Fibromyalgia/Scoliosis/Multiple Sclerosis

# What about Fibromyalgia, arthritis and other so-called diseases and Advanced BioStructural Correction™?

Many people think Fibromyalgia is a mystery. It is not. First is to understand that doctors have a habit of naming effects they observe on bodies in Latin and then calling the name of the observations a “disease”. It is silly because it does not note a cause of the effects and does not lead to being able to handle or correct what is causing the effects.

Fibromyalgia and arthritis are two good examples. Fibro- is Latin for fibers. -myo is Latin for muscles. -algia is Latin for pain. When someone says you have Fibromyalgia all they are saying is that your muscle fibers are painful to you. They might as well call it “muscle pains” in English. The question is WHY DO YOUR MUSCLES HURT?

If you think chemically as medical docs do, it is a big mystery (this is not to put down medicine in general the discoveries of what antibiotics could do changed more things on Earth than you might imagine). But not everything is chemistry.

One of the things that happen to bodies is that they get parts stuck in positions they cannot get them out of. An example is in the spine. If you look at the anatomy of the body (how the body is put together), you will notice that muscles attach to bones and pull on them. That might seem elementary but some people have the idea that muscles can push — they cannot. Muscles only pull. The way you seem to push is by pulling on a bone designed as a lever. An example is the arm. The way you put your arm out in front of your body is to pull on the upper arm at the shoulder (which raises it out from your body) and then you pull on the back of your elbow (which straightens the arm).

The reason I bring this point is up to explain how bones in your spine (spinal bones = vertebrae — vert-a-bray) move out of position in a direction your body cannot correct on its own. This is covered more completely in the article How your body untwists through old injuries (if treated properly). but briefly here. If you check the muscle attachments on your vertebrae (spinal bones) you will find you have muscles that attach from the sides of the vertebrae to the pelvis and ribs which are more to the side of the body than the vertebrae.

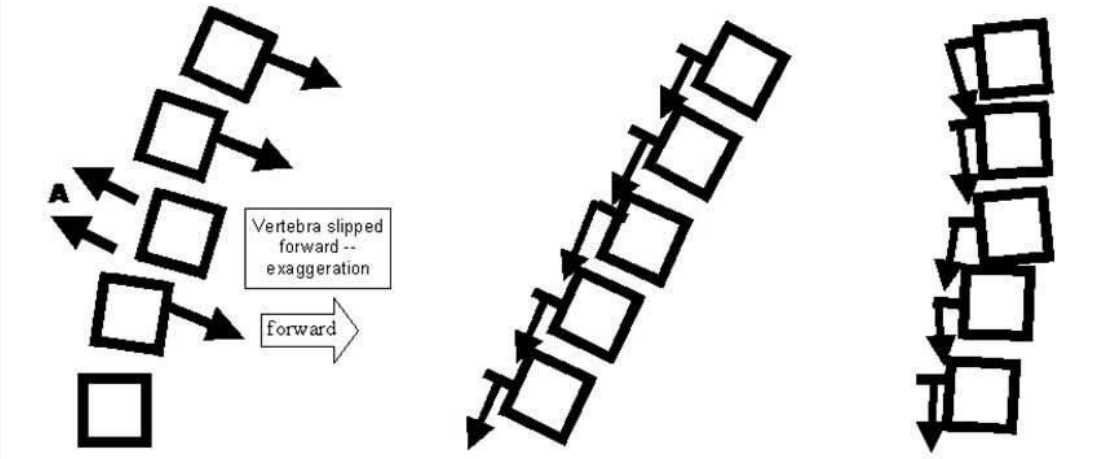
This means that if a vertebra moves out of position to the side the muscles from the other side can pull it back into place. So a vertebra moving out of place sideways is no big deal — your body can self-correct that.

If you check the front of the vertebrae, you have muscles that attach from the front of the vertebrae to something in front of the vertebrae. They go from the vertebrae to the front of the pelvis and from the vertebrae to the front of the

rib cage. So, if a vertebra displaces backwards it is no big deal, your body has muscles that can pull forward and reposition it.

If a vertebra in the spine slips out of place in the forward direction you have no muscle or muscles that can pull it backward.

You can lean your body backward — and have to, or you will fall over. But, if a vertebra gets stuck forward, there is no way your body can pull it backward to reposition it. This is THE thing that leads to many problems in your body.




There are no muscles that pull in the direction of the arrows shown as A.

This is the way the muscles actually attach.

And this is what happens when the muscles pull.

It is not that the vertebra get pulled backward it is that they are tilted or rotated backward. The result is your body leans backward from that point up and has to work to keep its balance.

