Chiropractic Care | Chronic Pain | Opioids

Mike Whitmer:

Good afternoon, and welcome. Thank you for joining us today. My name's Mike Whitmer. I'm vice president of corporate relations with NCMIC, and I'm moderating today's discussion. Before we get started, there are a few housekeeping items that I have, that I'd like to go over.

Mike Whitmer:

First of all, all listeners are on mute. If you have questions, please enter them in the questions feature on your Go-To Webinar menu. We will address questions as time allows. If we don't get to your question, please feel free to contact us, and we'll be happy to talk with you and connect you with resources to help.

Mike Whitmer:

Today's webinar is live, but it's being recorded. The recording will be emailed to registered attendees a couple of hours after the program. We'll also post that recording in the resources section of ncmic.com. It does take a little bit of time to process that recording and get it posted, so please be patient with us.

Mike Whitmer:

Our next webinar is going to be August 18th at 2:00 PM Central Time. We're going to be hosting a pediatric round table discussion with leading experts from the chiropractic profession in this area. So if you can't join us live, we will be recording that program as well. It will be posted out on our website, so keep an eye out for that next month.

Mike Whitmer:

Now, I'd like to get into our discussion and get started. We have a lot of ground to cover. And this is a really important topic. I think that we're all aware that chronic pain is a serious public health issue, and opioid use and abuse is something chiropractors see in their offices all too often.

Mike Whitmer:

I was doing a little bit of research on this in preparation for this webinar, and I found that two out of three overdose deaths in 2018 involved an opioid. In 2019, 9.7 million people misused prescription pain relievers, and 745,000 people used heroin. This is from the Department of Health and Human Services. I also learned that the issue has gotten worse since COVID struck. So this is an issue for communities all across the country, and doctors of chiropractic have a role in helping.

Mike Whitmer:

So I'm pleased to have with us Dr. Brandon Steele. Dr. Steele is a graduate of Logan College and is a board certified diplomat in orthopedics. Dr. Steele is in private practice at Premier Rehab, and is the co-founder of chiroup.com. He's a regular columnist in the journal of the Illinois Chiropractic Society, and a reviewer for the journal of The Academy of Chiropractic Orthopedist.

Mike Whitmer:

Dr. Steele, thank you so much for being here with us to help us unpack this topic. Let's go ahead and dive in. I'm going to turn the controls over to you, and then you can bring up your display.

Dr. Brandon Steele:

And can you hear me okay, Mike?

Mike Whitmer:

I certainly can.

Dr. Brandon Steele:

Excellent. And can you see the screen?

Mike Whitmer:

I can, but I'm not sure our audience can. Can you share your screen from your computer?

Dr. Brandon Steele:

Let's see here.

Mike Whitmer:

There we go. I just made you presenter, okay.

Dr. Brandon Steele:

How about now?

Mike Whitmer:

Perfect. Thank you so much. And I will turn my camera off and go on mute, and let you take it away. Thank you so much.

Dr. Brandon Steele:

You're welcome. Well, I think probably the most interesting part of this conversation is that the dopamine orthopedics, the more the research side of it is the musculoskeletal aspect. So how does that have to do with opioids? And I would probably ask, how do these opioid addictions happen to begin with? And that's where we come in.

Dr. Brandon Steele:

When you look at nonsurgical, nonpharmacological care, that's us. And if we, or other people in our area, don't do a good enough job, then unfortunately those patients can fall into this kind of a diagnosis. When I see chiropractic care, when I see chronic pain, when I see opioids, there's really not much delineation there. Essentially, we have to be asking, why are these things happening? How are these patients going from acute pain to chronic pain? Because we know most chronic pain starts with a musculoskeletal complaint.

Dr. Brandon Steele:

If we all have big enough egos, we can live in our own fairy land to say that we can help everybody. But this is one of those diagnoses that are tough. Now, when it's acute pain, we're the masters. When you look at the evidence, as chiropractors, we can help dramatic amount of patients get out of pain and never fall into this category. However, once they've hit this category, that's where things get fuzzy. That's when we need a multimodal approach.

Dr. Brandon Steele:

And if we have that... Whoops, there we go. Then that's where we may need help. And that help may not live in your office, it may not be your staff and it may not be you. It may be a psychologist, may a nutritionist, may be a sports medicine doctor, maybe an injection. And it's intriguing because when we look at what we do, it's confusing to these patients because all we do all day long is look at structure and function.

Dr. Brandon Steele:

Well, the patient has pain, and in the absence of red flags, in the absence of trauma, there is no correlation. You can't correlate this person's hip to pain. Even more so, a lot of times you can't correlate their function. So you and I spent all day looking at structure and function, and we're trying to relate to pain, but it's just not true.

Dr. Brandon Steele:

And sometimes, the patient will look at this image and they'll say, "Oh my gosh, that's my hip." And they are reading into their own dysfunction and they need a fix. And that fix comes in multiple forms. The fix for us is usually conservative, but that's

not what everybody else does. It's not what the evidence says, but it's also not what is in practice. So we can dull a pain, not necessarily us, as far as in practice. We can cut out the pain.

Dr. Brandon Steele:

But when you look at almost every research study ever published, when you start cutting out structural changes, somehow the pain still stays there, especially when it's not acute, not traumatic.

Dr. Brandon Steele:

There's a great paper by Chang. This was in 2022, that if you look at half of pre-arthritic hips, half of them didn't need surgery. Now, half kept on going to surgery. However, if you can have an intervention that works, you don't need to cut up the structure, normally because a structure isn't the cause of their pain. And what we know is we definitely don't need to numb up that pain. If you look at epidural steroid injections, unfortunately at six and 12 month outcomes, it's the same as if they didn't do that steroid injection.

Dr. Brandon Steele:

Now, it may give them some short-term relief. However, it's not going to give any kind of longterm relief. And unfortunately, what this paper also saw is that the Pennington Study in 2022, in clinical neurology, that these patients also got segmented to physical therapy. So they weren't just getting injections, whereas a patient would normally see us, they're also going to other providers for care.

