As the premier scholarly publication of the osteopathic medical profession, JAOA—The Journal of the American Osteopathic Association encourages osteopathic physicians, faculty members and students at colleges of osteopathic medicine, and others within the healthcare professions to submit comments related to articles published in the JAOA and the mission of the osteopathic medical profession. The JAOA’s editors are particularly interested in letters that discuss recently published original research.

Letters to the editor are considered for publication in the JAOA with the understanding that they have not been published elsewhere and that they are not simultaneously under consideration by any other publication.

All accepted letters to the editor are subject to editing and abridgement. Letter writers may be asked to provide JAOA staff with photocopies of referenced material so that the references themselves and statements cited may be verified.

Although the JAOA does not acknowledge the receipt of letters, a JAOA staff member will notify writers whose letters have been accepted for publication. Mailed submissions and supporting materials will not be returned unless letter writers provide self-addressed, stamped envelopes with their submissions.

All osteopathic physicians who have letters published in the JAOA receive continuing-education (CME) credit for their contributions. Writers of original letters receive 5 hours of AOA Category 1-B CME credit. Authors of published articles who respond to letters about their research receive 3 hours of Category 1-B CME credit for their responses.

Although the JAOA welcomes letters to the editor, readers should be aware that these contributions have a lower publication priority than other submissions. As a consequence, letters are published only when space allows.

Musculoskeletal Dysfunction and Drop Foot: Diagnosis and Management Using OMM

To the Editor:

I read with great interest the case report in the December 2009 issue of JAOA—The Journal of the American Osteopathic Association by John M. Lavelle, DO, and Mark E. McKeigue, DO, regarding osteopathic manipulative treatment (OMT) of a patient with drop foot. Lavelle and McKeigue reported that a single 15-minute OMT session resolved their patient’s symptoms. I have had extensive experience treating patients with OMT for nerve compression, particularly carpal tunnel syndrome, over 3 decades. Yet, I have never enjoyed the experience of seeing a patient get off the examination table with instantaneous recovery of three grades of muscle strength—from a grade of 1/5 to one of 4/5.

I commend the authors’ recognition of the cause of nerve injury in the case they present (ie, a compressed common peroneal nerve caused by posterior fibular head dysfunction), as well as their knowledge and abilities to apply OMT at the fibular head to alleviate the nerve compression. However, although the authors properly describe the pathoanatomic condition of the patient, they do not address the pathophysiologic change that explains the remarkable and rapid resolution of muscle weakness in this case. It was obviously a case of motor conduction block, also known as neuapraxia. Neuapraxic lesions most commonly result from acute nerve compression, and “recovery is complete within days or weeks,” according to Oh. Oh also notes that it is important to recognize those cases that involve neuapraxia “because of the good prognostic implication” in such cases. A determination of neuapraxia can be obtained only with electrodagnostic (EDX) testing, which is vital to rule out other causes of drop foot. These other causes commonly include L5 radiculopathy, lumbosacral plexopathy, motor neuron disease, and sciatic mononeuropathy.

Wilbourn, who has written extensively on peroneal neuropathy, states, “The EMG [electromyographic] examination is a superb diagnostic study for the evaluation of foot-drop [ie, drop foot] in general and peroneal mononeuropathies in particular.” Wilbourn classifies the conduction block type of lesion as “Type 2.” This type of lesion is common, though it is not seen as often in the clinical setting as the “Type 1” pattern of mixed axon loss and conduction block. Wilbourn also notes that conduction block lesions have an “excellent prognosis” and rarely require surgical intervention.

Typically, conduction block lesions do not become apparent (via EDX testing) until 7 to 10 days after the nerve becomes compressed. Therefore, it appears that Lavelle and McKeigue made a reasonable decision to avoid EDX testing in the case of their patient, who first noticed symptoms the day before visiting the primary care office.

Many osteopathic physicians may believe that an immediate and rapid recovery as described by Lavelle and McKeigue is unlikely, and that the patient’s “recovery” may instead sug-
gest a type of pseudoparalysis, possibly induced by pain inhibition. Nevertheless, the literature supports such a recovery in the early phase of acute motor conduction block. In their classic 1944 study, Denny-Brown and Brenner, who applied external pressure to laboratory animals’ nerves and measured the times to paralysis and recovery, noted the following:

Further, the time of recovery might be expected to vary in proportion to the latent period, for the more complete the ischemia the less rapid should be the recovery. No such relationship was observed. Recovery tended to either begin immediately or to be much delayed, without relation to the pressure employed or to the latent interval of conduction failure. Thus, after exposure to 56 cm of pressure, with failure of conduction in twenty-seven minutes, recovery in 1 experiment began immediately on release. In another experiment, after failure in twenty-five minutes, recovery began six minutes after release.