You will notice that even in that last picture the middle vertebra is still stuck forward though the body is tilted backward and stays upright. It is not well balanced with one vertebra tilting one way and others tilting another way, but it is upright.

If your body is able to tilt and twist so most of the mechanical stress is on the bones and not on the muscles, the extra mechanical stress begins to wear the bones at the joints and you get inflamed and degenerating joints which can be painful or not depending upon how the body shifts and compensates. ARTHR- = joint, -ITIS = inflamed there you have the basis for ARTHRITIS which is otherwise known as degenerative joint disease.

It is not a disease. It is an effect of the body not being able to self-correct certain misaligned bones — actually when it is that bad you can bet it is many sets of misaligned bone-compensation complexes.

Can it be that simple? Yes. Why has nothing worked to correct this before? Those are all answered here. See the testimonial (one of thousands from Advanced BioStructural Correction™ practitioners around the world.

As the article How your body untwists through old injuries (if treated properly) shows you and explains how, when you get treated properly, your body untwists backward through your sets of old injury-compensation complexes and then heals.

One patient treated by an associate of mine who had improved immediately, suddenly noticed she was getting a bad pain in her side. It took about a week for her body to untwist though it. One day she grabbed me in the hall told me that she remembered when she first had that pain. Her dad used to pull her by the arm when she was little and she remembered one time when he pulled and it hurt.

The reason the woman was so excited was that she had also had asthma since she was in about 5th grade — just after the time her dad pulled on her arm — and it just disappeared over after the last visit when she had her Advanced BioStructural Correction™. She was suddenly able to breathe fully and had no congestion whatsoever.

Her asthma was from a mechanical problem with her ribs.

Stories like that are common. Here is one from a patient of chiropractor Dr. Chari Markos in Shoreline WA.

Dear Dr. Jutkowitz,

This letter is to attest to the Advanced BioStructural Correction™.

I am 58 years-old and have had Fibromyalgia Syndrome since childhood. In my 20's I would have to rest during lunch and was

I have sought and used many therapies and remedies over the years, even psychotherapy because they told me it was all in my head!

At the time I started with Dr. Markos I had been getting traditional chiropractic.

After only a few weeks of the Advanced BioStructural Correction™ treatments with Dr. Markos, I experienced significant improvement in posture (fast) and incredible improvement in the muscle pain in my back, shoulders and neck. the spasms have worked out and have not returned plus I have fewer and fewer headaches. I became quite irritated when I had a headache the other day and was quite surprised when I realized I had not had one in quite some time. What I had constantly before is occasional now.

This has not been a complete miracle cure (at least not so far!).

I can say without reservation that Advanced BioStructural Correction™ is the only thing I have tried in my life that has had significant results. I recommend it for anyone with Fibromyalgia and hope your people with this disorder

receive this help much earlier and thus avoid the years of pain I have had to endure.

Sincerely,

Anne McClure

## Things About Scoliosis They Never Taught You

***…because they did not look to find them and thus did not know them.***

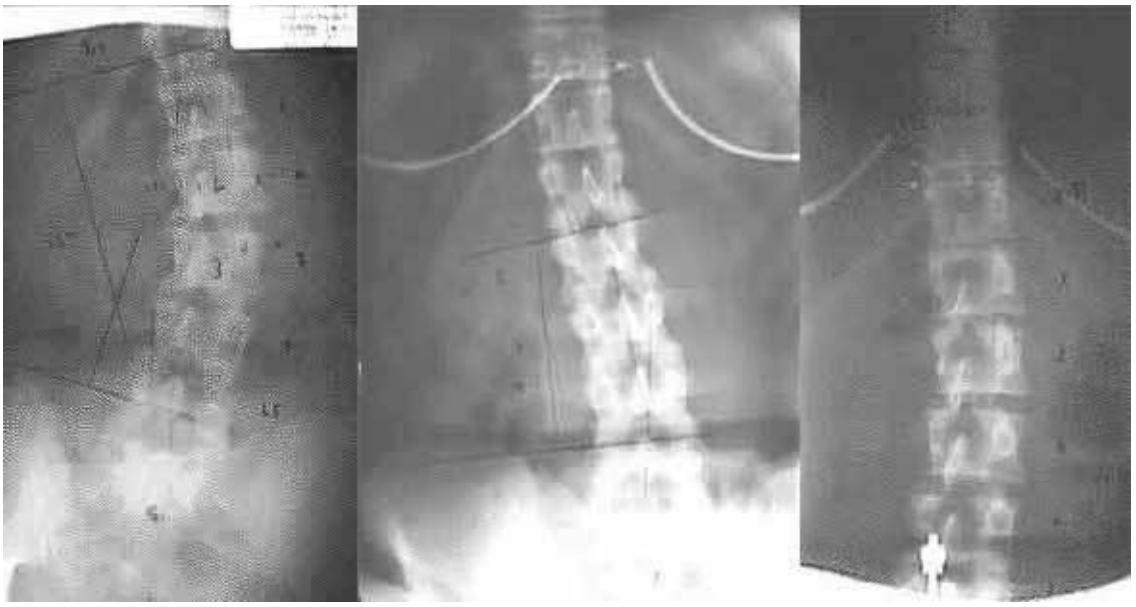
This is one of the best reasons you should buy the Advanced BioStructural Correction™ At-Home seminar and use it in your in your practice. By the way, x-ray is not needed in using ABC™ and you still still get the changes.

