TOWARDS DEFINING UNCLASSIFIED SYMPTOMS:

ECLECTIC CONDITIONS PRESENTING IN TWO CHIROPRACTIC CLINICS

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ABSTRACT

This paper outlines a number of obscure symptoms presenting in a clinical setting. These are usually quite distinct from the more commonly recognised symptoms one would generally find in practice.[1]

The patient-described symptoms were deemed 'unclassified', and viewed as one of the motivating factors behind their initial presentation to their chiropractor. Patients would present for initial consultation, or maintenance, preventive, symptomatic, or episodic care, in their usual manner.

The topic led to a discussion on defining a symptom, and just what qualifies as a symptom, and indeed what qualifies as a disease.

METHOD Most of the symptoms listed here were compiled as a result of an informal survey of patients. However, patient case history records were also sourced. In addition, some non-surveyed patient-reported symptoms were also recorded.

In the informal survey, patients were asked to respond to the question of, *"What benefit do you get from ongoing chiropractic care?*"

REVIEW Apart from the published papers, a review of a number of dictionary definitions was also conducted. We were surprised at the number of papers relating to "unclassified symptoms" and "non-diseases".

DISCUSSION Informal subjective, atypical symptoms may present as health complaints in varying degrees of severity. Experience and empirical evidence would indicate notable efficacy in explaining and ameliorating many such symptoms under the chiropractic model of spine-related health care, there being no specifically designated ICD classification for most of the symptoms listed here.

CONCLUSION As some chiropractic terminology is now included in the ICD, it would be appropriate to include further terms associated with the profession. Categorisation of symptoms may need to be broadened to accommodate an apparent limitation of current classification due to the high percentage of unclassified symptoms. This would necessitate defining the condition to which the symptom relates.

Key Words:

Symptoms, Health Care, Preventative Care, Chiropractic Health Care, Spinal Adjustments, Vertebral Subluxations.

INTRODUCTION

"…Research evidence leads us to believe that such (neurological) dysafferent input is associated with joint complex dysfunction, which explains why so many seemingly bizarre symptoms respond to chiropractic care."[1]

Symptoms are a common primary motivating factor for a patient to initiate a clinical visit to a health practitioner. We recognize that many symptoms can be due to a variety of etiological factors, however the emphasis here is in those that originate from the spine – vertebrogenic symptoms.

As primary contact practitioners, any patient with any symptom or any condition may seek a consultation for health care at any chiropractor's clinic at any time. They may present with, and express their perceived condition in descriptive terms that are not generally found in standard chiropractic or medical textbooks. To that extent, the word *symptom* may seem somewhat inadequate. If it is accepted that a symptom is an indication of a disease, the term *disease* may then also seem limiting. Of course, it could be declared that a symptom does not *have* to be officially documented in the literature, as it can be such a variable or vague subjective indicator.

The terminology used by patients in describing their presenting complaint may also be in a varied and descriptive format covering a wide range of conditions. However, the terminology may not include symptoms of a 'disease' in the customary sense. On the other hand, adoption of the term *dys-ease* could more appropriately describe some of the presenting conditions. In which case, the prefix "*Dys*" could mean; *abnormal, impaired difficult or bad.*[2] The circumstances may also be seen as a *disturbance of physiology*, or sense of well-being. A definition for such a symptom could then be defined as; *a subjective disturbance of anatomy, physical function and/or physiology which is recognised by a patient.* In the particular symptoms presented in this paper, the fact that they may have responded to manipulative interventions in the past by way of vertebral adjustments, would place them at a level which could be deemed a pathophysiological condition, indicative of a departure from a normal physiological state.

In relation to the symptoms generally addressed by chiropractors, such a clinical finding would tend to suggest a category of symptoms which could be regarded as spine-related and neurologically facilitated.

Because of the variety of definitions of both *symptoms* and *disease,* it could be deemed necessary to develop a new word or term for both. This would not only assist in identifying a patient's subjective indications of a *non-disease*[3], but also include *dysfunction and discomfort.* – recognition of *'something'* being abnormal or 'not quite right'. This is likely to be the very reason patients may have presented themselves to their practitioner in the first place.

METHOD

The motivation for this paper resulted from a list of symptoms when one of us requested patients to essentially list their reason for seeking chiropractic health care.

In this anonymous, informal survey, patients were asked to respond to the single question of, *"What benefit do you get from ongoing chiropractic care?*"

This review of the key term – symptom, is centred around the recognition of those that are not generally recognised in the traditional sense. They are however, changes in patients' noted health status and reported by them.

A search of Pubmed was also conducted and papers retrieved, where required.

In addition, there is a degree of empirical, narrative or anecdotal evidence derived from some 80 years experience of clinical exposure by the authors.

The 2002 paper on 'non-diseases' by Smith[3] created quite an interesting debate in subsequent letters to the editor. However, Wessely stated that the 'classification of the world of unexplained syndromes was *"a mess*"[4] In an earlier paper with colleagues, he also adopted the term 'non-symptom'[5].

During the literature search, we did not expect to find so much material on the topic of 'unexplained symptoms'. There was also surprise at material on the topic of 'non-diseases'. The topic raised by Meador and also Nuhan in 1965.[6,7]

In covering this topic, it was also thought necessary to consider the terms *pain* (as a symptom and sign), *vertebral subluxation complex* -VSC (as an etiological factor), and *psychosomatic* (as an historically utilised term for unexplained symptoms).

REVIEW

Atypical symptoms may not fit neatly into a textbook or ICD-type categorisation, but are present as genuine symptoms by the patient and therefore deserve recognition, analysis, consideration, and alleviation. After all, the patient has presented with a 'complaint(s)' which is real to them, and they understandably seek resolution to, or explanation of, that complaint.

The World Health Organisation has declared that *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*"[8] This definition is listed on the WHO website and dated 2003. It has not been amended since 1948.[8] Due to perceived shortcomings, the definition has apparently been subject to much debate *"…almost since its inception…"* [9]

Saracci felt the definition *"more accurately defines happiness than health."* [10] While in a perspicacious paper in 1986, Gillon argued that under this definition *"none of us is, has ever been, or is ever likely to be healthy."* He opines further that if it is the doctor's function to help achieve such health, then that description is too broad, and if it was aimed at achieving *adequate* well-being, it is still too wide a definition.[11]

In 2008, Guedes and colleagues surveyed practitioners on the topic of *undefined complaints*. Among other topics, they gathered data on *"the lack of conceptual precision in the use of nomenclature"* and, *"difficulties in establishing diagnostic criteria."* They concluded "that the biomedical model behind these difficulties has few tools for dealing with the singularities of human suffering…"[12]

In 2006, Walker and colleagues[13] state that *"Modern medicine is based on pathological diagnosis. But many patients present with symptoms that lack identifiable pathology."* And further, that *"the problem of medically unexplained symptoms is a big one"*. Stone and colleagues,[14] as well as Aggarwal et al[15] claim that some 1/3 of patients present with unexplained symptoms. Walker et al go even further on the topic to state that *"despite its size and importance the problem continues to be neglected"*. They state clearly that *"The failure to adequately address*

the problem of medically unexplained symptoms is in part due to the lack of accepted diagnosis.[13]*"* It would seem difficult for many patients to appreciate that 1/3 of their consultations on any given day are 'undiagnosable'!

