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Dr Toad's wild ride

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Narrative abstract: The author reports on the deceptions and costs associated with various types of spine care by US medical doctors and surgeons.

The simplicity and safety of Chiropractic care stands in stark contrast to opioid addictions and surgery scams.

Indexing terms: Chiropractic; back surgery; opioids.

Introduction

I grew up in SoCal near Disneyland where my favourite ride was '*Mr Toad's Wild Ride*', in Fantasyland based on the novel, *Wind in the Willows*.

Unlike most rides at Disneyland that were rather tame for families with small kids, Mr Toad's Wild Ride aboard his 'motorcar' went almost as fast as a roller-coaster with unexpected twists, sharp turns, bumps, and many near misses to surprise the unsuspecting, screaming riders. The end to this *wild 3-minute ride* that seemed to take forever was a relief, but we were none the worse for wear and ready to do it again!

> *'... Disney's wild ride to nowhere with Dr Toad and his magic car forms an analogy for medicine's Dr Toads who promise much but too often deliver a ride to nowhere with the management of back pain by drugs and surgery ...'*

Let me fast forward after practicing chiropractic care for 40 years to say that Mr Toad's Wild Ride reminds me of many patients suffering with severe chronic back pain who came to my office as a proverbial 'last resort'. Many were often stoned on opioid painkillers who had gone from one medical treatment to another guided by 'Dr Toad' through the medical world of spine treatments from drugs to shots to spine surgery to repeat surgeries then to spinal cord stimulators. (1) After their experience on Dr Toad's Wild Ride, most passengers did not want to do it again, so they finally came to the proverbial 'last resort'. Unlike riders on Disneyland's Mr Toad's Wild Ride, the passengers on Dr Toad's Wild Ride were never the same after their first ride ended.

Indeed, many were much worse for wear now suffering from chronic post-surgical opioid addiction painkillers and suffering from failed back surgery. For many, this ride with Dr Toad was a 'bad trip' only to find out it was unnecessary when to their astonishment, chiropractic

1. Failed back surgery syndrome: 5-year follow-up after spinal cord stimulator implantation

adjustments corrected their underlying back pain quickly and painlessly without drugs, shots, or surgery.

Chiropractic patients never left our office with screws in their spines or opioid painkiller prescriptions in their hands.

The cautionary notice at the top of the Disneyland poster for Mr Toad's Wild Ride forewarned passengers were ready to '*take a motorcar to nowhere in particular*'.

Let me suggest Disney's poster accurately described passengers after the euphoric effects of prescription opioid painkillers kicked-in but getting patients 'high' only got them '*nowhere in particular*' because today's research show prescription opioids are placebo and no better than NSAIDs and, at their worst, opioids are abused, addictive, and deadly, definitely ending in a 'bad trip' for most.

Indeed, when these patients were finished on their 'trip' on Dr Toad's Wild Ride, many looked like the poster of Mr Toad's eyes stoned on *chronic opioid therapy* after 50% were disabled from failed back surgery.

In fact, one brave conductor, Don Teater MD, of the *National Safety Council*, chided the use of prescription opioids, '*Opioids don't kill pain, they kill people*'. (2)

Although the real Mr Toad's Wild Ride at Disneyland got riders back to the start only a bit disheveled, they were certainly unharmed, but Dr Toad's Wild Ride cannot make the same claim. In the real medical world, many of Dr Toad's patients' lives were changed forever. There's a good chance that may be you or someone you know because post-surgical stress disorder after surgery (3) is well known especially when the outcome is poor.

Too often after a bad trip at the end of the first ride to surgery, Dr Toad often tells his captive passengers '*You can't depart yet because the first trip "didn't take" and there are more "bad discs" around the surgery site*'. Too many riders are still in too much pain and too high to work, so he tells them, '*Let's do it again*'.

The best estimate is 50% of passengers have multiple re-surgeries of diminishing returns that also failed. (4) Many patients are prescribed *chronic opioid therapy* after surgery, but have proven to be no more effective than taking two NSAID pills, the only difference is they get you 'high'. (5)

Too many addicted passengers go around and around again never knowing there was a better detour to take what should have been the first destination, that is, *chiropractic that reduces both opioid consumption* and *reduces spine surgery*.