These are typical examples of layered curves and why most methods do not undo scolioses. The most basics of explanations is below the presented case study.

This is a 31 year old female patient. The radiographs below demonstrate progressive reduction of adult scoliosis with the method taught by Dr. Jutkowitz in Advanced BioStructural Correction™.

This case is presented by Dr. George Kukurin of Pittsburgh, PA. It is nothing special, just a typical patient. What is special is that George has never been to a live seminar teaching Advanced BioStructural Correction™ and has never met Dr. Jutkowitz or been taught by him or anyone else in person. You too can learn to do this from just the At-Home seminar.

This women was a patient in my office since 1997. She had chronic back and neck pain.



In Oct of 1999 we switched her from diversified/CBP/Pettibon to Advanced BioStructural Correction™.

The films on the left were taken after several years of CMT and before we switched her to ABC™ . Note she has a scoliosis which measures 35 degrees by Cobb's method. The scoliotic apex is at L2 and the distance from the spinous-laminar line to the lateral aspect of the vertebral body is 1.75 on the left and 4.5 on the right suggesting vertebral body rotation.

After a course of ABC™ treatment she was re-x rayed on 12/22/1999. Note the spine has transformed into a lateral translation with a small 6 degree scoliosis (Cobb's method). This represents a 29 degree reduction in her scoliosis. The rotation of L2 did not change. (1.75-4.5)

The patient continued with ABC™ technique and was re-x rayed on 2/5/2001. Note the scoliosis has been eliminated, the lateral translation has been eliminated. The L2 rotation remained virtually unchanged at 2-4mm.

It is tempting to interpret the sp-laminar line / vertebral body measurements as indicating the patient has a structural scoliosis with asymmetrical pedicles. The right pedicle being substantially longer than the left which means it is a structural scoliosis with no change possible.

Dr. Kukurin

Additional comment by Dr. Jutkowitz:

Looking at the original films you can just barely see that L5 does not lineup as part of that lateral curve to the right. It is almost like L4 and 5 are in a line and then there is a bit more of a bend at L3-4 suddenly sharper bend at L3-2. I would have to see and measure the laterals also to get exactly how many

curves there are just from one set of films, but the follow-up films show a typical sequence of unwinding or untwisting layered curves.

When you see something like that flat spot in a curve (like at L4-5), you can bet large amounts there is an additional curve between the vertebrae involved in the flat spot. (It can be a short curve but a curve nonetheless.) The amount of mechanical stress in these curves that are pulled flat by compensations is just as important or, often, more important than the large obvious one. Without a technology of unwinding or untwisting these ENTIRE sets of curves there is no chance to “straighten” a scoliosis.

It is like when you twist a rubber band over and over until the twists start twisting on themselves into a double layered twist.

What is happening here is that the twists at L4-5 and L5-sacrum are being twisted even further by the large twist (to compensate) so they are pulled straight like a bent spring that straightens when it is stretched even though the twist is still there mechanically creating even greater stress on that area.

This is the reason treatment of scoliosis has been such a failure in chiropractic, osteopathy and even medicine. It is also the reasons for the severe reactions of patients who have their spine forced “straight” by surgery. When people have those reactions, as they do in most cases, they have not been straightened but wound up or twisted up more tightly.

With Advanced BioStructural Correction™ you are reducing the twist and the body unwinds or untwists like a big spring as seen in the above sequence of films. That is why doctors all over the world are so successful with more conditions than you might think using ABC™ get for your practice today. How to Learn ABC™.