In further comment, Wessely noted the transition of an illness to a disease after they had been being "falsely labelled".[16] Historical examples of such conditions include; peptic ulcers[17,18], asthma, chemical sensitivity, chronic fatigue, chronic whiplash, chronic widespread pain, Complex Regional Pain Syndrome (AKA as causalgia, Sudek's Atrophy, Reflex Sympathetic Dystrophy), Crohn's disease, fibromyalgia,oro-facial pain, irritable bowel, multiple sclerosis, lupus. multiple sick building syndrome, the side effects of silicone breast implants, and Gulf War syndrome.[15,19-21]

Another example of this is the Repetitive Strain Injury (RSI). Serious workers' compensation settlements were lost by patients with RSI, because they were deemed to be of psychological origin. The condition was subsequently found to have legitimate physical foundations. One must query aspects of a model upon which such misinterpretations are based.[22]

In a slightly different emphasis, *illness* has been defined in Collins Dictionary as *" a disease an indisposition; sickness, a state of ill health".* But it defines *indisposition* as a "disorder; any slight temporary illness'.[23] The authors are unaware of a classification of illnesses.

A further category is that of "unusual symptoms", a term which features in the titles of a number papers listed on the Pubmed website. However, this is a different category as they have generally been formally recognised in such papers as being associated with specific pathological conditions. A Google search also reveals the term "non-symptoms". Such expressions further highlight the constraints of the traditional understanding of the term *symptom* - and the prevalance of atypical symptoms. .

In this presentation on *symptoms*, we also found it necessary to take a cursory look at associated aspects of that term. It evolved further into considering the

associated key terms of, *sign* and *disease*. Other associated terms as health, wellbeing and homeostasis were not included at this time.

Many of the definitions of the term *symptom* either state or imply an association with a disease, disease process, or pathological state. It is noted in our patient-reported observations which are not normally found in standard textbooks, that they are perhaps not recognised enough to qualify for mention in those texts. Naturally, they would have to be identified as vertebrogenic in the first place. However, the symptoms were of sufficient concern to patients for them to seek attention for what they see as a health condition, discomfort requiring alleviation, or just an indication that something is not quite right.

A classification for unlisted clinical symptoms would seem worthwhile due to the distinct nature of some presenting complaints. Perhaps it is time to consider a term such as "descriptive symptom'; that being a biological symptom not confined to a single word. Perhaps there should be greater emphasis on descriptive phrases for symptoms as well as the standard terms.

This would be a similar idea to Smith's classification of a *non-disease* as *"a human process or problem that some have defined as a medical condition but where people may have better outcomes if the problem or process was not defined in this way."* He went further to state that *"The suffering of many with non-diseases, may be greater than those with widely recognised diseases.* He then associated the suffering from *"grief, loneliness, or redundancy*" as forms of *non-diseases*.[3]

SYMPTOMS

"The purpose of this work remains the same as when the book was first published in 1912, namely the presentation of symptoms and signs to enable the clinician in cases of difficulty to decide the precise cause of the malady which confronts him." Douthwaite AH [24]

The presentation of the patient-described symptoms that do not seem to have a standard textbook appellation tends to highlight the clinical limitation of the term. The fact that the ICD-10 expanded from 14,315 to 69,101 in the ICD-9, is an indication that the identification of symptoms is broadening.[25] This paper would suggest that further evolution of the ICD is indicated.

Before researching the topic, it was thought that such a term as *symptom* would adequately cover all presenting subjective observations. However, the range of so-called symptoms was broader than traditional classification would satisfy, and most definitions tended to be somewhat limited. A search for an appropriate published definition of the term *symptom* was in itself of interest, as both medical and plain English definitions varied considerably. The patient survey opened up a new range of symptoms. To our knowledge, these seemed to fall into the category of unexplained symptoms, as they had not been documented previously. They did however, appear to be spine-related, a matter essentially confirmed or implied by patients.

It could be argued that Dorland's definition of a s*ymptom* is broad enough to adequately cover the description of a vertebral subluxation – especially the definition's latter phrase of; *a change in a patient's condition indicative of some bodily or mental state.* In full, it states that a symptom is, *"Any functional evidence of disease or of a patient's condition; a change in a patient's condition indicative of some bodily or mental state."*[26]

However, the authors felt that in order to embrace the range of symptoms presented, perhaps a definition would need to be more germane to the type of patient-described conditions which do not attract a designated appellation. This could then apply to the numerous spine-related 'symptoms' associated with vertebral subluxations as depicted in this paper. (Table 1 & Appendix 1)

Dorland's Medical Dictionary (2007)[27] on-line definition differs slightly to the 1965[26] printed version[10], as it stated that a symptom was *"any* ***subjective*** *evidence of disease or of a patient's condition, i.e., such evidence as perceived by the patient; a change in a patient's condition indicative of some bodily or mental state."* The change from *functional* to *subjective* is perhaps understandable, but *functional* ***and*** *subjective* may have been more encompassing, as would *dys*-ease[2] instead of disease.

The etymology of the word *symptom* does seems to satisfy this rather broad connotation, and contemporary standard dictionaries tend to have both a generic as well as a medical definition. Webster's dictionary indicates that the origin of the

word refers to "*anything that has befallen one."* Its definition of a *medical* symptom is *"any condition accompanying or resulting from a disease and serving as an aid to diagnosis; a perceptible change in the body or its function which indicates disease.*" This definition does not specify that a symptom is subjective, indeed it could apply as a definition of a sign.[28] Both this and Dorland's[27] medical definitions specify a disease association, it also notes a synonym for symptom as an *indication*.

On the other hand Mosby's online medical dictionary notes a Greek etymology of the term as *"to feel with*" and "*that which occurs*." It defines a symptom as *"occurring in one body area when the causative lesion is actually in another area."*[29]

In other standard dictionaries, it was the non-medical part of the definition of a symptom that best suited many of the clinical symptoms noted in this paper. It may be that it is the medical definition that needs to be adapted to satisfy the many clinical situations or categories of 'no-name' symptoms. But most definitions of *disease* seem confined to an association of a biological symptom, rather than the terms dys-ease, disorder, discomfort, or dysfunction.

The non-medical definition of a symptom in a 1990 Collins Dictionary, states that it is: *"anything that is taken as an indication that something is wrong.*" In some ways that also seems appropriate, although the medical part of this definition specifies a disease association - *"An indication of a disease as noticed by a patient."*[30] A 1995 edition described a symptom as *"Any sensation of change in bodily function experienced by a patient that is associated with any disease.*" [31]

One Oxford dictionary defines a *symptom* as: *"perceptible change in the body or its function indicating injury or disease."*[32] Another offered, *"change in body or its functions indicating presence of disease; sign of the existence of something."*[33] A third defined a symptom as *"A change in the physical or mental and physical condition of a person, regarded as evidence of a disease. A sign of the existence of something."*[34] These variations portray a degree of a lack of consistency in definitions, even in the same publishers' dictionaries.

The term *symptom* also brings into consideration the patient's threshold of a particular sensation. Some patients may think a symptom is severe, others may regard it as being insignificant. A clinical presentation such as numbness of an extremity for instance, may be objectively corroborated by a patient's response to pinwheel testing of a dermatome or other sensory test. However the *degree* of numbness, like pain, can be particularly subjective.