Tourists at Disneyland realised Mr Toad's Wild Ride is a completely fictional experience in Fantasyland, but patients with back pain fail to understand the destinations on Dr Toad's Wild

2. The Illusion of Opioid Pain Medications. Why Do We Love These Pills?
3. Post-traumatic stress in the postoperative period: current status and future directions.
4. Failed Back Surgery Syndrome: A Review Article
5. Krebs EE, et al, Effect of opioid vs nonopioid medications on pain-related function in patients with chronic back pain or hip or knee osteoarthritis pain, 2018;, JAMA, 2018;319(9):872-2. DOI 10.1001/jama.2018.0899

Ride in the real world in America's Medical Land outside of Disneyland are dangerous, wasteful, and deemed placebo in many cases. (6)

Let me reference '*The power of the placebo effect*' from Harvard Health Publishing, December 13, 2021. Treating yourself with your mind is possible, but there is more to the placebo effect than positive thinking.

The placebo effect

Your mind can be a powerful healing tool when given the chance. The idea that your brain can convince your body a fake treatment is the real thing, the so-called placebo effect, and thus stimulate healing has been around for millennia. Now science has found that under the right circumstances, a placebo can be just as effective as traditional treatments.

'*The placebo effect is more than positive thinking, believing a treatment or procedure will work. It's about creating a stronger connection between the brain and body and how they work together*', says Professor Ted Kaptchuk of *Harvard*-affiliated *Beth Israel Deaconess Medical Center*, whose research focuses on the placebo effect.

Placebos won't lower your cholesterol or shrink a tumour. Instead, placebos work on symptoms modulated by the brain, like the perception of pain. '*Placebos may make you feel better, but they will not cure you*', says Kaptchuk. '*They have been shown to be most effective for conditions like pain management, stress-related insomnia, and cancer treatment side effects like fatigue and nausea*'.

The use of most medical treatments, up to 53% are placebo considering they merely mask chronic back pain and do not correct the underlying causes as I will explain. Temporary relief at best leaving chronic side effects is the modus operandi in medical spine care.

But for most patients, medical spine care is a Wild Ride they will never forget.

The patients on Dr Toad's Wild Ride may learn one thing too late as *The Washington Post* published, '*Going to the doctor for back pain can be a slippery slope*' that sounds like the Disneyland warning that Mr Toad's Wild Ride is going '*to nowhere in particular*'.

Anyway, hop on board Dr Toad's Wild Ride to see the excitement for yourself.

Destinations on Dr Toad's wild ride

Most shocking is the research showing much of medical spine care for the pandemic of low back pain is placebo. According to this study, *Placebo Effect of Sham Spine Procedures in Chronic Low Back Pain: A Systematic Review*, found that the overall placebo effect among the patients during the studied period was 53.2%:

> Results: Seventeen studies that reported 535 patients and 55 pain scoring episodes were considered eligible. Significant reduction in pain scores was reported in 21 episodes. The overall placebo effect among the patients during the studied period was 53.2%.
>
> Conclusion: Placebo effect was observed in nearly half of the patients during the first 6 months following a sham spine procedure.

6. Research shows the need spine surgeries may be as low as 5% to 7% of all low back pain (LBP) cases, according to Spinal Fusion for Chronic Low Back Pain: A 'Magic Bullet' or Wishful Thinking?.

Certainly that may come as a shock to patients convinced modern medicine is scientific, safe, and effective, but the following studies confirm that patients don't always get what they want on their Wild Ride with Dr Toad, but as one rather wild conductor, Mick Jagger, might have explained, '*you don't always get what you want, but if you try real hard you might get what you need*', even if it is placebo.