The case presented by Lavelle and McKeiguel is extremely unusual. It is highly unlikely that the average osteopathic physician will see a patient arrive at his or her office 1 day after onset of a relatively benign neurapraxic lesion, and that the osteopathic physician will know how to apply OMT to resolve the patient’s condition. An osteopathic physician may be more likely to encounter a patient who has been experiencing foot drop symptoms over an extended period—cases that would not be neurapraxia. I am concerned that the authors did not emphasize the importance in such cases of pursuing a definitive diagnostic workup and considering alternative or more aggressive treatments for patients.

Benjamin M. Sucher, DO
Medical Director, EMG Labs of Arizona Arthritis and Rheumatology Associates, Paradise Valley, Arizona

References

Response
I appreciate the interest shown by Benjamin M. Sucher, DO, in the case report that Dr McKeigue and I wrote for the December 2009 JAOA. Dr Sucher discusses a vital issue in regard to the diagnosis of drop foot. As he mentions in his letter, it is essential to rule out severe causes of drop foot. Therefore, a detailed history and physical examination, including an appropriate osteopathic examination, of the patient are necessary. Further diagnostic testing, such as magnetic resonance imaging or electrodiagnostic testing, should be performed if the diagnosis remains unclear and if the results of these tests would change the treatment of the patient. Nerve conduction testing and electromyographic examination are important adjuncts in localizing the cause of injury, in determining the extent of damage, and in making a prognosis for the patient.

After severe causes of injury have been ruled out by detailed neurologic and osteopathic examinations, the first treatment approach used by the osteopathic physician should be conservative application of osteopathic manipulative treatment (OMT).

As Dr Sucher suggests, the patient in our case report likely had a simple crush injury, without focal demyelination, resulting from nerve compression with the fibular head. This type of simple nerve injury was originally classified by Seddon as neurapraxia that “occurs with a crush or sustained compression to an area of the body where a peripheral nerve is vulnerable.” Seddon also states, “Recovery from neurapraxia is remarkably rapid—indeed, so speedy that it cannot possibly be explained in terms of axonal regeneration.” Furthermore, Salter notes the following in regard to neurapraxia:

There is only slight damage to the nerve with transient loss of conductivity, particularly in its motor fibers. Wallerian degeneration (breakdown of the myelin sheaths into lipid material and fragmentation of the neurofibrils) does not ensue and complete recovery may be expected within a few days or weeks.

For the patient featured in our case report, we concluded that the nerve injury was secondary to compression of the fibular head, based on findings within the detailed physical examination. According to Siegel, “Neurapraxia related to pressure has an improved prognosis if the nerve is decompressed early.” Dr McKeigue and I believed that with removal of the compressing force (ie, the fibular head), recovery of the patient would be complete and rapid. Neurapraxia has been described as “a true ‘nerve concussion’... Applying manual therapy here can speed up the recovery process and facilitate a complete recovery.” Therefore, simple—yet precise—OMT was performed on this patient to relieve the nerve compression. The routine techniques of OMT that we used allowed us to avoid additional, potentially painful diagnostic testing.

Our unusual case exemplifies the importance of focusing on the initial history and physical examination of the patient, as well as of using OMT before pursuing further, expensive diagnostic workups and treatments. Additional diagnostic and treatment approaches...
Drug-Induced Dysregulation of Mood Disorders

To the Editor:

Mood disorders have been recognized as being among the most disabling of illnesses.1 Diligent research has been unable to pinpoint a biological marker with specificity and selectivity for mood disorders, which have a complex, heterogeneous nosologic classification.2 Thus, physicians are dependent on their acumen to diagnose mood disorders, based on clinical presentation and characteristic signs and symptoms.2 The management of mood disorders is a challenge requiring careful scrutiny of numerous variables, including the natural longitudinal cyclic course of these disorders (especially in patients who are not in complete remission), patient noncompliance with treatment, complications from substance abuse, and undiagnosed new pathologic conditions.3

During my more than 20 years of clinical experience, I have treated patients whose mood disorders had been effectively stabilized, yet they experience mental decompensation and have a sudden onset of suicidal ideation. Suicidal ideation is a medical emergency. After scrutinizing such cases, I often discover that a new drug was initiated before the deterioration of the patient’s mental status. This drug may be a prescription medication, an over-the-counter (OTC) medication, or an herbal product.