In the case above there is more than one curve in that flat spot. There is a curve between L5 and the sacrum that remains unseen until you notice the way L5 does not go on the second film and the direction the spine takes starting at L5 in the last film. Once you know about it and what to look for you can see it on the first film. (That is why you need the laterals too; you can make a more complete determination on that first set when you have a full set of measurements in three dimensions. You can make a winning bet that L5 did not line-up smoothly with L4 on the lateral, though it may seem to on the first AP film.)

**That curve to the right in the lower lumbars of the first films is actually three curves:**

1. L5 or so going right – not seen until the second and third film as discussed above.
2. L4 going left – seen most obviously on the second film.
3. L3 going left on L4 (which is seen more obviously in the curve of the second film as she improves and the body untwists to the left at that point — This is not seen obviously unless you know what to look for but would

be on a film taken a short time after the second — which was not taken. It is not as obvious as the lowest curve to the right — L5 not going left but you can notice L3 does not lineup with L4 going left. It is a separate and additional curve.)

Note that the above is only a partial discussing of what is occurring on these films as it does not discuss the layered curves above the L3-L2 point.

Looking at the first film L2 and L1 appear to be part of the large curve to the right.

Looking at the second film you see that L1 certainly, and possibly L2 – not clear from this one view – are actually tilted/twisted to the right and not just coming back to center as it seems in the original film.

Because they never had a technology that truly unwound the multiple layered curves (that is not redundant, I mean MULTIPLE layered curves) and never understood it when they did see it on x-ray, chiropractic as a profession has generally thought that a spine that looked fairly straight on an original AP film and looked more scoliotic on a second film 4 weeks later conflicted with the basic tenet that chiropractors were straightening the spinal column and getting people more well.

What they missed was that the spinal column needed to be viewed as a whole in three dimensions and in multiple positions (multiple mechanical stress patterns) to see how it changes under different mechanical stresses as it unwinds its twists and bends. Only viewing and measuring the spinal column in three dimensions can you truly determine if you are improving its mechanics or not. This is easily done using standard full spine (14×36) films in the AP and Lateral projections with the patient relaxed in the sitting and standing positions.

The largest clue is noticing curves versus flat spots in the spinal column on either the lateral or the AP film.

Nice job GW.

For those of you having the question: This really is a typical result and many other docs report the same. It demonstrates and illustrates an unwinding or untwisting curve in its typical appearance. The fact that the curve to the right is LAYERED is missed by many. Trying to straighten this as one curve does not work and causes many docs and patients great anxiety because what they are doing does not work to untwist all the curves — therefore they do not change the scoliosis.

Dr. Strauss asks how you predict the changes.

Dr. Strauss,
The way to predict the changes is included in the discussion on above ("When you see something like that you can bet large amounts that there is a curve between L4 and L5 (a short one but a curve none-the-less) that is just as important or more important than the large obvious one. and In this case there is also one between L5 and the sacrum that remains unseen until the last film — unless you know what to look for.")

To predict exactly what will happen at a given point you need to measure the angles on the AP, on the lateral and the axial spinal length of the segment of the curve involved (on George's line) vs. the spinal length overall and their ratios to what people of that height typically have when other measurements approach a balanced ration (not a pathological balance).

It becomes even easier if you have standing and sitting films with those measurements made on each. In that case the changes occurring from position to position and their ratios can even give you a prediction of the order in which they will release.

The predictability is based on the vectors (remember direction AND magnitude) of force required to hold these curves in those positions. Remember that those vectors are torque, spiral and stretch along the axis of the spine as well as right-left and a-p.

The basic is that you can ask the question: This vertebra is stuck forward and– (the and can be any other direction except posterior), if I bring it posterior enough so it works properly in the lever system of the spine, what else will the body change?

That what else will depend upon what is occurring elsewhere in the spinal column or even possibly the legs, pelvis or head. In cases of certain types of injury it can even depend upon what is occurring in the arms.

For more data take a look at some of the other scolioses on Dr. Kukurin's web site.

Even though you only have the AP in the pre, you can still see that L4-5 do not curve with the rest of the scoliosis to the right and that L5 goes right on

the sacrum while L4 goes left on L5. In the second film you can see that start to show up.

As far as I know there were no sitting and standing and no full spines so what you have is a lack of the rest of the data needed to make accurate predictions for what will happen in the rest of the curve because in the second pic L3 and 2 are straight in the curve which means there is at least two more curves inside that original large curve to the right.

Hope this answers enough of your question Joe.

The two main points are that if you are truly correcting subluxations you will most certainly get all the changes in structure people are talking about ALONG WITH the changes in neurological tissues and response.

