Abdominal aortic aneurysms: case report.
JCCA 1998; 42(4):216–221.

To the Editor:

I would like to thank both the authors of this case report for an extremely interesting, well organized, and informative article.

My sole suggestion to the authors is that under the category of aetiology and epidemiology, I felt that they could have expanded on the genetic predisposition. In a chiropractor's initial consultation with patients, it is reasonable to expect the chiropractor to inquire about family history for any diseases. Often this would be a first clue if the patient was aware of other family members having had an incidence of abdominal aortic aneurysms (A.A.A.). Genetic predisposition to A.A.A. is well established in the literature and I recommend the following journal article which appeared in the C.J.S. Vol. 32, No. 2, March 1989. Dr. Cole and colleagues reported 11 percent of their patients in a retrospective study had a positive history of an affected first degree relative. Further in their study they reported that A.A.A. was reported to affect approximately 20 percent of the siblings at risk when the proband had an affected parent or sibling. They regarded these siblings as members of a high risk group that should be screened for early detection and elective management of A.A.A.

In a further article by Dr. William Cole, "Highlights of an International Workshop on Abdominal Aortic Aneurysms" which was published in C.M.A.J. Vol. 141, September 1, 1989, there are significant and substantial recommendations made by this group of specialists. One of the recommendations was to screen high risk patients with ultrasonography to determine the value of such a procedure in randomized trials.

It is my feeling that the prudent chiropractor can be forearmed and forewarned if he/she has an adequate family history which will help him rate the risk factors in a patient with a positive family history. In this office it is not an unusual protocol to inform patients who are a first degree relative of an A.A.A. patient of the reasonableness of attending to their physician for a routine ultrasonography of the abdominal aorta. This becomes even more imperative when the patient presents in our office with lower back pain. It is my opinion that the knowledgeable chiropractor can have an effective influence on early detection of A.A.A. which has been simply garnered from the family history.

Again, I thank you for a very interesting article and for refreshing my awareness of A.A.A. in day to day clinical work.

W. Reg Nicholson, MSc, DC
Midland, Ontario

Interexaminer and intraexaminer reliability of cervical passive range of motion using the CROM and Cybex 320 EDI.
JCCA 1998; 42(4):222–228.

To the Editor:

This is to congratulate the authors on an extremely well prepared article. I am pleased to see that your intraclass correlation coefficients (I.C.C.) are comparable to those that were published by the Mayo School of Health Related Sciences in Volume 42, No. 11, November 1992 of Physiotherapy.

I am in agreement with your conclusions that it would be of value to study the remaining cervical ranges of motion of lateral flexion and rotation, however I would hope that when a person is going to the trouble of doing a study of the additional ranges of motion that they would also include the other four ranges (protraction, retraction, [translation], sub-occipital flexion and sub-occipital extension) when using the CROM instrument. These other four ranges of motion are often overlooked and infrequently assessed. I am unaware of any reliability studies addressing these four ranges of motion and they would have significance in many medical/legal settings. I would ask that if you consider doing future studies in respect to the reliability of the CROM instrument that these four ranges of motion be included in your assessments. I thank you for a most interesting and pertinent article.

W Reg Nicholson, MSc, DC
Midland, Ontario

To the Editor in reply:

Thank you very much for your response to our research project. Positive feedback is always appreciated, especially on projects that take a great deal of time and energy.

Our intent from the commencement of this study was to begin with the flexion/extension comparison and then later examine the four other ranges of motion, those being left and right lateral flexion and rotation with respect to the CROM and Cybex 320 EDI.

Your suggestion of using the CROM to research other ranges of motion of protraction, retraction [translation], sub-occipital flexion and extension would be a fascinating study, so long as another device could be included in the study for comparison, since the Cybex 320 EDI does not have the capability to examine these ranges. This study may have to wait awhile however unless there is another instrument that I am not aware of that could be used to achieve this end. I agree that these studies would have significance in medical/legal settings. Once again thank you for your kind words.

Stuart Love, DC
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There are reasons why even after 100 years (commentary).
JCCA 1998; 42(4):197–205.

To the Editor:

Kudos to Dr. Ronald Carter for his insightful commentary: "There are reasons why even after 100 years". Dr. Carter clearly and concisely concludes what I suspect is thought by many to be Chiropractic's greatest enemy: ourselves. The "innate" driven Chiropractors who suggest developing splinter groups such as various "friends" or "awareness councils" do us far more harm than good, and Dr. Carter's dissertation clearly identifies the divisiveness that such movements provide. The same can be said for the "Orthopractic" movement with it's own uniquely political agenda.

Contemporary Chiropractic practice will survive and flourish based upon sound scientific principles, not philosophy or 'pseudo-science'. Clinical successes and the underlying scientific principles upon which these encounters are based are the testing grounds for hypotheses and are the breeding ground for research questions. Why is it that some patients find that their headaches are relieved following spinal manipulation? How can an acutely painful lumbar spine, refractory to weeks of rest and NSAIDS be (in some cases) tremendously relieved following spinal manipulation? Clinical encounters such as the foregoing are seen daily in practice but how many case reports are published and what are the mechanisms of action of these treatments?

In order to become accepted as a voice of authority regarding the non-surgical management of back pain in general, the contemporary Chiropractor must develop the clinical scientist role of academic inquiry, rigorous scientific integrity and be open to the scrutiny of his/her peers. Once mainstream Chiropractic has joined the 'big leagues' and shed the trappings of 'philosophy and innate' I suggest that the evidence based, scientific practitioner will win the day. Those practicing to 'regenerate' the disc, reverse degenerative disease, cure all manner of disease and other such nonsense are the ones who stand to lose; sadly they hurt us all. I suggest that we read Dr. Ronald Carters' and in the CCPA recent communique, Dr. Paul Carey's papers carefully, adopt their suggestions and let the chips fall where they may.

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