Certain prescription medications, such as interferon alpha-47 and anabolic-androgenic steroids and corticosteroids,7 are known to negatively affect mental state. A number of herbal products, such as yohimbe,8 have the potential for the induction of suicidal ideation. Various common OTC medicines can precipitate the recurrence of a mood disorder in a stabilized patient. For example, one of my patients experienced suicidal ideation after taking naproxen.9 Two of my patients who were taking a particular prescription antihyperlipidemic medication experienced suicidal ideation after 1 month of using the drug, and they recovered within a few days of discontinuing use.

Possibly derivative of frequent prescribing, the most common agents that have exacerbated mood disorders in my patients are antibiotics. At one point, I decided to assign nicknames to years based on the medication that most often caused a recurrence of mood disorders in my patients. For example, one year was the “Year of Erythromycin” because five patients, ranging in age from 8 years to 20 years, experienced acute suicidal ideation while using erythromycin. I have observed that patients who experience mental deterioration while taking antibiotics usually initially demonstrate such deterioration on the fourth day of the administration of the antibiotic. Fortunately, many of these patients recover from their mental decompensation approximately 72 hours after discontinuing use of the antibiotic. Other patients, however, suffer sustained mental decompensation.

A close scrutiny of each patient’s condition and history is required to determine the cause of changes in mental status. The institution of a new drug—especially frequently prescribed medicines, such as antibiotics—must be carefully evaluated. I routinely advise patients to keep diaries in which they record their moods, any incidental events in their lives, and any new drugs taken—without regard to how benign an event or a drug may seem. A precise timeline showing a correlation between a patient’s mental decompensation and the administration of a new drug may reveal a potential cause of the decompensation that can be corrected. The finding of such a correlation may also allow the patient to avoid complex modifications in the management of his or her mood disorder.

A number of published reports have suggested the attenuation of beneficial effects of antidepressants and the potential for the development of suicidal ideation while using antidepressants.10-15 Without recognition of the correct precipitating variable causing the reemergence of signs and symptoms of a mood disorder, a patient may inappropriately be removed from a psychotropic medication, have the dose of the medication increased or augmented with another drug, or be placed on a new psychotropic medication. Such inappropriate actions would complicate the course of the patient’s illness.

Edward H. Tobe, DO
Distinguished Fellow of the American Psychiatric Association; Clinical Associate Professor, University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine, Stratford

References


(continued on page 247)
Discrimination Against DOs Alive and Well

To the Editor:

I read the letter by Carl Hoegerl, DO, MSc, about discrimination against osteopathic physicians, published in the December 2009 issue of JAOA—The Journal of the American Osteopathic Association, with great interest. I am a retired DO, 83 years of age, and I am able to reflect on more than 50 years in the osteopathic medical profession since I graduated in 1952.

Discrimination against DOs and our profession has always been rampant. Our DO degree was established to keep our profession distinct from the allopathic medical profession. The DO degree has served its purpose well for the past century, allowing us to achieve legal recognition “across the board”—among all of our specialties and in all 50 states. However, if we continue insisting upon following the same pathway, another century will pass before across-the-board equality of the DO degree with the MD degree is obtained—that is, before the general public truly considers us as equals.

It is time to give serious thought to this discrimination problem.

Discrimination against DOs will not go away as long as we pursue the “ostrich” approach of failing to see the reality of the situation we face. Osteopathic medicine is worthy of being considered on its own merits. I am fully aware that my DO degree is equal to any MD degree, but, unfortunately, most allopathic physicians and allopathic societies, colleges, academies, and other institutions do not understand that fact. The osteopathic medical profession has made a great deal of progress in resolving this situation, but much remains to be done.

Some have suggested—as a way of resolving the discrimination problem—that our osteopathic medical schools opt to grant dual degrees—both DO and MD—or that the DO degree be renamed as an MD or MDO (medical doctor of osteopathy) degree.2,4 Yet another possibility is to grant a MOM (master of osteopathic medicine) at the conclusion of the fourth year of medical education, along with an MD degree. However, would these types of changes help or hinder our progress?

Having served on the Wyoming State Board of Medical Examiners, I am concerned about the legal recognition of alternate degrees with name changes. Granting both a DO degree and an MD degree might be a useful approach, but this would likely require a candidate to be licensed by both osteopathic and allopathic boards in states that have dual boards.

There are hurdles that will have to be overcome in any approach to tackling the discrimination problem. However, all serious suggestions are worthy of consideration. If we give in to “leaving well enough alone,” academic and societal discrimination against DOs will never be overcome. We must find ways for osteopathic medicine to be accepted into the mainstream of medicine by all disciplines and all governing bodies, as well as the general populace.