The other is that the thing to work on AND THE ONLY THINGS TO WORK ON are the things the body cannot self-correct and not the things the body can self-correct but does not.

## Multiple Sclerosis

Data From Multiple Sclerosis Patients

Re: **ABC™** Treatment (4-7-00)
I received my first treatment 3-6-00 at the North City Chiropractic Health Clinic from Dr.Cheri Markos. Since that date I have gone twice each week. I have been declining with multiple sclerosis and all the various symptoms since 1988. I have tried many treatments for relief and have been on Avonex since 1996. I have not seen any significant results or have had any real relief. Main stream doctors and naturopaths have no solutions.

My symptoms and disabilities have become more of a challenge in the past 5 years. I now know I have crossed over to secondary progressive.

After the very first treatment from Dr. Markos the results were amazing. There was no waiting period to see if there would be any results. It was immediate. Ever since that initial visit I notice more and more of my body coming back to me. My balance, strength, energy and mobility, to name just a few, have improved dramatically. I can now bend over and pick up things with bent legs without falling. I feel so much stronger and stable. I can look around without experiencing significant vertigo, a real bonus!!!!!!!

I could really go on and on. The bottom line is that the **ABC™** treatment provided by Dr. Markos works. It has worked for everyone that has received the treatment. I have referred a couple of people who also have seen immediate and dramatic results. Even those patients who have a lot more disability than myself.
I would like to recommend that anyone who has MS go for treatment from Dr. Markos. The results are staggering! I wish I could go on national news and let the whole country know.

Sincerely,
Katherine Bursert

Here are the results of patients diagnosed with Multiple Sclerosis. For more data on the reason this works so well with MS and other do-called "neurological disease" cases please see the article, Neurological Diseases or Mechanical Pathology (which can be addressed and improved).

**Advanced BioStructural Correction™** February 23, 2000
My name is Larry Conaway, I was DX with MS in August 1996, at the age if 50. I was DX with primary progressive, and at this time the VA put on a bunch of meds. Dr. Markos has been treating me off and on for the last two years. About six months ago I lost the ability to raise my left leg that Dr. Markos was able to keep working it for one and half years.

Dr. Markos learned the **Advanced BioStructural Therapy™** (now called **Advanced BioStructural Correction™**) and then asked me if I wanted to try this new procedure. I am always ready to try anything new that would help people with MS. Then I started the **ABC™** with DR. Markos on February 16, 20000.
Since then I have had three appointments, on the 18th, 21st, and the 24th .

The first appointment was like a miracle to me. After my very first session I could stand up straight and walk more stable, bend over from the waist and pick up objects off the floor and stand back up again, walk down stairs with less worry of my left knee giving out, and no back pain, which I have had for the last three years. I have only noticed a moderate improvement while walking up the stairs.

I noticed that when I walk, that my left leg does not hyperextend backwards. This has relieved the pain that I have been getting around my patella. The VA was about to make me a knee brace for that knee and now I don't think that I will need it.

When I walk forward, my left leg will bend forward at the knee and it has not done that for about two years. I can swing my left leg forward and now when I walk that makes it easier to walk smoothly. I can also turn around while standing up without having to hold onto a wall or other balance object and this is at a fast rate of turning.

My left foot has been a floppy foot since I was DX with MS back in August of 1996, and now I can hold it up as I walk and that keeps me from having to drag it along, and that keeps me from tripping over it also.

I noticed that I can now stand on either leg while resting the other one. My legs do not get fatigued as fast as before the procedure. I have been able to stand on my legs for a longer time with out having to sit down.

I find that it is a lot easier to get in and out of the shower. I can spend more time in the shower without my legs getting tired. I can bend over and get the soap with out worrying about falling down.

I am finding it easier to get dressed and undressed, and putting on my shoes is a snap now.

Working in the kitchen making dinner or just getting my coffee is easier now also. I think that this is a great benefit to be able to do what I need to do in the kitchen.

I now spend less time in my wheel chair and more time on my feet.

I have noticed that before my appointment on the 24th, that my head and neck were further forward and that my body has started to slump forward. After the treatment, I noticed that I was no longer slumped forward and my shoulders were back. I did notice that my left hip seemed to be lower than it was after the first treatment. I am now back at the point of the first appointment and the above descriptions.