Dr. Brandon Steele:

The last part of this, is other patients are looking for pain relief and what do they do? They cut the check engine light. And that's where facet ablation comes in, that's where surgery comes in, that's where pain core stimulators come in, that's where topical analgesics... Those are the kind of things that the problem's still there, but we're just going to cut the connection of there.

Dr. Brandon Steele:

And that's where things are unfortunate for these patients, because they're looking for a solution and we're not providing the solution. Instead, we're just offering something to help dull that pain. And that's what needs to stop. And what Mike brought up as far as the deaths that, unfortunately, once you have your access to something that feels good, that helps take away your symptoms that's cheap and easy, well, you need more and more of that.

Dr. Brandon Steele:

So we ended up with this thing called the opioid crisis. And I really believe this, as that we have the opioid crisis because of a lack of chiropractic care, and it's not opioids versus chiropractic care. We're not in competition with opioids. In fact, opioids when used appropriately, really in the short-term, do what they're supposed to do. They're designed around that, but that doesn't make them right. That doesn't make them a longterm solution.

Dr. Brandon Steele:

The problem lies not with you, it doesn't lie with the medical doctor and the medical profession, it doesn't lie with the pain management doctor. It lies in the patient. Because the most uneducated person in healthcare, which is the patient, unfortunately, makes the most important decision. And that's which doctor to see first. And unfortunately, based on that doctor, their education, their payment model, that's what's going to determine what treatment they get.

Dr. Brandon Steele:

And I'm not sure that we're going to cover how to solve that problem within this talk. However, I know what most people select, they select the opioid route. And we're extremely fortunate to have research in our field, like Gerts and Weedon and Jay Greenstein, and those powerhouses in our profession to give us this information. So you're going to see a lot of this information coming from those researchers, deeply rooted in our profession to help us.

Dr. Brandon Steele:

And one thing that I think is so interesting is that they just see us first. They never go down that train. They never get into the surgical train, they never get into injections. And most importantly, for this talk, opioids. Because if they do, then unfortunately adverse effects start to skyrocket. It's not in the first two weeks, but it's in the first year. They start to notice other symptoms, and we need other medications to solve those problems.

Dr. Brandon Steele:

42 times higher to have an adverse effect seeing or opioid care versus chiropractic. That's huge. That's something that I wouldn't want to tell my patients, and I don't think many patients know that, yes, if you choose the easy route, there is the possibility of these bad things happening.

Dr. Brandon Steele:

Now, the public outcry is increasing, but that's not enough. And I think that now with insurance companies understanding that these medications, while cheap at the beginning and more cost effective at the beginning, are causing problems later

on. To the total long-term healthcare cost, if you're not seeing a chiropractor, you're going to get opioids or other medications significantly skyrockets. Because we're not fixing the problem, and all of you know that.

Dr. Brandon Steele:

And if you also look at the references at the very bottom, I'd be happy to include any of those. And if you have any questions pertaining this lecture, Brandon, B-R-A-N-D-O-N, @chiro.com, C-H-I-R-O.com. Everything that I bring up is going to be factual, or at least within the evidence, to the best of our knowledge currently. And then if I ever give you my opinion, and there will be opinions, I'll let you know that, of course.

Dr. Brandon Steele:

But what we know that when we look at acute care, and that's where we need to focus. We need to focus on acute problems, or at least isolate problems. Because when we can do that, we can now look at the insertion point in the body, whether it's a peripheral, whether it's spinal cord, whether it's the brain, and we can start to have an impact on these patients. If we can start to do that, as we do as the chiropractor profession, we can significantly decrease cost. We could significantly decrease the amount of diagnostic imaging. And of course, for the purpose of this lecture, decrease the amount of opioids that are being used. We know that's the case.

Dr. Brandon Steele:

And unfortunately what happens, is that if they don't go down the non-pharmacological, the non-surgical case, is that there's just a pathway. You do physical therapy for four to six weeks. If that doesn't work, you go to epidural steroid injections, but you can only have three of those in the first six months. And if you fail that, then you get ablation. If that doesn't work, or we just kill off nerves and you keep on doing the same activities, now you have surgery. That pathway sucks.

Dr. Brandon Steele:

That's something that you and I feel when we're in the office, that when you look at a patient in the eyes and you know what pathway they're on, it hurts you. And it should hurt you. Because that patient has a very difficult decision to make. They can take the well paved route. The route that everybody takes, going to see more of an allopathic doctor and doing medication, or they can take the bumpy road. But they're going to get to that solution a lot faster if they take that bumpy road, but it's going to take a little bit of work.

Dr. Brandon Steele:

Now, with that being said, it's not just a bumpy road. There are some side effects to spinal manipulation. Patients tend to be more satisfied. So that's a good side effect,

is patients like us a little bit more. And I don't think it has anything to do with our education. I actually don't think it has to do with much of the way we practice, meaning I don't think they just like manipulation, it's that we care. That we're going to spend time with our patients, and we're going to dig into their lives and find those variables that are causing their problem, and we're going to attack them one by one. Some at our office, some with colleagues around.

Dr. Brandon Steele:

And there was a couple questions before this lecture about MDs. MDs are looking for a solution just as much as you and I. There's not a single MD that I know, and I'm in a medical physician group talking with doctors on a weekly basis, there's not any of them there sitting around chuckling and saying, "Oh, got to prescribe more opioids." They're looking for solutions. The question is, do you have that? And can you relay your solution to them?

Dr. Brandon Steele:

Now, we did a study, this is 18 months ago. It was over 630 some thousand condition reports that we put out in that 18 month period. But our patients, when it comes to our network, our evidence based providers, patients 92% satisfied with us. They rate us as excellent or good. Now that 0.03, that was my partner, so you can take those data out of there. He's mean to his patients, so I wouldn't worry about that too much.

