

Acute pain & the *Quintessential Applications* clinical protocol

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Abstract: A case history of a 39y male carpenter with acute shoulder pain is presented demonstrating the practical application of the Quintessential Applications (QA) Clinical Protocol in the evaluation and treatment of a patient in acute pain.

Indexing Terms: chiropractic; AK; Applied Kinesiology; Quintessential Applications (QA) Clinical Protocol; acute pain; shoulder

Introduction

A neurologically based comprehensive clinical protocol (the QA Clinical Protocol, outlined as Appendix 1), developed by Schmitt (1) was used in the evaluation and treatment of a patient in acute pain. The comprehensive clinical protocol proposed by Schmitt (QA Clinical Protocol) utilises the manual muscle testing (MMT) response (inhibited, facilitated, or over-facilitated - biased toward facilitation) as a reflection of the status of the anterior horn motor neuron pool (AHMN) for the muscle being tested. The results of initial consultation, examination and treatment are presented below and can be followed by referring to the *Quintessential Applications Clinical Protocol* (Figure 1). (2)

... rapid results can be seen in patients with acute pain using the *Quintessential Applications Protocol*



Discussion

History

Mr A, a 39y carpenter, presented in our office complaining of severe and debilitating left shoulder pain. Mr A stated that ten days prior to his visit with us he awakened with a mild ache in the left shoulder. That day, as he reached into the back of his truck to pick up his toolbox, he experienced sharp pain in the shoulder that '*almost brought him to his knees*' and since that time had suffered continued pain and severely restricted motion. He was seen by a medical physician, prescribed a muscle relaxant (*Skelaxin*) and an anti-inflammatory (*Vioxx*), and after ten days has seen little to no improvement. He had continued working until two days prior to his presentation in our office and finds that resting the shoulder eases the persistent pain and discomfort, but does nothing for the restricted range of motion, nor aggravation associated with same.

Chief complaints

Frequent, severe, sharp pain in the left shoulder joint, with limitation of motion; occasional, mild, neck stiffness, with pain across the left shoulder; intermittent, moderate, pins and needles in the left forearm and hand.

Physical examination

Mr A was alert and oriented times three. His seated blood pressure was calculated to be 130/80. Postural analysis revealed an elevated left scapula and an elevated right occiput.

Neurological examination

Deep tendon reflexes, including biceps, triceps and brachioradialis, were symmetric and bilaterally equal (2+). Dynamometer grip strength measured 105/110/115 pounds (46-52.2 kg) of pressure on the dominant right hand and 95/95/95 pounds (43 kg) of pressure on the left. Dermatomal evaluation for sensory acuity in the upper extremity revealed hyperaesthesia overlying the C5 and C6 dermatomes, on the left.

Orthopaedic examination

Orthopaedic examination of the cervical spine revealed pain on *Maximum foraminal compression*. Orthopedic examination of the left shoulder revealed pain on: *Shoulder abduction, supraspinatus tendon, Apley's scratch* and *shoulder apprehension*. Left shoulder range of motion, as measured by inclinometer: Forward elevation 100°, backward elevation 30°, internal rotation 90°, external rotation 80°, adduction 20°, abduction 95°. Pain and guarding was noted on all ranges of motion, but especially abduction.

Assessment and treatment utilising the QA clinical protocol

Postural and Temporosphenoideal (TS) Line analysis were used to help identify locations of specific muscle weakness(es) due to AHMN inhibition. MMT revealed weakness of the *Psoas* (left) and *Pectoralis Major, Sternal Division* (left).

Autogenic facilitation (AF) (using muscle spindle cell manipulation to strengthen/facilitate a weak muscle) was performed and did not strengthen weak muscles.

Injury Recall Technique (IRT) (micro-manipulation of the talus into distraction while the patient touches the area of pain) was used on areas of past injury restoring normal muscle spindle response to AF.

Nociceptor stimulation blocking (NSB) and set point (SP) techniques were performed to relieve pain in the shoulder. During the application of NSB and SP techniques, pain on movement decreased and range of motion increased until 90% of the pain was eliminated and range of motion was, for all practical purposes, fully restored. It should be noted that NSB and SP techniques use tapping of acupuncture head points coincident with an intermittent aggravation of the pain (NSB) and/or the patient touching the area of pain (SP).

Evaluation of local (shoulder) muscle function revealed a weak *Posterior Deltoid* (left) that was treated with origin-insertion (OI) technique followed by micro-manipulation of the talus into distraction (OI IRT). Other aspects of the QA Clinical Protocol were evaluated and appropriate treatment applied. Follow-up was recommended in one week.

Follow-up visit

Mr A reported that his shoulder had remained significantly improved (95%); that he had returned to work; and, that he was only experiencing a '*slight catch*' on certain movements of his arm and shoulder. The application of SP technique relieved all residual pain ('*catch*') in the shoulder.

