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. 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.

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.

Readers are encouraged to prepare letters electronically in Microsoft Word for Windows (.doc) or in plain (.txt) or rich text (.rtf) format. The JAOA prefers that readers e-mail letters to jaoa@osteopathic.org. Mailed letters should be addressed to Gilbert E. D’Alonzo, Jr, DO, Editor in Chief, American Osteopathic Association, 142 E Ontario St, Chicago, IL 60611-2864. Mailed submissions and supporting materials will not be returned unless letter writers provide self-addressed, stamped envelopes with their submissions.

Letter writers must include their full professional title(s) and affiliation(s), complete preferred mailing address, day and evening telephone numbers, and preferred fax number and e-mail address. In addition, writers are responsible for disclosing financial associations and other conflicts of interest. No unsigned letters will be considered for publication.

Although the JAOA cannot acknowledge the receipt of letters, a JAOA staff member will notify writers whose letters have been accepted for publication.

All osteopathic physicians who have letters published in the JAOA receive continuing medical 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.

**Chronic Psoas Syndrome Caused by the Inappropriate Use of a Heel Lift**

**To the Editor:**

I wish to add a brief response to the discussion of sacral base imbalance that began with the September 2007 case report by Christopher M. Rancont, DO.1

In his July letter to the editor, Dale E. Alsager, DO, PhD,2 notes several errors that he found in that case report,1 in which standing postural radiography was used to determine leg length discrepancy.

Despite the errors pointed out by Dr Alsager,2 I believe that Dr Rancont1 provided an excellent and detailed osteopathic structural evaluation for the patient described. Nevertheless, Drs Alsager2 and Rancont1 both fail to mention the most important point of all: for standing postural radiographs to provide an accurate picture of leg length discrepancy, any dysfunction in the pelvis must be corrected before the radiographs are made.

Preradiograph correction is important because a number of iliosacral and sacroiliac dysfunctions that cause functional changes in leg length would appear on standing postural radiograph images as a short leg problem. In such cases, the use of heel lifts could aggravate the problem.

I have seen a number of cases with associations between pelvic dysfunction and changes in leg length during my 57 years in practice. The most common pelvic dysfunction I have seen in such cases is a posterior innominate, which shortens the leg that is on the side of the dysfunction, and also everts the leg at an angle of more than the usual 15 degrees. The most thorough evaluation of the associations between pelvic dysfunction and changes in leg length was reported by Fred L. Mitchell, Sr, DO.3

Moreover, standing postural radiographs are an unnecessary technicality that result in an unnecessary exposure to radiation for patients. If an osteopathic physician has any diagnostic ability at all, a careful clinical evaluation will provide all the information that is needed for a quick and accurate diagnosis. The DO should observe the patient walking, noting the angle of the feet and the relative height of the hips and shoulders. Next, the DO should evaluate the standing patient from behind, again noting the angle of the feet, the height of the trochanters and iliac crests, and the position and motion of the superimposed spine.

If the patient’s trochanters are level and the iliac crests are asymmetric, a functional change is most likely present and in need of correction. As corrective treatment is being administered, the DO should keep in mind that, in chronic cases, ongoing treatment and reevaluation of the patient will be necessary.

If both trochanters and iliac crests are asymmetric, a short leg problem is indicated. In such cases, nature attempts to level the sacral base, almost invariably producing a posterior innominate, an inferior sacral shear on the side of the long leg, or both. The body’s natural compensatory adjust-
ments result in the shortening of that leg.

The present letter is not intended to address all the associated details of leg length discrepancy, however. I simply wish to relay a strategy I have found very effective in my practice. This strategy allowed me to stop using standing postural radiographs 30 years ago.

An osteopathic physician who is treating a patient with leg length discrepancy should make any corrections that are possible, then clinically reevaluate the patient, and, if appropriate, apply a heel lift.

Harold I. Magoun, Jr, DO
Greenwood Village, Colo

References

Response
I agree with Dr Magoun that Dr Rancont1 provided an excellent and detailed osteopathic structural evaluation for the patient described in his September 2007 case report. Indeed, I agree with most of Dr Magoun’s statements regarding physical diagnostic and treatment techniques for patients with pelvic, lower extremity, and sacral somatic dysfunction. I also agree that a reasonable sequence of events in the clinical setting includes conducting osteopathic diagnosis and treatment for such patients before the use of radiographic evaluation.

However, I respectfully disagree with Dr Magoun about the usefulness of the standing postural radiograph (ie, the Willman2 protocol). The primary purpose of obtaining a standing postural radiograph of the pelvis is to distinguish physiologic (ie, functional) leg length difference from anatomic (ie, structural) leg length difference.3

In a radiographic evaluation, the line perpendicular to the vertical plumb line, which transects the superior surface of the femoral heads, represents the sum of the length of bone and related arthrodial elements, between the superior edge of the femoral head and the inferior-most point of the leg (ie, where the calcaneous contacts the floor in the weight-bearing configuration). The Willman protocol can be used to detect anatomic leg length difference between the left and right sides—something no amount of osteopathic manipulation will change.

The Willman protocol is highly reproducible, with structural leg length differences not changing over time—except in cases where fractures or surgery to the leg bones have occurred. I agree with Dr Magoun that sacral base unleveling and iliac crest height variance, which may accompany a physiologic leg length difference, can be influenced by manipulation or somatic dysfunction (eg, counterrotation of innominate bones). Thus, the interpretation of a patient’s diagnostic results needs to correlate radiologic findings with clinical findings.