Dr. Brandon Steele:

When it comes to net promoter score, when you have to look at how successful is your practice, it's not new patients. It's not collections. If you look at longevity of your practice, this is the only number you should be looking at. This is what hospitals look at. Meaning, if someone walks out of your office and says, "Hey, Bill, would you recommend Dr. Steele to a friend?" If he rates me a nine or 10, he's a promoter of my practice. He's going to tell his mailman, he's going to tell the Amazon guy, his medical doctor, his neighbor, and his sister about the care he got at Dr. Steele's office. If he rates me a seven or eight, he's okay. It's like going to Chipotle. They do exactly what I ask every single time.

Dr. Brandon Steele:

However, if someone came in to see me and saying, "Listen, oh man, you got to go to Chipotle. It's the most amazing place ever." I'm probably not going to give them that review. And then of course, six or below is a detractor. But when you take that, it's actually a plus 100 to a negative 100 score.

Dr. Brandon Steele:

If you look at a world class organization, like your Four Seasons, they get a round number of 60 as far as the net promoter score. If you look at the average medical

practice, it's about a 30 to a 35 when you look at the data. Guess what we are? That's pretty good, a 90. That is unbelievable world class. Because we run our own practices. We know that we have to take care of that patient.

Dr. Brandon Steele:

SO let's actually get in there and let's solve these problems. And if we can solve these problems for these patients and we can do it effectively, they're going to rate us online. We have this service in Missouri, it's called Google. I'm sure it's going to go nationwide at some point. They're a growing company, but that's how people rate you online. And if you do a great job, people will put that out there. And I think that if we can do a great job, we can do with a smaller interface, then fortunately doing what we do as chiros, we get great results.

Dr. Brandon Steele:

80.24% improvement across all diagnosis, across our network of getting people out of pain in the musculoskeletal arena. Those patients are never going to hit the chronic pain realm because we're solving their problems fast. And that's the purpose of this conversation, is really getting into the problem, which is pain.

Dr. Brandon Steele:

And you guys have all had this patient. This patient came in to see you, and we're going to call her Sally. She came in on a Friday, she's leaving on vacation. I'm sorry, let's say it's on Wednesday. Came in on a Wednesday and she's leaving on vacation on Friday afternoon, and wants to get out of pain.

Dr. Brandon Steele:

Now, she's had this degenerative spondylosis with lumbar spine radiculitis. It's a 10 out of 10, she's had it for five years. And somehow, she wants you to do this magical adjustment that she's already seen seven other chiropractors. You know and I know, we're just going to be number eight.

Dr. Brandon Steele:

However, what does Sally do on Friday? Friday, Sally comes in and she says, "I feel amazing. I cannot get over how good I feel. Man, I don't know what you did, but it was just great." I run home and I take my kids off for ice cream. I cut the tags off my mattress. I'm just as excited as she is. And then what happens next time you see her? No, it came right back.

Dr. Brandon Steele:

You and I can probably agree there's nothing mechanically that I did for Sally. But what did I do for Sally on that first visit? I was confident in my diagnosis. I provided Sally a pathway, a process to help with her symptoms. And that's where today falls in.

Today falls in because we need to have that pathway and process to help these patients. Because when we look at pain, and I'm not going to go over this diagram in detail, because I'm not going to tell you guys about the spinothalamic tract.

Dr. Brandon Steele:

However, we need to understand where pain comes from. And if we understand in a 30,000 foot overview of where pain comes from, it allows us the ability to select methods, the things that we do, whether it's exercise, whether it's manipulation, whether it's myofascial release to help patients where they need it most. And if we can do that, and we can select the right method for their problem, we can help with chronic pain.

Dr. Brandon Steele:

Because it starts on the periphery where someone scratches their knee, like you see little Billy here. But what did little Billy do when he fell off his bike? He scratched his knee. Did he instantly start to cry, for those of you have kids? What's the first thing that Billy will do? He'll look up, and he'll look to see what his mom is doing. And of course, mom's going to have this look of fright, come running with their arms waving towards Billy. She's going to be screaming. All the other kids are going to look at Billy, and they're like, "Oh my God, Billy, are you okay?" Well, he has now just learned that that scratch causes pain and is something serious. That every time he does that and he gets that stimulus, it's going to be burned into his brain literally to have this response.

Dr. Brandon Steele:

Most of you, including myself, don't think we have an impact on the spinal cord, meaning within the cord, not the spinal column, but the cord. But we can, and I'll show you that towards the middle of the lecture. And then the brain, and this is where most people think the pain is, and that's where we perceive pain. That's where we process pain. But that doesn't mean that all chronic pain is centralized. It's not just being driven by the brain. You can have peripheralization of pain, you can have peripheral generators of pain. So we'll talk about that, and more importantly, how to solve those problems.

Dr. Brandon Steele:

I could tell you this right now, that if you were to ask every chiropractor in entire world, who loves manipulation the most, it's me. I honestly believe that when I go through and I adjust my patients, that sometimes I get more out of it than they do. I love manipulation. My mom used to pop my back when I was like four, and it always turned into... I just love that sound. I love the feeling. I love what I do.

Dr. Brandon Steele:

However, one of the downfalls of the chronic pain patient is that they possibly need more. That as powerful as this tool is with manipulation, they need something to break that loop. They have a pain cycle and we need to fix that pain cycle. We need to help that pain cycle. And if we don't, and we just take away some peripheral sensitization with manipulation, with manual therapy, with exercise, it may not be enough. They may go back into the same habits, hobbies, sports, activities, and it may just come right back. And I don't want that patient, just as much as you don't.

Dr. Brandon Steele:

I don't want the patient that feels great when they leave my office and four weeks say, their shoulder pain came back and then, "Oh, I'm go see my real doctor." That hurts. That hurts a lot. And that's not just me, you've had that same conversation with your patients. I don't ever want to have that conversation again. So instead of just doing the orthopedic examination, which I love orthopedics, we have to do more. And it's more about what the patient needs as compared to what I'm offering.

