Letter that questions OCF requires no response

To the Editor:
I am writing in regard to the letter by James M. Norton, PhD, "Questioning of OCF should rouse osteopathic response" (*JAOA* 2000;100:763).

Dr Norton appears to require a response from those in the osteopathic medical profession who have used and are using a "ten-fingered" cranial approach as a part of their practices. Perhaps individuals within the profession have not responded publicly because they feel that Dr Norton and others are incorrect in their findings and, therefore, a response is unnecessary.

Over time, clinical evaluations by palpation and management have proven the cranial methods and concepts of William G. Sutherland, DO, and others to be valid. The approach is not esoteric or illusory, but it is subtle.

Research by Harold Lippincott, DO, Viola Frymann, DO, Zvi Karni, PhD, John Upledger, DO, Fred Mitchell, DO, and others has proven with evidence from polygraphic recordings and special anatomic dissections that cranial motion exists and can be palpated by the well-trained, experienced therapist. These researchers also found that cranial motion (or whatever you wish to call it) is an individual motion in complete balance with all of the other rhythms of the body (in healthy individuals), and that these rhythms are expressed through each individual's neurophysiology.

I hope Dr Norton's intentions are clearly altruistic and alerting for the osteopathic profession and its positive mission of good patient evaluation and management with positive outcomes.

Richard C. MacDonald, DO
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Innovative approach to headaches

To the Editor:
I would like to describe what I believe is a previously unrecognized cervical reflex that is produced when intramuscular anesthetic blockade is placed near the 7th cervical spinal level. Over the past 5 years, this myofascial trigger-point injection at the C7-T1 level has produced reliable and rapid headache relief in patients seen in a private pain practice. This lower cervical injection is unique because it is identified by a characteristic paresthesia that rises to the ipsilateral occiput followed by rapid and consistent headache relief. The paresthesia is most reliably generated in the lowest cervical levels.

For successful completion of this simple procedure, the anesthetic blockade is placed at approximately the 7th cervical spinal level. The best level may be found slightly lower in some patients. Patients report a distinctive paresthesia that ascends to the upper cervical spine or ipsilateral occiput. This rising paresthesia is often described as tingling, cold, numb, releasing, or a heavy sensation. Immediate ipsilateral headache relief typically follows. Should the patient report a descending paresthesia, the needle should be redirected upwards or the needle can be withdrawn and reinserted at a slightly higher cervical level. Following the injection, application of pressure to the ipsilateral occiput will typically reveal greatly diminished allodynia and mechanical hyperalgesia that occurs in conjunction with headache relief.

This treatment consists of a simple myofascial trigger point injection 2 cm to 4 cm lateral to the 7th cervical and upper 1st thoracic spinous processes. Once the region is identified and sterile field has been prepared, 0.5 mL to 1 mL of 0.25% or 0.5% bupivicaine hydrochloride is introduced with a 25-gauge, 1.5-inch needle 0.5 inch to 1 inch into the spinal paravertebral muscles. For long-term anti-inflammatory relief, the provider may choose to add a small amount of methylprednisolone acetate.

This injection is effective for migraine, muscle tension, cervicogenic headache, and most other headaches, including acute and chronic posttraumatic headaches. As the needle is inserted approximately 2 cm to 4 cm lateral to the spinous processes and is intramuscular, there is minimal risk to the patient. Disadvantages of this procedure are patients' fear of needles and some minor discomfort at the injection site.

As many structures in the cervical spine are capable of generating pain and many headaches are associated with cervical spine hyperalgesia, it is remarkable that such rapid and complete headache relief could follow an ascending paresthesia from the 7th cervical level.

It is well known that the autonomic nervous system contributes to the severity of various classifications of headaches. I believe that the trigeminovascular system and/or sympathetic nervous system are potential anatomic substrates for headache relief in these patients.

An excellent anatomic appraisal of pain syndromes of the cervical spine by Bogduk[1] implicates the intersegmental sympathetic innervation via the vertebral and sinuvertebral nerves and the trigeminovascular system as the causes of neck pain and headaches. The sinuvertebral nerves are believed to accompany the vertebral artery as a repeating series of intersegmental sympathetic anastomoses from C2 to C7. Blume[2] reported effective cervicogenic headache relief with radiofrequency neurotomy to the sinuvertebral nerves in the C3 and/or C4 roots.

The trigeminal nucleus caudalis[3] and high cervical region are involved in generating of headache and facial pain. These trigeminocervical nuclear neurons are the site for referral of head pain. This anatomic arrangement accounts for the distribution

of pain in migraine and many other forms of headache[4] and provides an anatomic explanation for the referral of pain to the forehead and back of the head in migraine. Furthermore, it is known that a substantial portion of the trigeminovascular nociceptive information comes by way of the most caudal cells in the cervical spine.[3]

Most traditional headache specialists believe that headache generation is limited to no lower than the upper two to three cervical spinal levels. Although cervical involvement in headache generation is still vigorously debated in the United States, European medical literature describes the posterior cervical sympathetic syndrome and cervical migraine, where it is alleged that the vertebral nerve is involved due to osteophytic irritation.[5] This irritation is thought to influence the posterior circulation, resulting in the migraine symptom complex.

The neuropathophysiologic mechanism of rapid headache relief found with this precise intramuscular injection has many characteristics of a reflex. Somatosympathetic spinal reflexes have been recognized for more than 50 years,[6-8] and referred pain is commonly recognized in day-to-day practice.[9,10] Reflex headache relief from paravertebral intramuscular injection has not been previously reported.