1st stop or not, at your neighbourhood pharmacy

It's hard for most Americans not to try nonprescription medications as the first stop in their quest for pain relief. Considering the impact of TV ads is enormous to persuade consumers, Big Pharma has invested billions. In 2019, pharmaceutical and medical brands spent an estimated $6.16 billion on TV ads that generated over 515 billion impressions. (7) In 2020, the pharmaceutical industry spent 4.58 billion U.S. dollars on advertising on national TV in the United States, unsurprisingly representing a big shift in spending compared to the 2019 pre-Covid market. In 2020 TV ad spending of the pharma industry accounted for75% of the total ad spend. (8)

- *Primetime Pain Relief: OTC Pharma Brands Are Dominating Evening TV Ads*

  Headaches, backaches, and other minor pains; we all suffer from them at one time or another. And to combat our aches and pains, a significant percentage of us turn to over-the-counter (OTC) medications. It's a product class most of us can relate to, especially when we're kicking back to watch TV after a long day.

  Indeed, *EDO's new analysis of TV ads in the OTC pain relief category* finds that consumers are a whopping 94% more likely to engage with a primetime ad for a pain reliever than they are when an ad in this category runs during any other part of the day. And the most effective drug ads are the ones that show how the advertiser's medicine will help achy viewers get back to their favourite activities.

  Nor are OTC drugs required to mention any side effects and contraindications as are prescription ads in direct-to-consumer advertisements.

- *FDA Requires Side-Effect Disclosure in Prescription Drug Ad Rule*

  '*The rule (RIN: 0910-AG27) requires advertisements to present a major statement, a disclosure on a prescription drug's side-effects and contraindications in a clear, conspicuous, and neutral manner*'.

However, I have never seen an ad where supposed patients flatly said the medication did not help with their back pain. For example, one common side effect with opioids is known to cause *constipation*. To the surprise of football fans, in 2016 a TV ad during the Super Bowl concerning this condition aired, but the Big Pharma lobby called in their cards to have the White House complain as revealed by USA TODAY writer Gregory Korte in his article, *White House pushes back against Super Bowl ad*:

> '*The Obama administration has not done a good job of taking on the pharmaceutical industry on this', said Dr. Andrew Kolodny, the executive director of Physicians for Responsible Opioid Prescribing. 'It's as if they woke up overnight to realise how serious this problem is*'.
>
> '*Now you have these ads coming out normalising long-term use of opioids for a chronic pain problem*', said Kolodny, a senior scientist at *Brandeis University's Heller School for Social Policy and Management*. '*There's no question that their ads make this very dangerous and questionable medical practice seem normal*'.

7. TV Advertising Report – Pharmaceuticals
8. U.S. pharma TV ad spend 2020 - Statista

> The Super Bowl ad was funded by *AstraZeneca* and *Daiichi Sankyo*, two companies in a joint venture to market *Movantik*, a drug that treats opioid-induced constipation. The companies do not make opioids themselves. The companies say opioid-induced constipation needs to be treated differently because the painkillers block receptors in the bowel.
>
> '*This condition, which affects millions of Americans, is something we needed to raise awareness and dialog about. I think that is separate and distinct from the topic around the appropriate use of opioids*', said Dave Fredrickson, *AstraZeneca's* vice president of specialty care. But he said raising awareness about constipation could open the door for a broader conversation about the appropriate use of opioids and the possibility of addiction. (9)

Not only do opioid painkillers create huge problems for abuse and constipation, but people don't realise many studies have found common over-the-counter (OTC) medications initially used in treating spine related disorders were deemed no better than placebo for back or any musculoskeletal pain, at best up to half are placebo. (10) According to *The Placebo Effect: Usage, Mechanisms, and Legality*: Modern Therapeutic Placebo Use.

> In fact, it has been argued that all OTC drugs act mainly through the placebo effect, despite the fact that they contain ingredients that have known pharmacologic effects. (8) Many believe that some of the most widely used drugs in modern medicine are completely inert, and estimates suggest that 30% to 45% of all prescription drugs are nothing more than placebos. (9)
>
> Placebos have proven effective in many areas of medicine, but have been most noticeable in the treatment of pain. A study of placebo administration at a Canadian teaching hospital found that 89% of pure placebos administered were given to treat pain. (13) In 1985, Frederick Evans reviewed six double-blind studies comparing morphine to a placebo and concluded that placebos are 56% as effective as morphine in reducing pain. (14) Around the same time, researchers at the *University of California, San Francisco*, attempted to determine an appropriate control group in studies of placebo-induced analgesia. Among other things, they concluded that a placebo given for pain may be as effective as 8 mg of morphine. (15)

Visiting a drug store seeking a remedy for back pain is a quagmire of deceptive ads considering meds do nothing to correct the underlying problems and may bring many side effects. Searching the internet also proved to be deceptive with no mention of guidelines cautions, instead posting the sole opinion/bias of the reviewer.