A chiropractic definition of a symptom is offered as *"The feeling perceived by a patient that something is not right."*[35] This is somewhat similar to a definition for a presenting symptom on the website for the University of California San Francisco. which states *"The first change noticed by the patient or caregiver; the change that brings them into the doctor's office."* In this latter case however, the definition relates to frontotemporal dementia.[36]

Further, a vertebral subluxation may be both a symptom and a sign. A patient may be aware of a pain, discomfort or restriction of spinal movement, and present it as their chief complaint. The chiropractor may then confirm its existence by palpation, - making it a sign. It may also be confirmed through verbal communication with the patient, or the patient's response to other testing procedures.

A symptom associated with, or due to a spinal lesion (in chiropractic terms a VSC), and which is resolved or alleviated by manual spinal care (again in chiropractic terms a vertebral adjustment), hardly falls under the impression of the symptom being indicative of a disease in the traditional sense.

Use of the word *indication* in these definitions also raises issues. All these terms almost invariably suggest that signs and symptoms point to a biological disease or condition. Moreover, the issue then becomes; *what is the etiological factor, or what aspect of the condition is the etiological factor of that symptom or sign?* Chiropractors in particular, would appreciate the VSC as at least a contributor, if not the primary cause of many both traditional and less-broadly-recognised symptoms and signs that could be regarded as spine-related.

It could be said that many patients' chief complaints which prompts their initial presentation to chiropractic clinics, could fall into two categories:

1. Symptoms of a disease
2. Symptoms of a condition, part of which is dys-ease (dysease), and of which mechanical and physiological dysfunction and awareness of discomfort, may be common indicators.

At times, there may be a combination of the two. Distinguishing between them is accepted as critical in their management.

For a VSC-related symptom to be declared an indication of a mechanical spinal *disease* in the traditional sense would seem extreme. However, a clearer description of what constitutes the wider array of symptoms, and a more specific definition of what constitutes a *disease* as opposed to a *condition* or *disorder*, would seem necessary.

Synonyms for the word symptom include *indicator, indication, sign* and *warning sign*. It is submitted that these may be pathological, physically dysfunctional, pathophysiological or just dys-ease. This implies that a symptom must be indicative of *something*, be it a biological disease, disorder or condition. It would seem therefore, that a symptom should not be limited to the conventional understanding of the term *disease*.

As there is such a broad and somewhat ambiguous range of definitions, it would seem that the items listed in Table 1 should have been covered as symptoms by the definitions. However as they are not specifically related to a d*isease,* and do not appear in textbooks as related to specific conditions, they cannot as yet be officially designated or sanctioned, but remain descriptive terminology.

SIGNS

As opposed to the term *symptom,* there was a reasonable degree of uniformity of dictionary definitions for the biological term *sign*. Some definitions avoided using the expression ‘disease’ in their phrasing.

Taber’s states that *symptoms* “*…may be classified as objective, subjective, cardinal, and sometimes as constitutional. Another classification considers all symptoms as being subjective, the objective indications being called signs.”* It then

states that *signs "are more or less definitive and obvious, and apart from the patient's impressions."*[37]

Dorland's defines a sign as: *"an indication of the existence of something; any objective evidence of a disease."* [26]

PAIN AS A SYMPTOM OR A VITAL SIGN

A report from the Pain Summit in Melbourne in 2009 stated that the *"Understanding of pain has increased, however improved treatment has not improved over the past twenty years."*[38] Assuming this statement also refers to forms of vertebrogenic pain, there would seem to be a need for greater recognition of the pain associated with intersegmental dysfunction – or indeed any articular dysfunction.

Although advocated by the US Veterans Affairs department in 1999[39], there is also debate as to whether pain should be regarded as a *vital sign* along with the primary four – pulse, temperature, respiration, and blood pressure[40]. Keamy et al., state that it could be the *sixth* vital sign after oxygen saturation.[41]

Schiavenato and Craig argue that pain should not be regarded as a vital sign. While pain can be a "multi-faceted experience, with cognitive, emotional, as well as sensory components …(with biophysiologic and sociocultural determinants, as biopsychosocial models of pain)."[42] Pain is certainly a very handy clinical guide in terms of degree, type and position, as well as aggravating and relieving factors. At times it may also influence the other vital signs. While it is not as independently measurable as the other vital signs are, algometers, pin pricks, pinwheels, and conversely, numbness would render it a 'vital *symptom'* at least.

It would be the authors' contention that clinically, for musculoskeletal conditions at least, pain can indeed be a vital sign – an indicator of the numerous aspects of its nature can be fundamental in determining a diagnosis.

SUBLUXATION-RELATED SYMPTOMS

Due to the claim that there are many unexplained symptoms,[25,43] and the potential for VSC-related symptoms not being fully recognised, it is submitted that a

large percentage of such symptoms could foreeseeably originate from disturbed neural physiology due to articular dysfunction – the VSC. There are a number of theories proffered which would tend to explain/support/elaborate this possibility.[44-46]

Recognition of a wide range of neurovertebral-related symptoms brought about through this mechanical pathophysiology of the spine, is an area that has not been documented to our knowledge.

In view of such a significant difference between known and unknown conditions, it is reasonable to propose that the neurological component of vertebral dysfunction may well explain many of these previously unexplained symptoms.

Walker et al have identified this knowledge deficit in symptomatology and diagnosis. They state, *"Modern medicine is based on pathological diagnosis, but many patients present with symptoms that lack any identifiable pathology,"* and recognise that, *"The problem of medically unexplained symptoms is a big one." "But despite its size and importance the problem continues to be neglected."* And further, *"the failure to adequately address the problem of medically unexplained symptoms is in part due to the lack of accepted diagnoses…"Traditionally medicine has classified symptoms and therefore patients, into diagnostic categories based on presenting symptoms and the underlying disease or pathology assumed to be causal."*[13]

In addition, Carson et al, in acknowledging the 1/3 of new patients in general neurology who experience unexplained symptoms *"have been neglected"* and that *"they deserve more attention."*[47]

For over 100 years, patient presentation has permitted chiropractors to record and observe symptoms in individual patients, then correlate such findings with the locating and adjusting of vertebral segments and note the outcomes. This is more empirical evidence than anecdotal evidence.

If articular biomechanical disorders are not acknowledged in traditional medical courses, there would be minimal chance of recognising symptoms that may be associated with the VSC - especially the neurological dysfunction aspects. In

1977, the Australian Government Webb Inquiry noted that *"the majority of chiropractic patients have attended a medical practitioner for the same specific symptoms they presented to the chiropractor. …. The majority of patients in those studies had discarded conventional medical therapy because of failure to obtain relief…*" The report stated further, that, *"From these data the conclusion must be drawn that is emerging as an established occupation with a large and growing clientele* (sic)*, the majority of whom report high levels of satisfaction with the treatment they received."*[48]

We would submit that a number of symptoms do not fit a current traditional model, but would fit better under a chiropractic model. The medical model criterion is inadequate when up to 52% of patients present with symptoms which are "unexplained."[49] What a disappointment for patients and a weakening of the medical image if patients thought that they had only a 50/50 chance of being understood, diagnosed or their condition alleviated.