Dr. Brandon Steele:

Now, I'm going to go through a quick little lesson to elaborate on this, but here's a patient that comes into your office. They've got shoulder pain, it's a little bit of pain upon weakness upon arm elevation. Happens four times a year, and it's been recurrent. Worse with overhead activities, worse with sleep, worse when they pick up their grandkids, worse when they do some kind of movement. A.

Dr. Brandon Steele:

And here's the selection, here's the options that we have with this kind of patient. Can I just treat their shoulder pain? Absolutely. And depending on my credentials, depending on my experience, my care, my time that I have with my patient, I can poke around on the shoulder. I can find some trigger points, and I can probably find some things to treat. We're all pretty good at doing those things. And you rub on some trigger points, you do some ischemic compression, you do some manipulation, and magically these patients feel better when they walk out of our office.

Dr. Brandon Steele:

And there's nothing, not belittling that, we want our patients to feel better. You and I are graded, documented. It's a shoulder spring. They have a label, they have a treatment, how they walk out of your office and they feel better. And unfortunately, when we get that diagnosis of a shoulder sprain/strain with that current history, what do we do for a sprain/strain? Well, if you look at the evidence, you're going to throw some ice on it. You're going to maybe do some kind of anti-inflammatories, whether over the counter, whether supplement, whatever it is you do in your office is

just fine, but you're going to provide some kind of anti-inflammatory medication or supplement.

Dr. Brandon Steele:

We're going to tell them to rest. "Hey, it hurts? Stop doing it." And Johnny who has a shoulder pain is going to feel better, because we did all those things. And in fact, as you and I, what are we going to do? We're going to look at the studies, including even this one in the Rosedale Study, is that we see a lot of spinal problems turn into peripheral issues, whether it's the elbow, whether it's the hand or in this case, the shoulder. So we're going to do all those things. And Johnny's going to walk out of our office, and he's going to feel much better.

Dr. Brandon Steele:

However, did we do enough? Because if he had pain four times a year and it's been going on for this long of a period of time, is it truly just a sprained strain or is this possibly something else? And for those of you who do orthopedic testing, thank you. I love you. Keep on doing orthopedic testing, do the right orthopedic test. It shouldn't take five minutes. I can do an orthopedic test in one minute, two minutes, and so can you. Pick the most sensitive, the most specific.

Dr. Brandon Steele:

I know in school, we had to do 50 orthopedic tests in three minutes. That's not what practice is like. In practice, we need to do the best test. We need to rule at the red flags and yellow flags. We need to make sure they belong in our office and then select the right test to show what's positive. And if you can do the right test and say, "Oh my gosh, there's weakness in the shoulder." Then what do you do? Well, depending on your education, depending on your network that you have in your office, you may do an injection, if it's a rotator cuff problem.

Dr. Brandon Steele:

But what we know is, that's not a good intervention. One to two times more likely to have a surgery if they go straight into injection. God forbid they go into surgery. It's actually not, even medical standards, to do surgery right off the bat. And definitely not for impingement syndrome, and definitely not for anything that's been going on less than a year. So we need to make sure we get them in the right hands.

Dr. Brandon Steele:

Now, fortunately, those hands, how we're going to finish off this lecture, is us. Because what are we great at doing? We're great at listening to patients. And we can take that acute pain and say, you know what? It's been going on four times a year. They have some weakness, and there's a certain movement that causes pain, maybe they have this. They have tendinosis. That's why they have weakness. They

keep on irritating it. They are a mechanic, they paint ceilings, they're a baseball player. Whatever it may be, their activity is causing a problem that needs to be fixed.

Dr. Brandon Steele:

And what can you and I do for that? We can help create a controlled inflammatory reaction to help get that tissue to heal. Not only that, we can prescribe the right set of eccentric exercises. Sorry, that's a video, it's not playing. But we can do eccentric exercises for the biceps, for the [inaudible 00:23:59], the subscapularis, supraspinatus. We can do those strengthening exercise and remold that collagen, and help bring back some of the capacity of that tissue. There we go.

Dr. Brandon Steele:

However, sometimes in the chronic pain world, it's still not enough. You've had that patient. So have I, that I've done everything that at least I know how to do, and they're still not making things better. They're still having symptoms. And that's where I get frustrated, and more importantly, my patient is going to get frustrated. And that's where there is a difference in provider. Some providers will refer out, some providers will go deeper.

Dr. Brandon Steele:

And I implore you to look deeper, because there's something that patient is doing to themselves. They're not meaning the cause, in this case, a shoulder problem, a back problem, a widespread fibromyalgia problem. They don't know what they're doing. In the case of the shoulders, if you sleep on your shoulder and create ischemia, it exactify you're trying to have a healing reaction. It's not going to get better. Making sure they don't sleep on it, make sure they have their elbow rested when they're using their mouse, finding the different things they use to make sure their shoulder blade is moving properly and give them the right shoulder blade exercises.

Dr. Brandon Steele:

We have to make sure that we're doing all the things appropriately for every diagnosis. If we can use the best practice information, which is out there. We have best practice information for all the diagnoses that we treat as chiropractors, and we can apply them across all of our patients, we can make a dramatic impact on just the number of people hitting that chronic pain model.

Dr. Brandon Steele:

And that's where I think it starts, because if we can do that, we can eliminate a lot of our problems associated with opioids. So whenever I have a patient, it's not just diagnosing it as a sprain/strain. It's not saying, "Oh, it's a partial tear." It's listening to them, this has been happening for a long time that there's a weakness, an ongoing

structural problem. And making sure that I identify all the things, all the factors associated with that person's problem. Only then, can I help these patients.