- *Medications for Back Pain* (Backache; Degenerative Disc Disease; Pain, back; Slipped Disc) listed 81 drugs (Rx/OTC)
- *Good Rx: Which Pain Reliever Is Best for Back Pain*? By Kaliq Chang, MD, pain specialist, covers typical OTC and reviewed various spine treatments but inexplicably omits chiropractic care.
- Web MD: Which Medicines Help with Low Back Pain? By *Tyler Wheeler, MD*, covers the major OTC meds but omits any mention of chiropractic care. His answer about back surgery is just as deceptive and misleading: '*Most people who get back surgery have minimal, if any, complications*'.

9. *Barack Obama & the Opioid Crisis* revealed how the White House caved in to the Sackler lawsuit. Although a reduction in opioid supply was desperately needed, and close scrutiny of opioid manufacturers more than warranted, the Obama administration declined to do either.
10. A harmless pill, medicine, or procedure prescribed more for the psychological benefit to the patient than for any physiological effect.

Tylenol

Many guidelines recommend over-the-counter (OTC) NSAIDs (non-steroidal anti-inflammatory drugs) before using narcotics for chronic LBP, but apparently they are not without their own consequences, such as being ineffective and the leading cause of liver damage.

Recently a multicentre, 'double-dummy', randomised, placebo-controlled trial by Prof. Christopher G Maher, PhD, et al. across 235 primary care centres in Australia was published in The Lancet and confirmed a commonly used treatment for acute LBP, paracetamol, was no better than placebo.

'*Our findings suggest that regular or as-needed dosing with paracetamol does not affect recovery time compared with placebo in low-back pain, and question the universal endorsement of paracetamol in this patient group*'. (11)

Acetaminophen overdose results in more calls to poison control centres in the US than overdose of any other pharmacological substance. (12) Almost 80,000 people per year are treated in emergency rooms because they have taken too much, and the drug is now the most common cause of liver failure in this country. (13)

- *FDA Drug Safety Communication*: FDA strengthens warning that non-aspirin nonsteroidal anti-inflammatory drugs (NSAIDs) can cause heart attacks or strokes.

Based on our review and the advisory committees' recommendations, the prescription NSAID labels will be revised to reflect the following information:

- The risk of heart attack or stroke can occur as early as the first weeks of using an NSAID. The risk may increase with longer use of the NSAID.
- The risk appears greater at higher doses.
- It was previously thought that all NSAIDs may have a similar risk. Newer information makes it less clear that the risk for heart attack or stroke is similar for all NSAIDs; however, this newer information is not

11. Efficacy of paracetamol for acute low-back pain: a double-blind, randomised controlled trial, Dr Christopher M Williams PhD, Prof Christopher G Maher PhD, Prof Jane Latimer, Prof Andrew J McLachlan PhD, Mark J Hancock PhD, Prof Richard O Day MD, Chung-Wei Christine Lin PhD, The Lancet, Early Online Publication, 24 July 2014. DOI 10.1016/S0140-6736(14)60805-9.
12. Lee WM (2004). "Acetaminophen and the U. S. Acute Liver Failure Study Group: lowering the risks of hepatic failure". Hepatology 40 (1): 6–9. DOI 10.1002/hep.20293.
13. Special report: The dangers of painkillers, Consumers Report, July 2014.

sufficient for us to determine that the risk of any particular NSAID is definitely higher or lower than that of any other particular NSAIDS.

- NSAIDs can increase the risk of heart attack or stroke in patients with or without heart disease or risk factors for heart disease. A large number of studies support this finding, with varying estimates of how much the risk is increased, depending on the drugs and the doses studied.
- In general, patients with heart disease or risk factors for it have a greater likelihood of heart attack or stroke following NSAID use than patients without these risk factors because they have a higher risk at baseline.
- Patients treated with NSAIDs following a first heart attack were more likely to die in the first year after the heart attack compared to patients who were not treated with NSAIDs after their first heart attack.
- There is an increased risk of heart failure with NSAID use.