Guedes et al encapsulate the problem when they explain that patients present with *"...their discomforts and disorders.."* yet doctors are confined to fixed categories of disease.[12]

Further, it has been demonstrated that in relation to impaired cognitive ability, functional and structural brain abnormalities "*are reversible suggesting that treating chronic pain can restore normal brain function in humans.*" Such a finding associates the relief of LBP with vertebral adjustments as well as an influence on brain function.[50]

SPINAL HEALTH:

It is submitted that spinal health could be defined as; a *situation where a person's spine is supple, flexible, mobile within normal physiological limits, without biomechanical lesions called vertebral subluxations, and is then said to be in an optimal neurospinal condition. This situation demands that there is therefore no related compromise or disturbance of neural impulse transmission or neurological structures, thus allowing normal function of all elements associated with that segmental level – that is, homeostasis.*

Occasionally, a patient will present with a unique list of symptoms. Such a list is an aid in conducting a full assessment of the patient. While there were cautionary signs in this particular case (Appendix 1), the patient maintained that he had tried 'everything' for alleviation of this extensive range of symptoms, and that chiropractic care was the only means of relief.

Another patient was reluctant to mention that they had a pain localised only in the first toe. This symptom was critical in considering that particular case. While the patient felt embarrassed about this, he need not have been, as it was quite clinically significant in the diagnosis and resolution of an L5 radiculitis.

It is interesting to note that not all 'patients' necessarily present with symptoms – only with signs. One aspect of this is that the patient is precluded from a subjective role in assessment. This is further observed in the veterinary field. An emerging field is that of animal chiropractic – combined courses in spinal manipulation are in existence. Arguably, veterinary patients would mostly present with signs rather than symptoms.

PSYCHOSOMATIC SYMPTOMS

It appears that many obscure symptoms were thought to be of psychogenic aetiology – an area still evolving, and still somewhat controversial. As recently as 2008, Noyes and colleagues claim that the Diagnostic and Statistical Manual of Mental Disorders (DSM III) Category of Somatoform Disorders, has been "subject to controversy." They cite critics as claiming that the category "*assumes psychogenesis, and that it contains heterogenous disorders that lack validity.*"[51]

Unclassified symptoms have also been referred to as *"unexplained symptoms"* [14,15,47] as *"symptoms not associated with disease,"*[13] and by Guedes et al[12] as *"vague and diffuse symptoms in biomedicine."* They conclude that *"the field of so-called 'somatization' is nebulous -, riddled with ambiguities and paradoxes."* This is hardly science.

It seems that there is still much controversy as to the existence of somatoform disorders. One could go further and opine that if there is not a readily identifiable

physical pathological or pathophysiological explanation, then the condition seems to assume a psychological basis.

Based on the previously mentioned examples, it is interesting to note the sheer volume of so-called psychosomatic conditions. Just because a symptom does not fit a particular physical model, it doe not necessarily mean that the model is complete, or that all symptoms are officially recognised. It could just as easily be that the model is just inadequate. Nor indeed, does it confirm that the symptom is psychologically based, although, one could imagine that in this era of EBM, such a model would be difficult to research and prove.

It is suggested that research may eventually show that intervertebral dysfunction is associated with signs and symptoms of anatomical and physiological dysfunction, and therefore could lead to a whole new classification of so-called symptoms. The possibility of a spine-related factor should be seriously considered and researched.

DISCUSSION

Patients usually present to health professionals with clearly identifiable, or named symptoms and signs. Thus in subluxation-related disorders, the designation of an ICD classification may not necessarily be particularly applicable for a symptom, unless associated with one of the subcategories in the ICD-10 under section M99 - "Biomechanical lesions, not elsewhere classified."[52]

Anecdotally, some patients present themselves to chiropractic clinics because they 'just want a tune-up'. They report with no specific 'textbook' symptoms necessarily, but are aware of a sensation of being physically 'not quite right'. Previously, they may have experienced alleviation of the same condition or discomfort, but they may not have known the specific nomenclature at the time.

In our experience, examples of this are seen in the athlete who is astutely aware of a finely tuned body.[53] They are particularly conscious of not "running smoothly" or "freely". This can be reflected in subtle changes in their performance times. These sportsmen and women, be they runners, golfers, bowlers, tennis players or footballers, may relate that they just sense the need for normalisation of these indistinct symptoms, even where there is an absence of actual physical discomfort. This may present as more of a vague awareness rather than a distinct ache or pain. Other examples have been singers and wind instrument musicians, who present for spinal care when they feel their singing quality impaired, or an inhibited lung capacity.

The reasons nominated by the patients attending our clinics as outlined in this paper Tables 1 & Appendix 1, would suggest that they have elected to seek resolution, prevention, or preservation care and attention for what they see as a health concern. Rupert found that patients presented to chiropractors for the following reasons:- 95.4% "to minimise recurrence or exacerbation," 88.3% to "maintain or optimise health" and 88.1% for preventive care. [54]

While both standard and medical dictionaries vary in their definition of the term *symptom*, one appropriate meaning for the purpose of this paper, was that offered by Taber's Cyclopedic Medical Dictionary[37] as *"Anything that has befallen*

one. Any perceptible change in the body or its functions which indicates disease or the kind or phases of disease." The dictionary also included an extensive list of symptoms that included such obscure terms as, abdominal *"splashings, roarings and rumblings (borborygmus)"*; and under chest, *"queer sensations"* and "*heaviness"*. It defines an *accessory symptom* as, "*a minor symptom, or one that is not pathognomonic*," and a *sympathetic symptom* as, "*a symptom for which there is no specific inciting cause and usually appearing at a point more or less remote from the point of disturbance."* There is no expansion offered as to an association with the *sympathetic* nervous system as part that definition.[3] Such a scenario raises doubts as to how comprehensive the current symptom classification model is.

One of the inspiring aspects which the authors can find motivating in practice, is the challenge of diagnosing and establishing the probably etiological factors behind a presenting patient's condition. One can never be quite sure what condition(s) the next patient may present with. That in itself is stimulating.

It is acknowledged, that recognition must be given to the fact that it may be easy to focus on a single condition being present, but there may well be more than one condition in that patient at any given time. (Appendix 1) We observe that some patients seem conditioned to report recognised, or traditionally designated symptoms.

At other times, patient descriptions of symptoms can sometimes be vague or circuitous. Others may ramble without really answering or addressing the queries asked of them. For instance, the authors have noted examples where patients are not sure whether their pain is in the upper or lower arm – or in fact which arm!

Another example can be the response to the question of "What happened to trigger off your pain?" If the patient's response begins "Well last Thursday – no, it was last Friday when Johnny was at school and I was waiting for my friend (named) at the library, or was it the bakery." One would recognise the start of a tedious case history compilation.

One of us recalls on occasion, patients saying in response to asking whether they had ever been involved in a major car accident, their response was "Not that I

know of." Such an answer highlights the clarity of communication, the memory, or the confidence in certain patients. To accept such a evasive reply could cloud the symptom picture. It seems that a percentage of patients may also experience alexithmia whereby they have an inability to express feelings with words.