Follow-up by phone

Four months later Mr A reported that his primary complaint remains 100% resolved. He reported that he was maintaining full range of motion and expressed his appreciation for the excellent outcome.

Conclusion

The use of the *QA Clinical Protocol* provides context for clinical assessment and powerful tools for relief of pain. It allows the physician to navigate the terrain of the patient's physiology and be led through a forest of symptoms toward a favourable, and often remarkable, outcome.

Understanding that the neurological response to injury and pain (unbridled nociception) must be addressed first provides the physician with a clear and unequivocal point of entry; a first step along a clear cut path to an outcome that the dedicated physician desires and the presenting patient so richly deserves.

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References

1. Schmitt WH. The Neurological Rationale for a Comprehensive Clinical Protocol Utilizing Applied Kinesiology Techniques. Submitted for Publication in the Proceedings of the Annual Meeting of the I.C.A.K., U.S.A., Volume 1, 2005-2006
2. McCord KM and Schmitt WH. Quintessential Applications: A(K) Clinical Protocol. St. Petersburg, Florida: Privately Published, 2005.

Also by Schmitt & McCord

Schmitt WH, McCord KM. Set Point (Touch & Tap) Technique for chronic Injury, inflammation, and pain relief. Asia-Pac Chiropr J. 2022;316 URL apcj.net/papers-issue-3-1/#SchmittTouchTap

Schmitt WH, McCord KM. Measure, Measure, Measure: 'Indicator testing' and nutrients for musculoskeletal pain Asia-Pac Chiropr J. 2022;2.5 URL apcj.net/papers-issue-2-5/#SchmittMcCordIndicatorTesting

McCord KM, Schmitt WH. Quintessential Applications: A(K) Clinical Protocol. The Evolution of a Neurological & Biochemical Hierarchy. Asia-Pac Chiropr J. 2021;1.4:Online only. URL www.apcj.net/papers-issue-2-2/#McCord&Schmitt

QUINTESENTIAL APPLICATIONS Clinical Protocol

BEGINNING PROCEDURES

1. Postural Analysis
2. TS Line Analysis
3. Identify Weak Muscle(s)
 - a. Measure, Measure, Measure (ROM, Pain, etc.)
4. Does Autogenic Facilitation Strengthen?
 - a. No: Use IRT - Rubbing over Area(s) of Injury Strengthens Weak Muscle(s)
 - i. Use Origin-Insertion Technique with IRT for Muscle or Ligament Injury
 - b. Yes: Use NSB and/or Set Point Technique for Recent or Chronic Injury / Pain

SYSTEMIC NUTRITIONAL FACTORS

5. Test Aspirin, Acetaminophen, Ibuprofen Mix – If Strengthens or Weakens:
 - a. Check Essential Fatty Acids (BCSO, FSO, EPA, etc.)
 - b. Check EFA Cofactors (B-6, Mg, Zn, Niacin)
 - c. IRT Chapman's Reflexes with Animal and/or Trans Fat
6. Test Antihistamine Mix – If Strengthens:
 - a. Challenge for Allergen(s) / Offender(s)
 - b. IRT Chapman's Reflexes with Allergen(s) / Offender(s)
7. Sniff Tests – Aldehydes, Bleach, Ammonia
8. Test Nutrients for Strengthening Based on Patient History:
 - a. Vitamin E (Low Back Muscles); Vitamin C (Shoulder Muscles)
 - b. Iron, Folic Acid, Vitamin B-12
 - c. Cholesterol Lowering Nutrients (If Cholesterol Weakens PMS)
 - d. Chondroitin Sulfate (Joint Problems)
 - i. Check Sulfur (Cysteine) & Associated Nutrients
 - ii. Check Blood Sugar Handling (Insulin, Magnesium)

SYSTEMIC STRUCTURAL FACTORS

9. Is TL to K-27 (or Hyoid Challenge) Positive?
 - a. Straight TL – Cranial (Go to 11) – Immune or Mechanical?
 - b. Crossed TL – TMJ (Go to 10) – Immune or Mechanical?
 - c. Dorsal Crossed TL – Use Tooth Techniques
 - d. Hyoid Challenge – TMJ, Folic Acid and/or Thymus
10. Does TL to TMJ Strengthen Weak Muscle and/or Weaken Strong Muscle with Neck in Extension?
 - a. If TMJ IRT Right – Check Thymus (or Lower Sternum)
 - b. If TMJ IRT Left – Check Spleen (or Lower Sternum)
 - c. If TMJ TL but No IRT:
 - i. Check Nasosphenoid Cranial Fault
 - ii. Check Temporoparietal Jam
 - iii. Check Sphenoid Compression Fault
 - iv. Check TMJ Muscles