Don't stop at the drug store

'Warning: this drug has serious consequences including death'

Spanberger Leads Effort to Crack Down on Drug Companies & Misleading Ads, Increase Transparency for Consumers

WASHINGTON, DC: US Representative Abigail Spanberger today led the introduction of legislation that would protect seniors, prevent drug manufacturers from obscuring dangerous side effects of their prescription drugs in their advertisements, and help consumers make informed decisions.

The United States and New Zealand are the only countries in the world that permit direct-to-consumer pharmaceutical advertising, and there are serious consumer safety concerns around the proliferation of these ads. Frequently, the ads supplant the knowledge and judgment of physicians in determining whether a drug is most suitable for a particular medical condition. Studies *show* that an ad's use of visuals when discussing the side effects of a drug distracts American consumers from the risks.

To address these concerns, Spanberger's *Banning Misleading Drug Ads Act* would require the U.S. Food and Drug Administration (FDA) to finalise a 15-year old proposed rule clarifying that drug ads must include a statement related to side effects, contraindications, and effectiveness, while also prohibiting distractions from neutral information. If enacted, this rule would prevent advertisements from including '*distracting representations*', including statements, text, images, or sounds, that detract from the communication of the major statement.

Can We Stop Deceptive Drug Ads on TV?

According to*Fierce Pharma (May 1, 2023)*, an industry monitoring publication:

> 'Pharma companies forked out just under $8.1 billion last year on ad campaigns, according to Vivvix, with spend from 2021 being just over $8 billion, leaving things at an even keel year'.

Deceptive Drug Ads?

In a typical TV spot, you see someone suffering. Then after using the medication, with the brand name presented in large letters and possibly with a catchy tune, they begin to have a wonderful time. There's music and dancing and plenty of smiles, and often cute children or dogs as well.

Meanwhile, the voiceover rattles rapidly through a long list of potential side effects. One new commercial lists heart attacks, strokes, blood clots, depression, suicidal thoughts, abnormal liver tests, bone loss and hypertension. We suspect that most people ignore such a list of horrific adverse reactions. Another possibility is that they assume such complications are rare or would not apply to them.

Open-label placebo effect

Ironically, researchers have shown the placebo is effective for patients taking pills: *Open-label placebo treatment in chronic low back pain: a randomized controlled trial*:

Does placebo affect back pain? At 3 weeks: A reduction in pain of 27.9% has been found to correspond to clinical ratings of *'much improved'* and a 30% reduction has been recommended as an indication clinical significance. (7, 9) There was a clinically significant 30% reduction in both usual and maximum pain in the placebo group compared to reductions of 9% and 16% in usual and maximum pain, respectively, in the continued usual treatment group. Open-label placebo reduced minimum pain by 16% compared to an increase in pain of 25% with treatment as usual (TAU). There was also a 29% reduction in pain-related disability in placebo group compared to 0.02% in the TAU arm.

The study suggests that honestly described open-label placebo pills may have a role in chronic low back pain relief.

FTC Order

Doan's Pills Must Run Corrective Advertising: FTC Ads Claiming Doan's Is Superior In Treating Back Pain Were Unsubstantiated

The *Federal Trade Commission* has ordered the makers of *Doan's Pills* to run ads to correct misbeliefs resulting from their unsubstantiated claim that *Doan's Pills* are superior to other over-the-counter analgesics for treating back pain. The Order, contained in a Commission opinion announced today, would require advertising and packaging to carry the message, '*Although Doan's is an effective pain reliever, there is no evidence that Doan's is more effective than other pain relievers for back pain*'.

Active ingredient

Magnesium salicylate is a nonsteroidal anti-inflammatory drug (NSAID) in a group of drugs called *salicylates*.

Warnings

- Do not give this medicine to a child or teenager with a fever, flu symptoms, or chickenpox.
- Magnesium salicylate can increase your risk of fatal heart attack or stroke, even if you don't have any risk factors. Do not use magnesium salicylate just before or after heart bypass surgery (coronary artery bypass graft, or CABG).
- Magnesium salicylate may also cause stomach or intestinal bleeding, which can be fatal. These conditions can occur without warning while you are using magnesium salicylate, especially in older adults.