One 36-year-old male patient vowed and declared he had never had a serious injury, despite his presentation for chronic, unspecific, but debilitating neck pain. Upon radiological examination, it was revealed that he had a rather sharply angular kyphotic cervical spine[55] with localised degenerative changes at the apex posteriorly. Some two visits later he apologised as he had recalled that as an 11 year old, he was riding a horse on a farm at night, and charged into a clothes line which struck him across the throat. (It is thought that he must have just been rising out of the saddle at the time and was carried up and off the hindquarters of the horse.) It is conceded that there is no definite cause and effect in this instance, but the radiological finding would have been consistent with such a severe type of injury described by the patient.

In a casual discussion with a medical colleague (and patient), he was asked to estimate the percentage of his patients who would present with a condition 'straight out of a textbook.' His reply was *"about 30%"*. This was a similar figure arrived at by the chiropractor in his own practice. This observation could suggest that even if symptoms appear similar, they may be variations from the classic presentations, and stress the point that each patient should be assessed individually.

It has also been noted that at times, patients present with symptoms that do not necessarily follow a particular dermatome, myotome or segmental innervation. Such cases can present further intriguing diagnostic cases. In this realm of atypical symptomatology, we have noted that on occasion, even just digital pressure over the articular pillar of say, C2, may produce tingling in a patient's contralateral calf, at other times it may be reported in the ipsilateral calf. Either way, the neurological implications of such light stimuli would appear enigmatic.

It would seem that under the allopathic model, there could be limited inclusion of dysfunctional articular physiology, with more emphasis on exploring such phenomena as psychogenic disorders (somatoform) and frank pathologies.

As there seems to be a number of unclassified symptoms, there may be shortcomings as to a recognition or acceptance of an organic or physical association. It may also suggest that a more comprehensive understanding of physical conditions is yet to be fully appreciated and developed.

Somatoform disorders have been defined as *"Any of a group of disorders characterized by physical symptoms representing specific disorders for which there is no organic basis or known physiological cause, but for which there is presumed to be a psychological basis."*[56]

While the weight of evidence may not have been fully appreciated by some in the past, there would have to be a case for recognition of the wide range of spine-related (vertebrogenic) conditions brought about by neurovertebral pathophysiology in the spine. This could involve dysfunction (pathophysiology) of the associated structures that would include the articulations, neural and vascular conduction elements, as well as ligamentous and muscular structures. This possibility opens up quite an array of possible conditions that are not specifically named at this stage, although could be covered by the general ICD classification M99.1.[52] The 5-fold increase in listed symptoms between ICD-9 and 10 suggests that symptom recognition is still evolving.[25]

The many symptoms presented in this paper exemplify disorders which could be covered under a new classification of symptoms, as they are generally not found in medical texts – they are not necessarily atypical. Subsequently, there would also seem to be a need for further ICD sub-classifications under 'biomechanical lesion' to incorporate associated neurological disturbances.

Alternatively, the designation of a new classification of biological complexes covering vertebrogenic signs and symptoms could then exist in recognition of apparent Subjective Biological Syndromes (SBS). Those that at least anecdotally respond to SMT, could be designated Vertebrae-Related Subjective and Objective Biological Complexes (Vertebral Subluxation Complexes -VSC's). This would then emphasise attention to the need for a new category of recognised conditions, or disorders identified as being a part of, or due to, the subluxation complex, and which may be ameliorated or resolved by an adjustment (a correction) of that VSC.

We considered the following questions as ones to be explored in explicating the role of health practitioners and patients in relation to such spine related symptoms.

- Could the presence of such equivocal 'symptoms' be regarded as an *unhealthy* state, or is it a sign of an aberrant disorder?

- Should *all* patient symptoms or concerns be regarded as a threat to their health – even the more subtle ones?

- Is there a need for the atypical signs and symptoms of alternative and complementary health professions to be researched and classified?

We also considered the possibility of proposing a categorisation of symptoms as Type I, Type II, and Type III, where:-

Type I would constitute patient-reported observations which may be indicative of a possible disease, pathology, or severe dysfunction – a named or literature-classified symptom that could be regarded as traditionally covered in the ICD-10.

Type II - Patient reported observations noted as a discomfort, uneasiness, concern, or secondary discomfort – more of a descriptive symptom.

Type III - Dysfunctional spine-related neurological and musculoskeletal symptoms (Associated with VSC's).

In addition, it may be advisable to categorise Type I, Type II, and Type III Health Conditions (Disorders, Disease).

Type I. Pathology of anatomy, physiology or function – frank tissue pathology – a named or classified disease or condition, especially those noted in the ICD.

Type II. Secondary disturbance of anatomy, physiology or function – perhaps more profound, or more difficult to demonstrate due to a lack of tissue pathology.

Type III. Pathophysiology, pathoneurophysiology confirmed by signs and symptoms associated with spine–related dysfunction.

It is recognised however, that many symptoms could be simulated[57] or related to a categorised disease condition. However, even simulated conditions deserve being considered and ameliorated when possible.

An example of a Type III condition to verify clinically, would be that of a cervicogenic headache. Apart from empiricism, it is somewhat difficult to actually prove that such a headache originates in the neck. There is considerable supportive empirical and narrative evidence in existence.[44-46, 58-63]

In general practice, it would be difficult to demonstrate the existence of a headache, or diagnose 'tiredness', unless there are valid clinical signs?

In a chiropractic sense, and in cases presented here, patients with a recurring symptom (under symptomatic care), or those who seek preventive or maintenance care, have found that by seeking redress of their dysfunctional vertebral factor(s) through a segmental adjustment(s), their condition is deemed to be spine-related - that is, after due consideration of other differentially diagnosable or underlying conditions. While some of these cases may be based on an empirical approach, this is not unique to chiropractic. Much of medicine is anecdotal or narrative,[64-66] as it must be in varying degrees with all the health professions, including such culture-based methods as acupuncture. As Campo stated *"Whether we choose to admit it or not, the anecdote continues to be an important engine of novel ideas in medicine."*[67]

We would submit that the symptoms noted in this paper reflect some of the many and varied conditions which confront all health practitioners. They emphasise the need for diagnostic skills to manage, treat or triage those patients.

It should be noted that chiropractic health care is not purely to administer spinal manipulation - chiropractors employ a number of health management measures. Hawk states that *"...chiropractic is a health care profession in which the doctor cares for the patient,"* rather than being synonymous with the "*spinal adjustment*".[68]

SUMMARY

In considering the variety of presenting symptoms, this paper looked at some of the inconsistencies in definitions of the term *symptom*. It was felt that there were certain limitations in the generally accepted understanding as to what classified as a symptom.

A further issue concerned whether a *condition* not listed in the ICD is still a 'disease' – or at what stage does a biological condition qualify to become a disease? If by definition, a symptom is indicative of a disease, then the key issue for the manipulative professions is whether a symptom caused by a VSC implies that the VSC is in fact a *disease*. Even though it may be listed in the ICD-10 as a 'biomechanical lesion', this would be hardly specific enough to cover the wide range of possible symptoms associated with VSC's.[25] The ICD category would need to be extended further to delineate various biological structures and pathophysiologic conditions supplied by the disturbed neurophysiology within a VSC.