February 26th, 2000: I noticed that I was leaning to the left and a little slumped forward since the last adjustment and Dr. Markos adjusted it back so that I was standing up straight again. At this appointment, we started **ABC™** procedure on my friend Mark Wheat. I helped DR. Markos with this by being the camera man. At first I found it hard to stand and hold the camera for a long period of time and hold it steady too. Then after do this for a few minutes I was able to settle down and even hold the camera steadier. This was hard for me while I was standing with just one eye open and the other eye in the view finder. It took a couple of minutes and then my body got trained, as far as holding the camera steady and moving with one

eye shut, to filming the procedure. I could stand and move with the camera and hold it fairly steady at this point.
I also stopped taking Baclofen and now I am waiting to see if I need to keep taking it or not.

Another
Catherine Sykes Seattle, WA

**Advanced BioStructural Correction™** With Dr. Markos began March 1 5. 2000.
The following physical capabilities began to occur after treatment.

I use a walker or am assisted by someone in public because my balance is poor and my left leg is weak, when at home I use a cane or wall walk.

3/15/00
I am able to breathe deeply for the first time in years. My body feels less stiff arid more open. I am able to make the transition from barefoot to AFO & arch supports much easier.

3/1 7
I am sleeping 10 hrs at night w/ 1 hr naps.

3/18
I am able to stand straight and up right with my shoulders back, I am no longer hunched over. The left leg has an AFO but I have noticed it collapsing on me.

3/20
I can stand up straight without holding on to anything or using my arms for balance, I can flail them about w/o being thrown off balance.

3/21
My feet, calves and arches ache and I noticed I am sleeping 10 hrs w/ naps.

3/22
I feel stiff, very emotional & crying all day.

3/23
I was in my barefoot and bent down to pick up a bowl off the floor w/o planning how I was going to manage this endeavor. It just happened! I have noticed the warmth returning to my feet and hands. I can walk better w/o my AFO and support.

3/24
My walking flows and is less choppy. I am able to stand up straight with my hands clasped in front to my chest or abdomen. I do not have to hold on to anything or use my arms for balance.

3/27
My hands and feet are warm / I had a massage and feel so much better.

4/3
I can feel the arches in my feet, as though they are returning to me.

4/4
My dog(70 lbs) began laying on my legs, I could feel exactly where he was and feel his paws as he raced over my shins and jumped off the bed. Before I would just feel a weighted mass at my legs and was unable to distinguish it, this all occurred w/o looking at what was happening to my legs.

My left leg is weaker than the right but I have noticed that I am able to bare weight equally on both legs w/o favoring to the left or having it collapse on me. I am able to take 5 steps w/o using my cane or wall walking, this all occurred in my barefoot. (I hyper extended my left leg )

4/6
My AFO and supports were bothering me so I took them out, I barely noticed they weren't in when my left foot did turn out, I was tired and needed to rest. I tried this for only 4 hrs today.

Dr. Jesse Jutkowitz
Member

What everyone seems to miss, because they did not post it, was my answer to Dr. Rob Ward.

What he states is based on the preliminary data in ADVERSE MECHANICAL TENSION ON THE CENTRAL NERVOUS SYSTEM. Ward did not bother to get SKULL TRACTION AND CERVICAL CORD INJURY which was published 11 years later (1989) and included a further decade of research.

There, the further case studies are well documented and the further conclusions are drawn. Rob Ward's comments were on incomplete researching of the data.

He got very quiet when I posted the exact quotes from SKULL TRACTION…
GWDC Member
not to defend JJ, but rather to further understanding…I am glad that you posted the post you did. Perhaps it should be included under Gary's post.

Do you really believe that the errector spinae transmit forces the way the article's author suggests???

If so could you please provide me with EMG documentation of the same?

So it would appear that the critic uses unsubstantiated claims to slam a fellow DC.

After reading both of David Butler's books, don't you feel that the neural tension model is viable???

Would not a more mature statement be " an alternative explanation to neural tension, might be the transmission of tension in the erector spinae muscles"?

Isn't this a case of the kettle calling the pot black?

What is Soto-Hall's maneuver?? Flexing the neck re-producing lower body pain….by what?? Dural tension! The concept has been around for years.

In our rush to be right, do we fail to consider that we may not have all the knowledge needed to understand the concept?

Neitche (sp?) said it best…there is no bird's eye view….everything is looked at from one perspective…our own!!!

BTW1:I was particularly un-impressed by Dr. Wards lack of refs to back up his OPINIONS
ーーーーーー
BTW2: DM you have read Butler's books…If my reading of Butler is correct it seems to contradict Ward's assumptions of the mechanisms of dural tension….see the "slump test" Butler's first book…It's been a while am I incorrect???
GWDC
Member Just a follow-up to Rob Ward's opinions…

"However, the simple experiment that Dr. Jutkowitz proposes you perform will in fact demonstrate to you that due to the overlapping nature of the erector spinae, you will become aware of greater tension on the cervical musculature with head flexion in a squatting posture.