Fredrick W. Boling, DO
Hot Springs, Arkansas

References


To the Editor:

In his letter to the editor published in the December 2009 issue of JAOA—The Journal of the American Osteopathic Association (2009;109[12]:654-655), Carl Hoegerl, DO, MSc, asserts that the American Academy of Neurology (AAN) is arrogant and discriminatory. As a member of the AAN for 39 years, I would like to come to some defense of that organization.

The AAN is indeed discriminatory, and that is part of its purpose. The AAN is a professional organization that creates its own rules of membership. A candidate must have served in an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency program to become an active member or a fellow member in the AAN. An osteopathic physician who has trained in an American Osteopathic Association (AOA)-approved residency...
program can belong to the AAN as an associate member. A number of allopathic physicians who either did not pass the allopathic board examinations or chose not to take them are in the same associate member category in the AAN.

To me, Dr Hoegerl’s demand that the AAN accept his osteopathic neurology board certification is analogous to a bishop in the Episcopal Church claiming that he should be entitled to be a bishop in the Roman Catholic Church if he changed denominations. Any organization has the right to set its own rules. It is as simple as that. The AAN is under no obligation to honor Dr Hoegerl’s osteopathic neurology board certification, and Dr Hoegerl is not entitled to a class of membership reserved for individuals who took and passed the allopathic neurology board examinations.

I was in the first wave of DOs who chose to train in an ACGME-accredited residency program in neurology. I joined the AAN as a junior member in 1971. At that time, only a handful of DOs were members of the AAN. When I was certified by the allopathic neurology board in 1975, I automatically became an active member of the AAN. I was elected a fellow in 1986, making me one of the first DOs—if not the first—to achieve this membership rank. I was very proud of that accomplishment. At no time have I ever felt discriminated against by the AAN.

When an early DO mentor asked me to take the osteopathic neurology board examinations as a favor to him, the AOA did not automatically certify me just because I was previously certified by the allopathic neurology board. Thus, I had to take the osteopathic board examinations.

I should add that at every possible point during and after my allopathic residency training, the AOA and the osteopathic neurology board were obstructionist regarding my training—such as by insisting that I quit all allopathic professional organizations before being eligible to take the osteopathic examinations. The AOA also insisted on conducting its own accreditation review of the residency program at Wayne State University, at my expense, even though the program was already accredited by the ACGME. I found such actions to be not only obstructionist but also demeaning and embarrassing.

I am proud of the exclusivity of membership and of the category of fellow in the AAN. Membership means more to me because of this exclusivity, and I feel that my membership would be diminished if the AAN allowed candidates who passed alternate board examinations to be co-equal members.

George E. Ristow, DO
Fellow, American Academy of Neurology; Fellow, Royal College of Medicine (Neurology); Professor Emeritus, Michigan State University College of Osteopathic Medicine, East Lansing

Response

Times have changed at the American Osteopathic Association (AOA) since Dr Ristow applied for AOA board certification. Today, the AOA welcomes osteopathic physicians (DOs) who are certified by the American Board of Medical Specialties (ABMS) to apply for AOA board eligibility. We fully respect a physician’s decision to maintain board certification in both ABMS and AOA boards in their specialty. While neither the AOA nor the ABMS certification boards offer reciprocity, the AOA will work with ABMS board-certified DOs to establish AOA board eligibility.

In 2005, the AOA Board of Trustees approved a pathway through Resolution 56 (Certification Eligibility for ABMS-Certified DOs) to facilitate AOA board certification for ABMS-board-certified DOs. The application to become AOA board certified is available on DO-Online at http://www.do-online.org/pdf/crt_res56abmscert.pdf. Staff in the AOA Department of Education work daily with applicants in this process. Although we are required to obtain primary source verification of training completion and ABMS board certification, the process to become eligible has been streamlined to facilitate the opportunity for all DOs who want to be AOA board certified.

Current AOA leaders embrace measures to facilitate processes that encourage DOs who trained in Accreditation Council for Graduate Medical Education (ACGME) programs or are certified by the ABMS to be engaged in the osteopathic medical profession. Opportunities are available to serve as preceptors and program directors, establish dual training programs in hospitals, and serve on AOA bureaus or councils. The AOA appreciates the time and commitment Dr Ristow and other ACGME-trained DOs have given to the profession.

Diane N. Burkhart, PhD
Director, Department of Education, American Osteopathic Association, Chicago, Illinois

Correction

The JA O A regrets that an error appeared in the following letter:


The author’s middle initial and academic degree were omitted. The author’s name should have appeared as Diane N. Burkhart, PhD.

These changes will be made to the full text (http://www.jaoa.org/cgi/content/full/110/3/193) and PDF (http://www.jaoa.org/cgi/reprint/110/3/193) versions of this article online.