I feel that this previously unreported cervicocranial reflex validates the tenets of osteopathic medicine and that this reflex might be the mechanism of headache relief first illustrated in the 19th century by Andrew Taylor Still, MD, DO, the founder of osteopathic medicine. Perhaps an understanding of this reflex might explain why different headaches have many common symptoms, and it may clarify some aspects of headache classification.

The headache relief imparted by this proposed somatosympathetic-trigeminovascular cervicocranial reflex merits further research by the medical community. If corroborated, this novel theory will likely allow physicians to avoid other more complex, time-consuming treatments and reduce medication prescriptions.

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More on spirituality

To the Editor:

In an editorial (*JAOA* 2000;100:775), John M. Travaline, MD, and Gilbert E. D'Alonzo, DO, warn physicians to proceed with caution when bringing spirituality into their practices. Perhaps these clinicians are confused as to their roles and are in need of the Spirit.

Physicians are beginning to show an increased interest in how spirituality affects their patients' health. They now realize that spirituality has influenced how medicine is practiced today. This is evidenced by the increasing numbers of lay articles and television time devoted to spirituality factors in healing.

This is not a new interest, as the historical evidence of the relationship between spirituality and medicine dates back to the beginning of written records. This relationship began to be studied and researched in the United States in the early 1950s. One such research project was the Redmond Study, which looked at the effect of prayer on healing and the clinical course of various diseases. Today, many physicians do not even consider the potential health benefits of a patient's faith and spirituality because they were never taught to do so.

Five years ago, few medical schools in the United States devoted any part of their curriculum to the teaching of spirituality in medicine. Today, about half of all medical schools in our country have courses that teach this aspect of medicine. It is with special interest and pride that I note that many osteopathic medical schools have enacted this important curriculum revision. The osteopathic triad is body, mind, and spirit, and osteopathic medicine has ignored spirituality far too long.

Today's students who are fortunate enough to have had a course in spirituality now have an adjunct to their medical armamentarium. This adjunct hopefully lies within each patient and can be called on to assist in recovery from illness. One of today's best-known spirituality researchers is Herbert Benson, MD. He has investigated the healing power of faith extensively and is known for his best-selling book, *The Faith Factor*. His work has encouraged many to pursue research in this exciting aspect of medicine.

Drs Travaline and D'Alonzo state, "We must be careful. Engaging in the area of spirituality in the context of a physician-patient relationship raises a number of potential ethical issues. In making an inquiry into a patient's spiritual well-being, a physician may create some confusion with respect to his or her role as a healer."

We, as physicians, aid our patients in the healing process and strive to improve their quality of life. "We must be ever mindful of the body's inherent capacity to heal itself." Sound familiar?

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To the Editor:

I read with interest the editorial by John M. Travaline, MD, and Gilbert E. D'Alonzo, DO (*JAOA* 2000;100:775), regarding

the article by Donald G. Spaeth, DO (*JAOA* 2000;100:641-644). The editorial seems rather negative about physicians incorporating spirituality into their patient care, as revealed in the comments: "... time and attention paid to spirituality in the context of patient care must exist as an adjunct to conventional medical practice and should not be substituted for any aspect of this care," and "Physicians need to be careful in entering into spiritual matters with their patients in the context of the professional-patient relationship." Thus, your editorial reflects a rather utilitarian and secular viewpoint of the physician-patient relationship. Or perhaps that was just my impression of the tenor of the piece.

I concur with you that we must be careful, but we must also be intelligent, educated, and spiritual when we deal with spirituality! Your viewpoint came across rather one-sided in its conclusions and is reminiscent of a piece written by four hospital chaplains (available at: *www.nejm.org/content/2000/0342/0025/1913.asp*) with letters sent in response (available at: *www.nejm.org/content/2000/0343/0018/ 1339.asp*) and a relevant article (available at: *www.aafp.org/afp/20010101/contents.html*) along with comments by several editorialists (available at: *www.aafp.org/afp/20010101/medicine.html*).

We have three professional chaplains and a couple of lay volunteers at our 300-bed facility, which has 90% occupancy. As the volume of their work is high, they can only attend to inpatient and occasional employee needs, making clear the need for religious training and/or counseling education for physicians. I suggest that we can and should participate in the spiritual care of our patients. It is a simple fact that my patients want me to discuss spiritual matters in the context of my practice of medicine and cardiology.

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Southern California Permanente Medical Group
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OFFICIAL CALL

To the officers and members of the American Osteopathic Association:

You are hereby notified that the annual business meetings of the American Osteopathic Association will be held July 10–15, 2001, at the Fairmont Hotel in Chicago.

The opening session of the annual meeting of the Board of Trustees will be held at 8:30 AM on Tuesday, July 10.

The House of Delegates will convene for the annual business session of the association at 10:30 AM on Friday, July 13. All meetings of the House of Delegates will be held at the Fairmont. The House's Committee on Credentials will register delegates and alternate delegates beginning at 8 AM on Friday, July 13. The House will conclude its session on Sunday, July 15.

By Monday, June 11, the secretary of each state osteopathic medical association and each osteopathic specialty college must certify to the Executive Director of the American Osteopathic Association a list of names and addresses of delegates and alternate delegates.

Donald J. Krpan, DO
President

Mark A. Baker, DO
Speaker of the House