>>> It is doubtful that this phenomenon is related to spinal cord stretching, >>>> which doesn't become apparent to most people until you flex the entire spine, flex the hip, extend the knee, and possibly add dorsiflexion of the ankle."

Is this correct???

1: J Orthop Sports Phys Ther 1997 Dec;26(6):310-7

The slump test: the effects of head and lower extremity position on knee extension.

Johnson EK, Chiarello CM

Physical Medicine and Rehabilitation Center, Englewood, NJ, USA.

Maitland's slump test is a widely used neural tissue tension test. During slump testing, terminal knee extension is assessed for signs of restricted range of motion (ROM), which may indicate impaired neural tissue mobility. A

number of refinements that modify hip and ankle position has been added to the basic slump test procedure, but no research to date has measured the effects of ankle and hip position on knee extension ROM during testing. The purpose of this study was to examine the effect of neural tension-producing movements of the cervical spine and lower extremity on knee extension ROM during the slump test.

Thirty-four males with no significant history of low back pain were tested in the slump position with the cervical spine flexed and extended in each of three lower extremity test positions: neutral hip rotation with the ankle in a position of subject comfort (neutral), neutral hip rotation with ankle dorsiflexion (ankle dorsiflexion), and medial hip rotation with ankle dorsiflexion. >>>>>>

Results showed significant decreases in active knee extension ROM ($F_{1,198} = 29.53$, $p < 0.0001$) in the cervical flexion compared with the cervical extension conditions.

Subjects also exhibited significant decreases in active knee extension ROM ($F_{2,198} = 56.76$, $p < 0.0001$) as they were progressed from neutral to the ankle dorsiflexion to the medial hip rotation with ankle dorsiflexion positions of the lower extremity. The results of our study indicate that limitations in terminal knee extension ROM may be considered a normal response to the inclusion of cervical flexion, ankle dorsiflexion, or medial hip rotation in the slump test in young, healthy, adult males. In addition, the presence of a cumulative effect on knee extension ROM with the simultaneous application of these motions is noted. These findings may assist clinicians when assessing knee extension ROM during slump testing.

This is part of a discussion from a MD message board.

I am a 45 year old pediatrician who was given a diagnosis of multiple sclerosis due to progressive neurologic signs and symptoms. I wish to publicly thank my neurosurgical colleagues who determined that the correct diagnosis was congenital and acquired cervical spinal stenosis. Although clinically I had classic “MS”, my MRIs revealed no plaques. I underwent a laminoplasty from C3 to C7 and have now fully recovered. A bonus is that it also cured a lifelong history of severe neurocardiogenic syncope with prolonged episodes of asystole and resting bradycardia – the sympathetic tracts were also compromised. My cardiologist was amazed at my recovery! He no longer recommends a pacemaker. Perhaps there are many others with such misdiagnoses.
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Response –

MS without plaques on MRI? MS should be more than simply cord problems–even transverse myelitis usually appears on MRI. Did you have eye problems or other brain problems in your “Classic MS”?
I have seen patients with both MS and cervical stenosis, but if the only symptoms are related to the neck I wouldn’t think MS.

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Response –

Did the LP show Oligoclonal Banding?
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Response –

: Hail fellow! You have been so fortunate in having such astute physicians investigating your problems. I assume that a complete workup including all the necessary studies to r/o MS and that other causes thus were investigated. Do not be skeptical. You have been essentially cured and have made an astonishing recovery. The proof is in the pudding. God Bless!
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(Supe again)…Now, I'm no great believer in Jesse's proprietary technique, but maybe ol' Breig was onto something… I would say that perhaps certain pathologies that irritate or put tension on the spinal cord produce clinical presentations that are clinically indistinguishable from classic MS.

More from the original discussion:

Supe,
did any of the MDs on the board jump all over this doc and talk about how it's just an anecdotal story…and then suggest that the recovery was merely placebo???

I didn't think so!!!

The big question is: can any manipulative procedure performed by DC's have any effect on a stenotic canal? I say again: an atomically stenotic canal? Mirtzy

———

Dr. Mirtz,
perhaps this should go under scanners anecdotal evidence…

Patient getting left arm numbness down into fingers, burning sensation into neck and face.

Worse at night.

Cardiologist wanted to do a catheterization. Your old boy in the burgh does some neuro-othopedic tests and can reproduce the patient symptoms…

I say MRI c spine…cardiologist says cath lab.