Dr. Brandon Steele:

So it's no longer about what you learned in school. I graduated in 2009, and there are things that I knew that just aren't true anymore. There are things in tests like the Hawkins County test nears an empty can, that cluster has been just around forever for diagnosing the supraspinatus tear. There are better tests now. So the question is how in depth are we willing to go in our own practice to solve these problems? Because there's a knowledge transfer loss in our profession. Meaning when you're reading from books, when you're reading from school and in classes, that's already out of date. We need to be looking at the research on a weekly and monthly basis to get the new best test, new best exercises. So we can educate our patients to solve their own problems.

Dr. Brandon Steele:

And I forgot the years on these. Schneider did these papers, and they were in different countries about knowledge transfer, and that about 75% of chiropractors wanted to be evidence-based. They see the value in it, but less than half actually use any kind of evidence in their practice. And I say that with other ancillary tools. I'm not saying against manipulation, obviously manipulation is probably the strongest school we have. But when you look at the research, manipulation plus manual therapy gets better results. Manipulation plus manual therapy plus exercise gets the best results when it comes to the non-surgical, nonpharmacological realm.

Dr. Brandon Steele:

Now, if you don't do that, great. You don't have to do that. If you're a Jedi in manipulating, and that's all you want to do, phenomenal. Keep on doing it. And that's why you're still in practice, and that's why you have a busy practice. However, if that patient is not getting better fast enough, that's when I would look, to say, is there other stuff that I can do? Is there another chiro, who I refer to other chiros all the time, that can help me get this patient on the pain? Because otherwise they're going to be on a pathway that we just talked about.

Dr. Brandon Steele:

That pathway is the problem, is that unfortunately, that we're getting patients who we think we can help, we're not helping. And they're going along the segmentation of care, whether it's PT, injections, facet ablation, and surgery, and we're not stopping it. The first thing you can do in practice is start to use yellow flags questionnaires. I do these, are automated in our questionnaires we send to patients. If they answer two questions above a certain level, they automatically get sent the yellow flag questionnaire.

Dr. Brandon Steele:

So I don't ask everybody. If it's little Johnny who's 14 is playing in baseball, I don't need to probably ask him all the questionnaires for the YFQ, however someone else I may need to. And the reason I bring that up is we need to make sure we're dealing with the right patient. And we know that there's layers of dysfunction in that patient. For example, when you look at fibromyalgia. Did you know 50% of people with fibromyalgia also have issues of chronic back pain or chronic stomach pain and myofascial pain syndrome across their entire body? That's crazy.

Dr. Brandon Steele:

So if you put your head down and you dig into TMD, which we also should be treating, obviously, but if that's all we focus on and we take an isolated approach, unfortunately, that patient is still having those other problems. I work with a guy named Dr. Bertelsman. When he wanted rack cards, those little cards that you put in your office that you probably saw in the 1970s. And I was like, "There is no way in 2015 that we're putting out rack cards. That just seems backwards."

Dr. Brandon Steele:

And I am never more amazed when a patient walks into my office, and "Oh, I didn't know you treated children problems. I didn't know you treated plantar fasciitis." They don't know us as those kind of doctors. So make sure you have that kind of educational tools in your office. Because they know you as the doctor who treat their back or their neck, or whatever they came in from the very beginning.

Dr. Brandon Steele:

So here's where the treatment comes in. And I think it's important to think less about methods. Methods are what we do as far as the manipulation or myofascial release or what have you. And to go more towards the principles, meaning what's happening with this person. Because unfortunately, when we start randomly applying methods, mean we just manipulate everybody and expect to fix fibromyalgia and plantar fasciitis, tarsal tunnel syndrome, and rotator cuff syndrome, it may be powerful and work enough for some people, but not for everyone.

Dr. Brandon Steele:

So we have to look at all the different insertion points of pain. The first one that we brought up was the periphery. Now this isn't just the spine. This isn't the hand, if you get scraped. It could be IBD, it could be some kind of peripheralization of pain from a past injury, a scar, or what have you. Because what's going to happen in that outside periphery is that tissue's going to start to release inflammatory cytokines injury or Lukens or prostaglandins. And it's going to bathe that primary neurons, "Hey, there is a constant problem here." That's why they come in to see us. And it's up to us to

use the right methods to solve that problem. Otherwise, that inflammatory chemical bat stays in that area and causes the problem.

Dr. Brandon Steele:

Now, one thing that is new to at least to me, are the things that we can do to the actual spinal cord. Because if you have constant information coming into that spinal cord, as we see with chronic pain, the reason people take opioids is because of this problem right here. As far as that propagation of pain, going up to the brain, there are things that we can do in that area. And then lastly, in the brain, how are we affecting the tertiary neuron, the thalamus dropping up all the way into the somatosensory cortex.

Dr. Brandon Steele:

So let's go into that. Let's figure this out. Because the most interesting thing about what we do is that depending on who the patient sees, depends on the treatment they're going to receive. If they see massage therapist, they see a surgeon, they see a nutritionist, they see one of us, that determines their care and it's wrong. Because we should all be working together to solve these problems.

Dr. Brandon Steele:

In fact, one of the things that, this is my opinion, this isn't a fact. However, one of the things to grow in my practice is we started doing initial reports and release reports to every medical doctor. Patient Debbie comes in and she has this problem in her shoulder. And I say, "Who's your primary care doctor? Send her intake form." Isen Dr. Smith and notes, and say, "Hey, Dr. Smith, I've seen your patient, Debbie. She's got this problem. I'm going to see her six times over the next two weeks. She's going to be percent better. Thanks for letting me participate in caring your patient." It's instantly faxed over on the first day. For those in counting your pennies, faxing is free. It's a great way to market your practice. Your logo, your name on a medical doctor's office on a daily basis.

Dr. Brandon Steele:

And then guess what happens, is that I do a great job, and you guys do a great job. However, that message never gets back to the primary care doctor. So we would do a release report that says, "Hey, Dr. Smith. I saw Debbie. She's back to a 100%. Thanks for participating in Acurio patient." I'll usually write something in a red pen, so you see it's a different color and I fax that over.