Consideration was also given to whether *all* forms of symptoms should be regarded as part of conditions or disease processes that would qualify for listing in the ICD. That issue could essentially be expressed as, 'Can one have a symptom without it being generally thought of as indicative of a 'disease'?' For example, *is pain a disease?*[69-71]

The many definitions of the term symptom do not appear to adequately cover all possible clinical situations. As such, we would propose a broader definition, or new terms. Possible new terms could include:

- Descriptive Symptoms
- Symptoms Complex
- Pathophysiological Symptoms. This term could form part of a definition for the first two. *Dys-ease, Dysfunction, Dys-comfort,* could also conceivably be seen as symptoms of a pathophysiological condition in an expanded definition.

It could also be said that there is general patient acceptance and understanding of 'traditional' or common symptoms. But this general understanding of a symptom

would seem to be limited in scope, when one considers the terminology emerging from other health professions.

Given the wide range of signs and symptoms which present to a primary contact chiropractic practice, and considering the trend towards health maintenance, wellbeing, and preventive care, there would appear to be a case for continued studies to explore and develop the perceived potential of the VSC as a central factor in a number of symptoms.

Today, with multi-disciplinary clinics, and inter-professional collaboration and co-operation in research, as well as in conference presentations, and a greater understanding between the professions, a more comprehensive definition of symptom, disease, and conditions, seems necessary.

CONCLUSION

This discussion portrays limited examples of the wide range of patient symptoms presenting to chiropractors. The nature of these particular conditions present in various forms as a lack of well-being. The alleviation of such ailments contributes towards the maintenance of a patient's health status.

It is noted that the conditions or symptoms cited in this paper are not normally found in traditional textbooks. They represent a range of patients, who by initiating consultations, are deserving of serious acceptance and resolution of their health complaints. Such a broad non-specific range does not appear to be covered by the ICD-10, nor specified as being spine-related.

The issues discussed tend to suggest that some patients choose to monitor and maintain their sense of well-being by seeking maintenance health care, whereby they address early symptom appearance by preventive care.

The cited variety of patient-nominated symptoms, mostly in the absence of more serious pathology, would suggest that at least some patients are aware of their health status and are more pro-active in remaining symptom-free, at what they see as their optimal level of health and comfort.

As part of this, there would seem to be a need to clarify and classify spine-related symptoms, syndromes, disorders and conditions – especially those biomechanical lesions that could be classed as being related to a VSC, and ones capable of being resolved by spinal adjustments. Further, studies and consensus would be required to finalise such a proposal as mentioned here.

Inasmuch as atypical symptoms can be the motivating factor behind a patient seeking relief or health care, and just because they may seem "unexplained" as an organic disease,[14] they should be worthy of a designation because they are regarded as negative sensations by the patients. While they may be designated as unexplained, it does not necessarily mean that they do not exist physically. It may be that science has yet to accept or explain their association or aetiology.

Given that there are so many unrecognised symptoms, (up to 52%[49]) it would seem that there may be limitations as to recognising all biological possibilities. Alternatively, this may imply that traditionally, there is a limited adoption of all biological possibilities in the traditional model[12], and that the catalogue of symptoms is indeed incomplete.

In cases identified as being spine-related, a clearer definition of the term 'symptom' is indicated. We would also submit that a VSC hardly classifies as a 'disease' as in the 'International Classification of *Diseases*'. It would be deemed more of a condition or disorder than a disease. In addition, the term 'biomechanical lesion' is not definitive enough, given the nature and variety of VSC's.

Where patients respond to spinal adjustments, a number of classifications could be designated Vertebral Subluxation Related Disorders (VSRD), identified by Vertebral Subluxation Related Symptoms (VSRS) and/or signs.

To our knowledge, a paper of this nature has not previously appeared in the referenced literature.

"Listen to the patient' and their words will tell you the diagnosis".- Sharma[72]

REFERENCES.

1. Seaman DR, Winterstein JF. Dysafferentation: A novel term to describe the neuropathophysiological effects of joint complex dysfunction. A look at likely mechanisms of symptom generation. J Manipulative Physiol Ther 1998;21(4):267-280.
2. Santos EH, Stainbrook E. Nursing and modern psychiatry. Am J Nurs 1949;49(2):107-109.
3. Smith R. In search of "non-disease." BMJ 2002;324(7342):883-885.
4. Wessely S, White PD. There is only one functional somatic syndrome. Br J Psychiatr 2004;185:95-96.
5. Wessely S, Nimnuan C, Sharpe M. Functional somatic syndromes: one or many? Lancet 1999;354(9182):936-939.
6. Meador CK. The art and science of nondisease. N Engl J Med 1965;272:92-95
7. Nahun LH. The non-disease clinician. Conn Med 1965;29:165-166.
8. http://www.who.int/suggestions/faq/en/index.html
9. Problems with the WHO definition of 'health'. web.aanet.com.au/.../Problems%20with%20the%20World%20Health%20definition%20of%20'health'.HTM.
10. Saracci R. Education and debate: The World Health Organisation needs to reconsider its definition of health. BMJ 1997;314(7091):1409-1410.
11. Gillon R. On sickness and on health. Br Med J (Clin Res Ed) 1986;292(6516:318-320.
12. Guedes CR, Nogueira MI, de Camargo KR. [Vague and diffuse symptoms in biomedicine: a review of the literature.] Cien Saude Colet 2008;13(1):135-144. Abstract (Portuguese)
13. Walker J, Sharpe M, Wessely S. Commentary: Symptoms not associated with disease: an unmet public health challenge. Internat J Epidemiology 2006;35:477-478.
14. Stone J, Carson A, Duncan R, et al. Symptoms 'unexplained by organic disease' in 1144 new neurology out-patients: how often does the diagnosis change at follow-up? Brain 2009;132:2878-2888.
15. Aggarwal VR, McBeth J, Zakrzewska JM, Lunt M, Macfarlane GJ. The epidemiology of chronic syndromes that are frequently unexplained: do they have common associated factors? Int J Epidemiol 2006;35(2):468-476.

16. Wessely S. What do you think is a non-disease? (Letter) BMJ 2002;324:912.
17. Warren JR, Marshall B. Unidentified curved bacilli on gastric epithelium in active chronic gastritis. Lancet 1983;321(8336):1273-1275.
18. O'Neill G. Science watch. Aussies upset stomach folklore. Sunday Herald Sun, Melbourne, Australia (Newspaper) April 21, 1996;75.
19. Katon W, Sullivan M, Walker E. Medical symptoms without identifiable pathology: relationship to psychiatric disorders, childhood and adult trauma, and personality traits. Ann Int Med 2001;134(9 Pt 2) 917-925.
20. Barsky AJ, Borus JF. Functional somatic syndromes. Ann Int Med 1999;130(11):910-921.
21. White C What do you think is a non-disease. (Letter) BMJ. 2002;324:913-914.
22. Barbe MF, Barr AE. Inflammation and the pathophysiology of work-related musculoskeletal disorders. Brain Behav Immun 2006;20(5)423-429.
23. Collins English Dictionary. 2nd ed. Glasgow: Harper Collins;1992.
24. Douthwaite AH Ed. French's index of differential diagnosis. 9th edn. Bristol: John Wright & Sons Ltd, 1967:Preface.
25. icd10cmcode.com/abouticd10.php
26. Dorland's Illustrated Medical Dictionary. Agnew LRC, Avaido DM, Brody JI, et al. eds. 24th edn. Philadelphia: WB Saunders Co;1965.
27. Dorland's Medical Dictionary for Health Consumers. WB Saunders, an imprint of Elsevier, Inc. http://medical-dictionary.thefreedictionary.com/dys. 2007.
28. Webster's New Twentieth Century Dictionary of the English Language. McKechnie JL. ed. 2nd edn. Cleveland: The World Publishing Co;1960.
29. Mosby's Medical Dictionary, 8th edition. 2009, Elsevier. Online etymology dictionary. http://www.entymonline.com/index.php
30. Collins English Dictionary. Hanks P. Chief Ed. 2nd edn. Glasgow: HarperCollins;1990
31. Collins Concise Dictionary. Makins M. Managing. Ed. Sydney: Harper Collins Publishers; 1995.
32. The Oxford Dictionary of Current English. Sykes JB. ed. 7th edn. Oxford; The Clarendon Press. 1982.
33. The Oxford School Dictionary. Mackenzie DC. Oxford. Oxford University Press 3rd edn 1974.
34. The Concise Oxford Dictionary. Thompson D. Oxford: Clarendon Press; 1995.