The Willman protocol is not the only radiographic technique available for measuring anatomic short leg. Many radiologists prefer to use computed tomography (CT) to scan the entire pelvis and the lower extremities. As part of this CT technique, the total bone length in the lower extremities can be easily calculated. However, the CT technique has certain disadvantages that limit its application. For example, CT technology exposes much more of the patient’s body to radiation than does the Willman protocol. Furthermore, a CT scan may not be as accurate as the Willman protocol in terms of evaluating anatomic leg length difference because the CT scan does not assess leg length in a weight-bearing stance, in which interarticular soft tissue spaces may distort the total limb length values. Computed tomography is also more expensive than the Willman protocol.

It is important that certain elements of the Willman protocol be followed carefully during physical examination. For example, the patient should be standing on a floor grid to ensure that the feet are positioned properly and consistently in each examination session. In addition, a steel plumb line must be suspended from the ceiling above the bucky and passed in front of the radiograph film, behind the film cassette-holder surface panel.

If the Willman protocol is followed carefully, it is brilliant in terms of its simplicity, reproducibility, and cost-effectiveness.

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References

Editor’s Note: In an upcoming issue of JAOA—The Journal of the American Osteopathic Association, Christopher M. Rancont, DO, will respond to this series of letters regarding his case report (2007; 107:415-418).

Osteopathic Medicine and Community Health Fairs: Increasing Public Awareness While Improving Public Health

To the Editor:
Please accept my commendations regarding the August special communication article about community health fairs by Heather M. Stamat, DO, and colleagues.1 I found the study inspiring—not only for demonstrating that health fairs can increase public awareness of osteopathic physicians and osteopathic medicine, but also for showing that advocacy efforts can be conducted while also providing for the greater good of one’s community.

As the executive director of the American Osteopathic Association (continued on page 669)
(AOA), I am proud to report that our board of trustees unknowingly proved the results of the Stamat et al study during its board retreat in New Orleans, La, in April. Through collaboration with Heart to Heart International, several board members and their spouses staffed a health fair in the St Bernard parish of New Orleans, an area that was severely damaged by Hurricane Katrina in 2005. Virtually all of this neighborhood’s 28,000 homes were demolished during that
storm. The community outreach of the April health fair provided much-needed healthcare access and services to more than 100 residents of the parish. Interested readers can learn more about this mission trip in my “Executive Director’s Desk” column in the May issue of The DO magazine.²

Readers of JAOA—The Journal of the American Osteopathic Association may also be interested to learn that the National Osteopathic Medical Association (NOMA) recently provided guests at the 113th AOA Annual Convention and Scientific Seminar, in Las Vegas, Nev, with an opportunity to perform community service.

On October 25, NOMA held a health fair—as it has during the past several years for the AOA convention’s host city. This year, the NOMA health fair was held for inner-city and homeless residents of Nevada at the Las Vegas Rescue Mission.

With the assistance of volunteers from the AOA and other service organizations, NOMA conducted health screenings for adults and children. An on-site clinic provided necessary follow-up care. Since NOMA initiated this annual project, it has raised close to $20,000 for homeless individuals in AOA convention host cities.³

I would like to thank the JAOA for the opportunity to comment on the excellent study by Stamat et al¹ and to encourage further efforts that build on the work of these researchers.

John B. Crosby, JD
Executive Director
American Osteopathic Association
Chicago, Ill

References

Praise for October JAOA

To the Editor:

The improvements that you and your staff have achieved are outstanding. The quality of the papers has improved beyond recognition. I particularly enjoyed the endocannabinoid system article by John M. McPartland, DO (2008;108:586-600), as I am also speaking on a similar aspect.

George T. Caleel, DO
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Chicago College of Osteopathic Medicine
Arizona College of Osteopathic Medicine
Midwestern University
Downers Grove, Ill

Corrections

The JAOA deeply regrets several errors that appeared in the following September article:


The changes detailed below were made to the full text (http://www.jaoa.org/cgi/content/full/108/9/508) and Adobe Portable Document Format (http://www.jaoa.org/cgi/reprint/108/9/508) versions of this article online.

Page 508—In the third paragraph of the article, the following statement was added mistakenly without the authors’ knowledge: “The Osteopathic Research Center, located at the University of North Texas Health Science Center in Ft. Worth, provided administrative and fiscal oversight of MOPSE, which was supported by numerous osteopathic medical foundations.” The appropriate financial disclosure statement appeared with the authors’ biographical information on the same page.

Page 513—In the description of soft tissue technique in Figure 2, the phrase “Apply soft tissue massage across thoracic paraspinal muscles” was inaccurate. Although the term “massaging” may be better understood by the general public, “kneading” is the more accurate osteopathic term. Therefore, the term “kneading” should have appeared in parenthesis after the term “massaging.”

Page 514—In the description of the rib raising technique for the Multicenter Osteopathic Pneumonia Study in the Elderly protocol, a portion of the technique was improperly described as follows: “With his or her fingers flexed, the operator applies traction to the rib angle. While traction is maintained and using the subject’s arm as a fulcrum with the wrist kept straight, the subject’s rib angle is raised (moved anteriorly).” Instead, the technique should have been described as follows: “With his or her fingers flexed, the operator applies lateral traction to the rib angle. While traction is maintained, the operator’s wrists remain straight as his or her hands move toward the anterior side of the patient’s body, raising the subject’s rib angle. The operator’s arm is used as a lever and the side of the bed as a fulcrum to produce smooth, steady raising and lowering of the rib cage.” ♦

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