Prescription painkillers (5 mg/300 mg hydrocodone/acetaminophen initially followed by 5 mg/325 mg hydrocodone/acetaminophen) and hot packs were her main sources of pain relief. She stated that the medications made her feel groggy and often incoherent; therefore, she did not want to take them unless she was at home, which impacted her social life. Normal activities of daily living were also difficult, such as personal hygiene, getting dressed, and doing chores around the house.

Shortly before her presentation for chiropractic care, she had experience a fall secondary to low blood pressure. She had been ambulating with the assistance of a walker since recovering from the MVA due to her leg and LBP. A motivating factor for this patient to get well and start moving more was the fact that during an orthopedic consult for a knee replacement she was informed that she had to “lose weight and get healthier” before she could be a candidate for surgery. She was unable to achieve this task on her own. Her T-scores on the PROMIS Global short form during her initial chiropractic visit were 29.6 (physical) and 36.3 (mental).

A chiropractic examination was performed but was limited due to her severe limitations in mobility and fear avoidance. The examination consisted of visual inspection, visual assessment of active range of motion, testing of the deep tendon reflexes, dermatome testing, myotome testing, and palpatory findings. Aside from weakness secondary to pain and lack of sensation in the areas of skin grafts on the right lower leg, her neurologic examination was normal in the upper and lower extremities bilaterally. She had difficulty getting on and off the examination table in the prone position because of the severity of her pain levels. She also presented with a slow, shuffling gate with limited range of motion. Motion palpation revealed hypomobile segments in the lumbar, thoracic, and cervical regions.

She was given a working diagnosis of chronic pain syndrome, segmental dysfunction throughout the spine, and myalgia. A treatment plan of 2 visits per week for 4 weeks, followed by reassessment, was discussed and agreed upon. Conservative treatment was performed, consisting of the Activator technique (Activator Methods, Phoenix, Arizona) in the cervical and thoracic regions, along with Cox protocol 2 in the lumbar region, utilizing a Lloyd table (Lloyd Table Co, Lisbon, Iowa). Shortly after initiation, the treatment plan was amended to include the use of Thompson Drop and Reinert Diversified techniques, which utilized the same Lloyd table. Along with chiropractic treatment, she was educated on nutrition and therapeutic exercise. She was counseled by chiropractic student interns and chiropractic physician clinical supervisors who encouraged focusing on food intake by using a food journal, and she was given a handout regarding prudent food choices and portion control. She was encouraged to try

water aerobics classes at a local gym to increase her activity levels and to aide in weight reduction. She also was directed on how to perform a home exercise program consisting of straight leg raises and balancing on 1 foot and on how to properly stand from a seated position by utilizing her core muscles appropriately.

Within several treatments, she reported feeling better, had increased mobility, and used less painkillers for palliation. Within the first month of treatment, she had improved mobility, made dietary changes, increased her social activities, began water aerobics classes, and was able to sleep through the night without waking up due to pain for the first time in the years since the MVA. Her improvement progressed steadily during the first month of care. She was able to stop using the walker and started using a cane, eventually only carrying it “just in case.”

After a month of treatment, her relative improvement enabled her to take a vacation. She was absent from care for approximately 1 month. The month after her return, she could only attend 2 visits because of transportation issues. Following that 2-month lapse in consistent care, she visited the emergency room due to severe left-sided sciatica-like pain. She had lumbar radiography performed, which demonstrated degenerative changes of the lumbar spine. She was prescribed ibuprofen 600 mg, 1 tablet every 6 hours or as needed, and discharged from the emergency room the same day. She presented again for chiropractic care at the same FQHC a few days later. Two weeks after restarting her care plan of 2 times per week for 4 weeks, followed by reassessment, the resurgence of LBP and sciatica was reduced and under control, returning to “pre-vacation” levels. Although no viable outcome measures are available for this juncture of the care plan, the patient noted “feeling great once again.”

After 3 months of chiropractic care, her T-scores on the PROMIS Global short form improved to 39.8 (physical) and 50.8 (mental). Her progress in her overall function and weight loss has made her a viable candidate for a knee replacement, and the orthopedic surgeon has agreed to perform the operation in the near future. Another result was that she reduced her reliance on and intake of prescription opioid pain medication. She received her last prescription 6 months (September 2017) after she began chiropractic care, with no refills of pain medication due to her pain resulting from her accident after that point. She eventually had a refill of pain medication 10 months later (July 2017), but only because she underwent surgery to remove the hardware from the previously injured right leg in preparation for her knee replacement surgery. The patient provided consent to report her health information.

## DISCUSSION

Chronic pain is a burden on public health in the US, affecting more Americans than diabetes, heart disease, and

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