35. www.chiro-online.com/interadcom/dcgloss2.html
36. memory.ucsf.edu/ftd/overview/biology/terminology
37. Taber's Cyclopedic Medical Dictionary. Taber CW. ed. 10th edn. Philadelphia: FA Davis Co; 1965.
38. Anon. www.painsummit.org.au. Pain Summit Summary. 2009, 17th September. Melbourne.
39. Kerns, R.D., Wasse, L., Ryan, B., Drake, A., Booss, J. (2000). Pain as the 5th Vital Sign Toolkit. V.2.. Washington, D.C.: Veterans Health Administration http://vaww.va.gov/pain_management/508FrameTest2.htm. [Veterans Health Administration Memorandum: Pain as the Fifth Vital Sign. March 1, 1999. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1924634]
40. Mularski RA, White-Chu F, Overbay D, MillerL, Asch SM, Ganzini L. Measuring pain as the 5th vital sign does not improve quality of pain management. J Gen Intern Med 2006;21(6):607-612.
41. Keamy M, Kolbe A, O'Connor M, Dean R. http://mkeamy.typepad.com/anesthesiacaucus/2007/08/pain-the-sixth-.html
42. Schiavenato M, Craig KD. Pain assessment as a social transaction. Clin J Pain, 2010;26(8):667-676.
43. van Bokhoven MA, Koch H, vander Weijden T, et al. Influence of watchful waiting on satisfaction and anxiety among patients seeking care for unexplained complaints. Ann Fam Med 2009;7(2):112-120.
44. Gatterman MI. Foundations of chiropractic subluxation.. 2nd edn. St. Louis, Miss. Elsevier Mosby; 2005.
45. Leach RA. The chiropractic theories. principles and clinical applications. 4th edn. Baltimore: Williams & Wilkins. 2004.
46. Haldeman S. (Ed). Principles and Practice of Chiropractic. 3rd edn. Appleton-Century-Crofts, Norwalk, Conn. 2004.
47. Carson AJ, Ringbauer B, Stone J, McKenzie L, Warlow C, Sharpe M. Do medically unexplained symptoms matter? A prospective cohort study of 300 new referrals to neurology outpatient clinics. J Neurol Neurosurg Psychiatry 2000;68:207-210.
48. Webb EC. Australian Committee if Inquiry into Chiropractic, Osteopathy, Homeopathy, and Naturopathy. Canberra: Australian Government Publishing Service;1977:49, 499-500.

49. Nimnuan C, Hotopf M,Wessely S. Medically unexplained symptoms: an epidemiological study in seven specialities. J Psychosom Res 2001;51(1):361-367.
50. Seminowics DA, Wideman TH, Naso L, et al. Effective treatment of chronic low back pain in humans reverses abnormal brain anatomy and function. J Neurosci 2011;31(20):7540-7550.
51. Noyes R, Stuart SP, Watson DB. A reconceptualization of the somatoform disorders. Psychosomatics 2008;49(1):14-22.
52. World Health Organisation's publication, World Classification of Diseases (ICD-10) Chapter X111, 2006. http://www3.who.int/icd/currentversion/fr-icd.htm. http://apps.who.int/classifications/apps/icd/icd10online/
53. Harding S, Swait G, Jonson IP, Cunliffe C. Utilisation of CAM by runners in the UK: A retrospective survey among non-elite marathon runners. Clin Chiropr 2009;12(2):61-66.
54. Rupert RL. A survey of practice patterns and the health promotion and prevention attitudes of US chiropractors. Maintenance care: Part I. J Manipulative Physiol Ther 2000;23(1):1-9.
55. Kessinger RC, Boneve DV. Case study: acceleration/deceleration injury with angular kyphosis. J Manipulative Physiol Ther 2000;23(4):279-287.
56. www.thefree**dictionary**.com/sources.htm The American Heritage Medical Dictionary 2007, Houghton Mifflin Company.
57. Nansel D, Jansen R, Cremata E, Dhami MSI, Holley D. Effects of cervical adjustments on lateral-flexion passive end-range asymmetry and on blood pressure, heart rate and plasma catecholamine levels. J Manipulative Physiol Ther 1991;14(8):450-456.
58. Gatterman MI. Chiropractic management of spine related disorders. Baltimore: Williams and Wilkins; 1990, 235, 249-252
59. Hall TM, Briffa K, Hopper D Robinson KW. The relationship between cervicogenic headache and impairment determined by the flexion-rotation test. J Manipulative Physiol Ther 2010;33(9):666-671.
60. Vavrek D, Haas M, Peterson D. Physical examination and self-reported pain outcomes from a randomised trial on chronic cervicogenic headache (RCT). J Manipulative Physiol Ther 2010;33(5):338-348.

61. Denny EM. Chiropractic intervention for cervicogenic headache in a pediatric patient. J Clin Chiropr Pediatr. 2008;9(1):547-552.
62. Fitz-Ritson D. Assessment of cervicogenic vertigo. J Manipulative Physiol Ther 1991;14(3):193-198.
63. Bogduk N. Cervicogenic headache: anatomic basis and pathophysiologic mechanisms. Current Pain Headache Reports. 2001;5(4):382-386.
64. Winett B. There is value in anecdotal reports of relief from migraine with botulinum toxin. J Manag Care Pharm. 2009;15(1):78-79.
65. Altman DG, Bland M. Absence of evidence is not evidence of absence. British Medical Journal, 1995;311:485
66. Vandenbroucke JP. In defence of case reports and case series. Ann Inter Med. 2001;134(4):300-334
67. Campo R. "Anecdotal evidence": why narratives matter to medical practice. PloS 2006;3(10)"e423. dol:1371/journal.pmed.0030423.
68. Hawk C, Long CR, Boulanger KT. Prevalence of nonmusculoskeletal complaints in chiropractic practice: reports from a practice-based research program. J Manipulative Physiol Ther 200124(3):157-169.
69. Bradshaw Y. Is pain a disease? es.tufts.edu/prep/2009/02/22/is-pain-a-disease-or-a-symptom/
70. Dreaper J. Pain: should be viewed as a disease in its own right. BBC News forums.ivillage.com/t5/News-items…/Is-Pain-a-Disease…/2761492
71. Benson K. Push to take chronic pain seriously. The Age, Melbourne 2009;Oct 19:5 Col 3-5. (Citing Prof M Cousins, www.painsummit.org.au Melbourne 2009.)
72. Sharma OP. Listen to the patient: they will tell you the diagnosis. Current Opinion Pulmonary Med 2001;7(5):253-254.