Dr. Brandon Steele:

When you can show other providers your successes, instead of us trailing our failures, we can grow and change the perception of chiropractic. That's one way that we do it. And it doesn't matter if it's a massage therapist, functional medicine, doctor

or surgeon, we do it for everybody. And it's really gone a long way. Being a better doctor and having those open lines of communication, I think it goes a long way.

Dr. Brandon Steele:

So let's talk about the primary neuron. What can we do for the primary neuro on it? And this is one of the most interesting things, because those patients in chronic pain who have been taking opioids, that eventually they get that joint, that muscle, that tendon, whatever it is, gets replaced, gets removed or degenerates. However, once you have that chronic pain centralization of pain, or in this case, peripheralization of pain, it's still there. Even if you cut that joint out, it's still there.

Dr. Brandon Steele:

So even if the patient has a surgery to remove the area that's causing their pain, we still have to treat those patients. Manual therapy, cognitive therapy. It's okay to walk now, it's okay to walk faster, and making sure they understand that. Now, speaking with a choir here, obviously we know that manipulation and manual therapy for first neurons and joints goes a long way, so I'm not going to cover that too much.

Dr. Brandon Steele:

But here's one thing that I don't do, and it has nothing to do with it if it doesn't work, it's that I would rather change your religion than change your diet. I don't know how functional medicine doctors do it. I honestly don't get it. I have read so much on nutrition, I recognize the importance that the research is right there. But getting a patient to change their diet, to take away food sensitivities is huge in these patients with peripheral sensitization.

Dr. Brandon Steele:

If it's not you, that's okay, but that doesn't mean the patient doesn't need it. So make sure you have a functional medicine doctor, in your area, that can provide that service. And if you have that, you're sending patients back and forth. It's great. Don't just live in your box, get outside your box and find other people who think like you, practice like you, that they're Jedis at nutrition, you're a Jedi at manipulation. You've got this guy doing this four specific rehab. That's the way you're going to build and scale your practice.

Dr. Brandon Steele:

Finally, obesity. And that's one of those touchy subject. But someone's got to bring it up. Though we have to be at least in their ear and putting them on the right path as far as obesity issue can perfectly sensitized issue. Now, this is a question that someone had as far as pre-lecture looking at creams, looking at e-stim units. And I don't use a lot of these in my practice, and that's not based on opinion. It's that sometimes patients can use these, and there's a lot of great research on them. But I

always think about as putting sunglasses on top of my head. Then if I put sunglasses on top of my head, my brain's going to say, "Brandon, you have a threat on top of your head."

Dr. Brandon Steele:

After about 30 seconds, my brain's going to like, "Nope, nevermind. Just your rabions." And it's going to just turn off those pressure and painter receptors in that area, and guess what's happen five minutes later when I start looking for my sunglasses? I don't feel them. So there's some great research on these modalities, but we have to treat them as just as that. Your topical antigenics and your e-stim units don't do as much biologically, at least that I can find the research.

Dr. Brandon Steele:

And I hope I'm proven wrong because I'd love for patients to get some kind of outside systemic relief from these types of therapies, but the research isn't supporting it right now. And the research does support as far as chronic pain, really not a single modality. None. There's not one thing that helps everybody in chronic pain, but that's okay. That's the riddle, that's the pattern. That's what we get to decipher in our office to figure out what the patient needs.

Dr. Brandon Steele:

So let's get into the second order neuron. Now, our second order neuron jumps into the dorsal ganglion, and it says, "Hey, I've got a problem here. Why don't you go and tell the brain what's going on?" Well, what we forget about is that we can actually stop this transmission. Now, opioids can do that, and we'll cover that.

Dr. Brandon Steele:

But what else can do that? We have interneurons there, from the descending inhibitory pathway, AKA get out and walk and do some exercise. They can also do the same thing. If we can block substance P from hitting that secondary neuron, and from going up that spinal spinothalamic tract, we can have a dramatic impact on stopping the source of the pain. So opioids don't necessarily work just in the spinal cord, they work on almost every cell in the body and they dead them. They just say, "Hey, this isn't that big a deal." It brings a threshold up. They competitively buy into different neurons and don't allow the transmission of those singles substance feed to move over to the next cell.

Dr. Brandon Steele:

And we can take advantage of that with opioids. However, we can also take advantage of, like I said, with the descending inhibitory pathway. I think that if we can do that, that's when we can be more in our realm of the nonsurgical nonpharmacological realm. Because what we know is exercise. Stretching, getting

the person to do something different will go a long way in helping them get out of pain. Because if we don't, they're going to go into other routes that can help them. And opioids can do that.

Dr. Brandon Steele:

I know personally, I can just speak from experience. I had a surgery, it was a big surgery. And I took opioids. When I was in the post-surgery, they worked. There's no question about them. However, I would be very worried if I needed those long-term. Because they can help you recover from surgery, they can help with back pain and headaches. But you can't just give them to everybody, and it doesn't make sense.

Dr. Brandon Steele:

Just like we talked about, there isn't one treatment for every single person. We have to make sure that we're providing the right acute therapy so they never fall into needing that cheap, effective white pill. And what we've seen in the history is that, it's just easier. The last, since the 1990s is that the increased use of opioids, and now it turns into illicit drugs, and now we're starting to see cheap, easy drugs being manufactured in 2013 until we hit now. And now we're in the fourth wave.

Dr. Brandon Steele:

And then unfortunately, when you look at the amount of insurance claims that are paid out, MSK, number one. Number one treatment for MSK problems, opioids. Nonsteroids are going to work. We all know that, we've seen the research on that. But people are looking for a solution. The question is who's providing that solution. And sometimes providing a solution isn't as simple as just taking a pill. Sometimes it takes stopping whatever caused that problem to begin with. And that's where we can fit in.