11. Does Pre-Test Imaging Strengthen? If Yes – Check Cranial Bones
 - a. If Cranial IRT Right – Check Thymus (or Lower Sternum)
 - b. If Cranial IRT Left – Check Spleen (or Lower Sternum)
 - c. If No Cranial IRT – Mechanical Correction Needed

SYSTEMIC NUTRITIONAL FACTOR

12. Does Rebreathing in a Paper Bag Strengthen?
 - a. If Yes: Check Citric Acid Cycle & Electron Transport Chain Nutritional Factors

HEART-FOCUSED ACTIVITY

13. Does Specific Thought of Appreciation Felt in the Heart Strengthen?
 - a. Yes: Use Heart-Focused Technique(s)

SYSTEMIC ENDOCRINE EFFECTS

14. Does TLR Strengthen as Expected?
 - a. No: Identify and Treat Appropriate Endocrine Chapman's Reflex
 - b. Yes: Check for Endocrine Related Muscle Weakness – Treat Appropriately
15. Does Rubbing Adrenal Chapman's Reflexes Cause Pituitary Chapman's Reflex to TL?
 - a. Yes: IRT Adrenal Chapman's Reflexes with Offender.
16. Does Adrenal Challenge (Pinching) Induce Adrenal Related Muscle Weakness?

If Yes:

 - a. TL to Adrenal Chapman's Reflexes – If Strengthens: Rub Reflexes
 - b. TL to Pituitary Chapman's Reflex – If Strengthens: Go to 15a
17. Does Ligament Stretch Cause Muscle Weakness?
 - a. Yes: Rub Adrenal Chapman's Reflexes
18. Test Endocrine Related Muscles – Identify and Treat Primary Chapman's Reflex
 - a. Test PMS (Liver) and TFL (Colon) – Treat Primary Chapman's Reflex
19. Does Rubbing or Pinching Liver VRP Strengthen Weak Muscle? – If Yes:
 - a. Test Liver Detoxification Nutrients
 - b. Challenge Liver Chapman's Reflex with Offenders – If Positive:
 - i. IRT or Rub Liver Chapman's Reflex with Offenders
 - c. Challenge PMS with Cholesterol – If Weakens:
 - i. Rub Liver Chapman's Reflex with Cholesterol in Mouth
 - d. Challenge PMS with Thymus Thump (Cytokines)
 - e. Challenge Liver Chapman's Reflex with Sugar in Mouth (Triglycerides)
20. Pinch Pancreas VRP and Test Biceps Brachii (or Other Upper Limb Flexor) – If Weakens:
 - a. IRT Pancreas Chapman's Reflex with Offender(s) in Mouth

GASTROINTESTINAL TRACT

21. Challenge for Hiatal Hernia / GERD
22. Challenge Ileocecal Valve – Open or Closed
23. If Digestive Problem – Rub and Pinch Visceral Referred Pain area(s)
 - a. If Rubbing Strengthens: Rub Chapman's Reflex for that Organ
 - b. If Pinching Strengthens: IRT Chapman's Reflex with Offender

- c. Challenge for Closed ICV with Fat (Ileal Brake)
- d. Challenge for Open ICV with Sugar
- e. 3-Step Challenge for Gastrocolic Reflex

EMOTIONAL STRESS

- 24. Perform Emotional Recall Challenge – If Positive: Do Emotional Recall Quick Fix

LOCAL PROBLEMS

- 25. Check Weak Muscle(s) for Chapman's Reflexes and Origin / Insertion Technique
- 26. Check Fascial Sheath Shortening
- 27. Check Iliolumbar Ligament
- 28. Check Pelvic Categories, Iliac & Sacral Fixations
- 29. Check Spine (and Feet) Using FRA Activity:
 - a. Challenge Vertebra (or Foot) to Determine Direction of Correction
 - b. Add Spinal Position to Determine Optimal Coupled Position for Spinal Adjustment
 - c. If Uncoupled Mechanics: Look for Source of Uncoupling
- 30. Challenge Extremities and Adjust as Indicated

GAIT ASSESSMENT

- 31. Check Gait (Backward Step First)
 - a. If Gait Testing Facilitation / Inhibition ABNORMAL
 - i. Check for Iliolumbar Ligament or Spinal, Pelvic, Foot / Ankle Subluxation(s)
 - b. If Gait Testing Facilitation / Inhibition NORMAL
 - i. Pinch Pancreas VRP – If Pinching VRP Disrupts Gait: Test Related Nutrients and Rub Pancreas Chapman's Reflex
 - ii. Pinch Other VRP's – If Pinching Disrupts Gait: Rub Chapman's Reflex

CHRONIC PAIN

- 32. If Chronic or Persistent Pain: Use LQM and/or Tonification Point Techniques

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