TABLE 1.

INFORMAL SURVEY OF PATIENTS' RESPONSES TO THE QUESTION OF
"What benefit do you get from ongoing chiropractic care?"
In their own words.
Some of the motivating factors described by patients in their own words.
Do these constitute symptoms per se?

- "Adjustments help me cope with stress better. I am less panicky."
- "Adjustments reduce my asthma. I use less Ventolin."
- "After a visit to the chiropractor I have better bowel function."
- "After being adjusted my range of neck movement improves, I think that may delay degeneration."
- A nine year old, hyperactive boy, was asked what benefit he felt he got from ongoing adjustments. He pointed to his chest and said "Peace" when asked, "What else?" He responded, "Does there need to be anything else?"
- A singer sought adjustments because she felt she could simply "Sing better".
- "Can that affect my breathing, because I can breathe easier?"
- "Decades ago I had frequent migraines, recurrent neck pain, and I always seemed to catch whatever was going around. Regular care seems to have stopped all that."
- "Following chiropractic treatment Mason (16 months old) is now like a new baby. His grizzling, crying and moaning has gone, and he is now a smiling, happy, and inquisitive little boy who spends his days exploring cupboards…"
- "For years I have had groin pain when I started to walk, regular adjustments minimize that."
- "Hey, I can see more clearly."
- "I am more articulate."
- "I came because when I am adjusted I get a relief from the sense of tension in my bowels."
- "I can deal with life a lot easier than if I didn't have regular care."
- "I can get my arm up to write on the board and hang washing out."
- "I come because adjustments reduce my confusion, what is in my thoughts is not what I say, when I am adjusted my word order improves."
- "I feel crotchety."
- "I feel a loss of concentration and acuity."
- "I feel less confused."

- “I feel more centred with more energy for recreation."
- “I feel that after being adjusted my sense of health improves immediately."
- “If I am adjusted on a regular basis my moods don't fluctuate anywhere near as much and my hay fever is far less severe."
- “I find I have less elbow pain, improved calmness, and my eyes are less sore and tired."
- “I get adjusted regularly so that I have less period pain."
- "I get happier and feel healthier."
- “I lose my desire to go to bed too early.”
- “Improvement, that’s what I’m paying you for.”
- "I no longer catch everything that goes around and my moods are better. I pay you to keep me healthy and happy."
- “I simply feel more confident."
- “I noticed that while having regular chiropractic care my golf improved heaps. In 1995, my (golf) handicap was 45 and it same down to 14 as of October 1997.”
- “It improves the quality of my life.”
- “It is great that I actually need to sleep after an adjustment."
- "I used to have one migraine a week and that has stopped."
- “J” a chorister, surprised with this comment; "When my spine is well adjusted I gain greater depth and resonance, when singing I hold deeper notes and easily sing in tune."
- ML was a 49 year old male executive. He stated that he always knew when he needed a neck adjustment because his thinking was garbles and he lost concentration abilities.
- “My daughter’s lazy eye used to deviate, that is no longer as noticeable. Her emotional related hives are nowhere near as severe or frequent, and she now eats what the others eat at meal-times.”
- “My golf game is off.”
- "My migraines went from one a week to one a month."
- “My moods improve. I am less tense. I have more energy."
- "My previous bouts of acute low back pain don't recur if I have regular adjustments."
- "My stinging eyes stop."
- "My vision improves".

- Patient D, an 8 year old boy, suggested to his mother after a stressful session of hyperactivity, irritability and aggressive behaviour, that he should be taken to his chiropractor by saying “I think I need to see the chiropractor.’
- “Prevents sinusitis headaches and painful eyes. My nose does not get red and blocked."
- “Prior to being adjusted I could not recognise symptoms that meant I should see a chiropractor. After being adjusted I can compare my differences. That experience of knowing what is different and what I can do about it is very reassuring."
- “Prior to being adjusted I find it hard to start sleeping, after an adjustment I can fade off”
- "Regular care helped me avoid having an advised lower back operation."
- "Regular care seems to keep my health on an even keel."
- "Spinal adjustments improve my libido."
- “To avoid back surgery.”
- “To avoid contagious ‘flues.”
- "When I have been adjusted I can control getting upset."
- “When I need to be adjusted I get negative and upset, I can't concentrate, I feel restless and I don't want to go to bed." (Patient X then went on to clearly describe how after being adjusted those symptoms reversed.)
- "When my back is out, my old fracture of the knee pains intolerably and when my back is adjusted the pain in the knee goes away."
- “When my spine is well adjusted, I gain greater depth and resonance when singing (and) I hold deeper notes and easily sing in tune.”
- "With regular adjustments and exercise I am able to remain mobile and in less pain, without the aid of any drugs."
- "With regular adjustments I can do light exercises. I am headache free and my health is immensely improved."
- "With regular care I don't get low back pain, I feel better and have fewer headaches."
- “You adjust my back and my foot pain goes.”

(It is interesting to note that while these patients report symptoms, the clarity of their sense of wellbeing tends to suggest more of a diagnostic condition, many of which may not be a so-called named condition. - Au)

APPENDIX 1.

SYMPTOM PICTURE OF A SINGLE CASE.

MS was a 69 year old male retiree who had attended various health practitioners for over 10 years following whiplash in a motor vehicle accident. On attending a chiropractor he found he responded best to particular vertebral adjustments. MS chose symptomatic care following an initial course of spinal adjustments. He determined for himself when he needed SMT. On one occasion he was asked what symptoms made him aware of this. The next visit he provided the following list. He noted that these symptoms did not all occur at the same time, and were in varying degrees of severity. Although his practitioners were wary of the obvious orange flags (and at times red) that were evident, he had been cleared through MRI, neurological and various other examinations for potentially serious underlying pathology. On any particular occasion, various combinations of these symptoms could all be present. He reported that they resolved almost immediately following a specific adjustment on almost every occasion. Not only that, but the patient was astute enough to request specific adjustments, and even the order in which those adjustments should be carried out for best results .

Blood nose (Epistaxis)
Blurred vision
Face becomes florid with small vein dilation
Giddiness
“Head does not swivel correctly.”
Irritability
“Light headedness”
Localised and constant pain over the left eyebrow
Migraine
Pins and needles bilaterally
Saliva dribble from the left corner of the mouth (Ptyalism)
Severe neck cramps only on left side
Shortness of breath.
Slurred speech
“Sore eyeballs”
Swollen lips

Tendency to pull to the right when driving

Unable to think clearly

This patient listed the above symptoms upon request, but stated that over many years, no other treatment eliminated them., and that they were “immediately rectified by a neck adjustment”. Such symptoms are not infrequent in isolation. But it should be noted that many of them, particularly in combination do raise “red flags” and could be of concern. However, chiropractors are aware of these possible ‘danger signs’, and approach the case with necessary caution, then examine and manage accordingly.