Dr. Brandon Steele:

Now, when you have a patient that comes in your office that you are thinking is maybe taking too many opioids, you're looking for those neurologic signs, slow heart rate, going to be done your physical exam, shallow breathing, and just lethargic. Those are the patients that I get concern about. I've never had a patient in severe pain from a herniated disc that walks in and just coolest can be and real calm and relaxed.

Dr. Brandon Steele:

They're bent over sweating red and yelling at you. So a patient has a serious problem. And then he turned this kind of presentation, I would be worried. I would also be worried about these names. When you start to see these names, which are the proper names and names from the bottom, those are the things that patients

are taking. You should be collecting what kind of medications your patient are taking and talking to them about their medication.

Dr. Brandon Steele:

Now, it's not our place to tell them to stop taking something, in order to start taking more. However, it is a good conversation to have, is like, "Why don't you talk to the medical doctor, and as we start treating you, to see if it's okay to start to taper off those things?" Maybe treatment isn't alleviation of back pain, maybe treatment is allowing you to get off of the medication providing that relief. So it's setting realistic goals and may not be to take that Sally, who has neurogenic claudication going down her legs and saying, "Sally, there's probably nothing I'm going to do to verbally take away your stenosis. However, I can probably get you to pick up your grandkids. I can probably get you to walk around target for 20 minutes."

Dr. Brandon Steele:

Let's set realistic goals that are measurable and make sure we can help these patients as much as possible. What are the things that you can do, and I can do in my office for these kind of problems? How can we affect that second order neuron? There's a lot of good research on CBD. Now, this is an opinion, this is not effect. However, I just have a tough time prescribing CBD when you can buy it in a gas station. Now that's not to take away from CBD, there's a lot of great research on it, but make sure that your patient is on that product, they're getting it from a good source. Now, it's the same thing when you look at any kind of supplement. Unfortunately you can buy them at your local grocery store, or you can buy an actual good product from a good quality manufacturer.

Dr. Brandon Steele:

Exercise. That's another great one. And epidural steroid injections. Now people may look at me a little sideways when I say epidural steroid injections, but a steroid into that area will take away inflammation and block inflammatory cascade. Now, if every epidural steroid injection worked, then we'd probably be out of jobs. And we know that's not true. But they do work for some people. In fact, there's a lot of people they work for. And do they come back into our office and say, "Hey, Dr. Steel, I saw the pain management doctor, Dr. Smith. And he took care of my back pain. I'm just here to say hi."

Dr. Brandon Steele:

No. And the same thing happens with you and I. They go to see the pain management doctor and say, "Yeah, I saw the chiropractor seven times and he didn't get any better. Now I need the epidural." So all day long, we're trading each other's failures. And that's where the poor perception of chiropractic lies.

Dr. Brandon Steele:

What else can we do as far as cognitive therapies? Is that we can have them create attention or distraction. Meaning you can actually have someone squeeze an object harder before they pick something up. It'll take away the shoulder pain, or the same thing creates scapular retraction before opening a car door. Finding different strategies take their mind off of that, her joint and getting them and showing them success, whatever that may be doing. Doing a push up or bending over to pick up their children, or distraction techniques.

Dr. Brandon Steele:

In fact, if you do math while you run, it can help take away your pain. It's finding different ways to distract your brain and allow you to do things. A lot of times when we're treating a patient, we're not rotating their head, we're showing and teaching that patient they can rotate their head that far. Now, obviously manipulation myofascial release exercise is going to keep that, but our job is to get them to believe they can do those things.

Dr. Brandon Steele:

Brain. This is where everybody drops off, and myself included. I was like, "I'm not doing this kind of stuff. I'm not going to be a psychologist in my office." But there's a lot of things that we can do for our patients. Now, I can't teach you all of those things. Fortunately, Butler and Mosby did a great job in their block trying to teach me how to teach patients.

Dr. Brandon Steele:

I'm from Missouri. So the average reading ability of somebody in Missouri is sixth grade. That's crazy when you think about it. The way we talk, the words we use, matter. And if my words are too big for Sally sitting across me, she's not going to understand. So we need to find better ways to explain pain to our patients. I highly recommend this book. If you ever get a chance, Michael Shacklock is also a physio. He does lectures in the US. He's out of Australia. But his book Clinical Neurodynamics is tremendous in how to actually instead of treating the muscles, treating the joints, treating the bones, treating the actual nerves. Nerves are allowed to move too. They slide across bones. They go in between muscles.

Dr. Brandon Steele:

So looking at neurodynamics is going to be huge. And if you haven't looked at any kind of clinical neurodynamics, or how to do nerve floss in their tensioners, please let me know. I'll give you any resource you need, because it's going to help our patients desensitize those nerves and subsequently get them out of pain.

Dr. Brandon Steele:

Closing up here, structure. You cannot educate your patient, that this structure is causing this pain. So in the absence of red flags, absence trauma, there is no correlation. Now, that doesn't mean this structure doesn't matter. I'm not saying that at all. That's a huge complication. That's fine, it's going to be a problem. However, we can't say this is the cause of your pain. I've had patients and you've got patients that walking with severe neurogenic claudication, or just stenosis, and they don't have any symptoms.

Dr. Brandon Steele:

So we need that. We need that variable to understand the entirety of that patient's condition. However, when we start to relate their pain to a path of anatomical source, unfortunately, we're leading person and we're labeling something incorrectly. I've included some infographics on here. If you want that, once again, you can email me brandon@chiro.com. If I ever repeat myself more than twice to a patient in one day, I'm making an infographic.

Dr. Brandon Steele:

Guys, I get paid to evaluate and manipulate. That's it. So if it's not evaluating and it's not manipulating, I shouldn't be the one doing it. Now that doesn't mean it's not important, I've got staff that does exercises. I'll do some manual tape. We have nurse, a chiro that does manual therapy for me. In the educational piece, I can use infographics for, what is TMJ? What is chronic pain? What are the things that I can do to help my patients, what kind of mindfulness techniques, what kind of meditation techniques, all those things are tremendous. But I'm not a master at that. I can't remember all those things. I have to remember how to treat tarsal tunnel syndrome and serve with any headaches and then low back pain within a 20 minute period.