Before the patient could get the catheterization…she gets the MRI…DC wins cervical stenosis…patient refused cath….

long story short….chiropractic reduces cord compression enough that the patient has not had S & S in several years (I see her 2-3X per years as follow-up).

As for lumbar spinal stenosis….I've treated literally 100s…had 1 go onto surgery.

BTW: interesting that the surgeons (some) feel that cervical spondylitic myelopathy results more from tension in the dentate ligament on the cord than from compression from stenosis…..yikes this supports JJ (Dr. Jutkowitz's) ideas!!!!

I'll get the ref soon.

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1: J Spinal Disord 1991 Sep;4(3):286-95

Cervical laminectomy and dentate ligament section for cervical spondylitic myelopathy.
Benzel EC, Lancon J, Kesterson L, Hadden T
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Seventy-five patients who underwent surgical treatment for cervical spondylotic
myelopathy were evaluated with respect to the operative procedure performed and
their outcome. Forty patients underwent a laminectomy plus dentate ligament section (DLS), 18 underwent laminectomy alone, and 17 underwent an anterior
cervical decompression and fusion (ACDF). The patients were evaluated postoperatively for both stability and for neurologic outcome using a modification of the Japanese Orthopaedic Association Assessment Scale. Functional improvement occurred in all but one patient in the laminectomy plus
DLS group. The average improvement was 3.1 +/- 1.5 points in this group; whereas
the average improvement in the laminectomy and the ACDF groups was 2.7 +/- 2.0
and 3.0 +/- 2.0 points respectively. All of the patients who improved substantially (greater than or equal to 6 points) in the laminectomy plus DLS and the laminectomy alone groups had normal cervical spine contours (lordosis).
The remainder had either a normal lordosis or no curve (no kyphosis or lordosis). All patients in the ACDF group had either a straight spine or a cervical kyphosis. These factors implicate spine curvature, in addition to choice of operation, as factors which are important in outcome determination. No
problems with instability occurred in either the laminectomy or the

laminectomy
plus DLS group. Two patients incurred problems with stability in the ACDF group.
Both required reoperation. In addition, four patients in this group who initially improved, subsequently deteriorated. Six patients in the laminectomy plus DLS group had a several day febrile episode related to an aseptic meningitis process. Laminectomy plus DLS is a safe and efficacious alternative
to laminectomy for the treatment of cervical spondylotic myelopathy. The data
presented here suggests that myelopathic patients with a cervical kyphosis are
best treated with an ACDF and that patients with a normal cervical lordosis are
best treated with a posterior approach. Although some selected patients may benefit from DLS, no criteria are available which differentiate this small subset of patients.

PMID: 1802159

1: J Neurol Neurosurg Psychiatry 1997 Apr;62(4):334-40

Pathogenesis of cervical spondylotic myelopathy.

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OBJECTIVE: To determine whether either of two mechanical theories predicts the
topographic pattern of neuropathology in cervical spondylitic myelopathy (CSM).
The compression theory states that the spinal cord is compressed between a spondylitic bar anteriorly and the ligamentum flava posteriorly. The dentate tension theory states that the spinal cord is pulled laterally by the dentate ligaments, which are tensed by an anterior spondylitic bar. METHODS: The spinal
cord cross section, at the level of a spondylitic bar, is modeled as a circular disc subject to forces applied at its circumference. These forces differ for the two theories. From the pattern of forces at the circumference the distribution of shear stresses in the interior of the disc-that is, over the transverse section of the spinal cord-is calculated. With the assumption that highly stressed areas are most subject to damage, the stress pattern predicted by each
theory can be compared to the topographic neuropathology of CSM. RESULTS: The
predicted stress pattern of the dentate tension theory corresponds to the reported neuropathology, whereas the predicted stress pattern of the

compression
theory does not. CONCLUSIONS: The results strongly favor the theory that CSM is
caused by tensile stresses transmitted to the spinal cord from the dura via the
dentate ligaments. A spondylotic bar can increase dentate tension by displacing
the spinal cord dorsally, while the dural attachments of the dentate, anchored by the dural root sleeves and dural ligaments, are displaced less. The spondylotic bar may also increase dentate tension by interfering locally with dural stretch during neck flexion, the resultant increase in dural stress being transmitted to the spinal cord via the dentate ligaments. Flexion of the neck increases dural tension and should be avoided in the conservative treatment of
CSM. Both anterior and posterior extradural surgical operations can diminish dentate tension, which may explain their usefulness in CSM. The generality of these results must be tempered by the simplifying assumptions required for the
mathematical model.