Dr. Brandon Steele:

So find resources to help educate your patients. And if they have an interest in that and they have chronic pain, find someone in your area. That person might be a psychologist, it may be a nutritionist. But it depends on the patient needs on what you should be providing. And if we can do that, then we can provide the right multimodal approach, we can have a significant impact on these patients.

Dr. Brandon Steele:

Creating new habits and hobbies. I think this is probably one of the most important ones. I tell patients to get out and the walk. Because when you look at the research that your kinesiophobia dramatically decreases, if you're just getting out and doing exercise. Having a new habit, and if you can do that, you can really create desensitization of nerves and significantly help these patients with having a pain syndrome.

Dr. Brandon Steele:

Don't give up. And that's probably the number one thing that I think I gave up a little too much when I was early on practice, possibly due to a lack of confidence, just as a new practitioner. But I have a hard time giving up now. Just because someone has knee pain, I'm not going to say after six visits, at 12 visits, "While I didn't get you out of pain, go get your knee surgery, we're going to try something else. We're going to do PRP." There's a lot of evidence on PRP as far as peripheral joints, and different blood products that can be injecting in that area to create building a catabolic process, because we're going to import a lot of growth factors in that area to help improve that symptoms, take away that peripheral sensitization and help with that chain. So don't go to surgery.

Dr. Brandon Steele:

When you look at surgery, that surgery, even if it didn't have, in this case, the knee, if it didn't have degenerative problems now, it's going to. That's the reason we don't see acromioplasty anymore. That's the reason we don't see a surgeon for degenerative meniscus anymore, is because they know if they break that seal, the capsule, that bad things happen to it, that joint's not as stable. And unfortunately that just leads people down the wrong pathway. You told them they need surgery to fix this problem. And what we know is that's not true.

Dr. Brandon Steele:

The other thing is, don't tell patients just because it hurts, stop doing it. It doesn't mean they can just keep on doing everything, but we need to change their hobbies, their habits, their sports, their activities to help solve that problem. In the case of kids, really look at not the kid. It's probably the parent. I've had three kids that play competitive sports year long. And I'll tell you what, there's a lot of pressure on kids these days, that it's up to us to help give them time to rest. Because if we don't rest, that unfortunately bad things happen to those kind of kids. That tendonitis turns into a tendonosis, or in the case of kids, possibly creates anti-psychopathy. So making sure that we protect our kids and we protect their activity.

Dr. Brandon Steele:

And the same goes for the opposite end. If you've got someone who loves running, find a way to keep them running. And if we can do that, we can do it appropriately, we can have a dramatic impact on the patient. They're happy with their care. We're taking all the variables that are associated with their problem, and we can hopefully create outpatient base that is excited to tell other people about the care they received in the chiropractic office. Because the worst thing we can do is tell people to stop being active. What we know is that words matter. And how debilitating would it be if you could not get off the floor? Think about that. That's some of your patients.

Dr. Brandon Steele:

So one of the things we should do is to help get them off of the floor. If I've got Billy and he needs to be a construction worker, because he needs to support his family, I can't tell Billy just go in workman's comp. We need to work through Billy, the way he squat, the way he moves, manipulation, manual therapy, exercise. Take a very isolated approach with the right orthopedic exam, to find a tissue of injury and solve it as fast as possible. If that's not the only thing related to their pain, they're going to plateau and they still have some discomfort. That's when you can dig into your reason, whether it's dry kneeling, whether it's manual therapy, whether it's exercise, or we can look at Billy to see if maybe we can look at a nutritional problem. Maybe he's got some yellow flags that are possible, that we can look at. Is there another provider that could also help us get Billy out of pain.

Dr. Brandon Steele:

In conclusion, any questions, please let me know. My email is brandon@chiro.com. I'm a practicing provider. My entire day is full of hopefully solving people's problems. One of those is chronic pain. And I think as a profession, that if we can do that well and we can demonstrate how well we do it, the future is bright. With that, I'll open up for questions.

Mike Whitmer:

All right. Thank you, Dr. Steele, very much. That was very interesting. We do have one question that came in. First of all, for our audience, many questions were submitted during the registration process, and Dr. Steele did walk those into the presentation. So I hope that those needs were met, but we do have one other. Have you had any experience using alpha-lipoic acid for neuropathic pain?

Dr. Brandon Steele:

I've had no experience in that. However, I will say this. Well, here's the best thing. I'll tell you what, your functional medicine doctors in your area or around the area went virtual. The chiropractic functional medicine doctors had a corner in the market and they still do, and I am forever grateful to the ones in my area that I work with. Find someone who's good around you. And if you recognize that they have neuropathic pain, that you're not helping with, find one. And a lot of times they can do it virtually, and it's been tremendous for my patients.

Mike Whitmer:

Okay. Thank you very much. I think we'll go ahead and stop there. Thank you, Dr. Steele. Great information. I appreciate it very much. Before we go, I'd like to remind our listeners of our resources page on ncmic.com. This webinar will be posted there as soon as the recording is processed, and you can find our past webinars out there as well.

Mike Whitmer:

While you're out there on our resources page, have a look around. We've got a ton of information out there on a lot of topics focused on your daily practice. You can also keep up-to-date on new resources from NCMIC by following us on Facebook, Twitter, LinkedIn, and Instagram.

Mike Whitmer:

Our next webinar is scheduled for Thursday, August 18th at 2:00 PM Central Time. I hope you'll be able to join us for that. Once again, thank you for listening. And once again, thank you, Dr. Steele. Appreciate it.

Dr. Brandon Steele:

Thank you for having me.