English study

Ibuprofen 'Barely better than placebo' at treating back P\pain

'Widely used anti-inflammatory drugs such as ibuprofen have little more benefit than a placebo when it comes to treating back pain', reports the *The Guardian*.

This is based on a study looking at more than 6,000 people with back pain, comparing *non-steroidal anti-inflammatory drugs (NSAIDs)* with a placebo ('dummy' medicine).

While NSAIDs were found to reduce pain and make moving and doing daily activities easier, the difference compared to a placebo was not large enough for the researchers to consider it important. Also, people taking NSAIDs were at greater risk of gastrointestinal problems compared with those taking a placebo.

This was a good piece of research that looked at a number of high-quality studies to reach the conclusion that, generally-speaking, NSAIDs aren't that effective for back pain.

However, this research doesn't mean NSAIDs don't work at all for back pain and shouldn't be used. It's possible that some people will still benefit from them, with the study suggesting that around one in six people taking NSAIDs, rather than placebo, experience a significant reduction in pain.

Back pain usually gets better by itself after a few weeks but it might be a good idea to seek help if your pain is continuing for longer than this, is getting worse, or is stopping you from doing your daily activities. Discuss the treatment options with your doctor.

NSAIDs are currently recommended by the *National Institute for Health and Care Excellence (NICE)* as a treatment option for lower back pain, alongside other approaches such as staying active, group exercise classes and manual therapy, such a *chiropractic*.

Denmark study

Ibuprofen Can Increase Heart Attack Risk, Study Suggests

A new study out of Denmark shows people who took over-the-counter NSAIDs (non-steroidal anti-inflammatory drugs), including *Ibuprofen*, had an increased risk of heart attack.

The 10-year study, published recently in the *European Heart Journal*, looked at 30,000 Danish patients who had heart attacks outside of a hospital. Researchers found the use of ibuprofen was associated with a 31% increased heart attack risk.

It's thought NSAIDs can cause constriction of arteries that control blood flow to the heart, blood clotting and a rise in blood pressure.

Prof Gunnar Gislason of the *University of Copenhagen*, who led the study, called for tighter controls on the sale of ibuprofen and other NSAIDs. '*Allowing these drugs to be purchased without a prescription, and without any advice or restrictions, sends a message to the public that they must be safe*', he told *The Guardian*.

> Gislason said people should not take more than 1,200mg of ibuprofen in one day

This is not the first time doctors have *warned about the use of NSAIDS*, as they can cause serious gastrointestinal problems, too, CBN News reported.

While avoiding ibuprofen could help lower your chances of having a heart attack, there is another type of pain reliever that actually helps prevent a heart attack and can even save your life during one: *aspirin*.

According to *Harvard Medical School*, aspirin can help prevent heart attacks in patients with coronary artery disease and in healthy men over 50 years of age. Only low doses, between 81 and 325 mg a day, are needed.

If you experience a heart attack, first call your country's emergency number. Then immediately chew a 325 mg tablet of aspirin. Chewing it gets it into your system faster. Also, make sure it is not coated.The coating causes it to act too slowly, even if chewed.

Aspirin helps by inhibiting platelets in the bloodstream to form clots, which can block an artery carrying oxygen to the heart. Since a clot can grow minute by minute, time is of the essence.

On March 23, 2017, another news release from the *New England Journal of Medicine* found *Pregabalin* (*Lyrica*) for acute and chronic sciatica was no better than placebo.

Trial Of Pregabalin for Acute and Chronic Sciatica

Background

Sciatica can be disabling, and evidence regarding medical treatments is limited. Pregabalin is effective in the treatment of some types of neuropathic pain. This study examined whether pregabalin may reduce the intensity of sciatica.

Conclusions

Treatment with pregabalin did not significantly reduce the intensity of leg pain associated with sciatica and did not significantly improve other outcomes, as compared with placebo, over the course of 8 weeks. The incidence of adverse events was significantly higher in the pregabalin group than in the placebo group.

Australian Study

The drugs don't work, say Back Pain researchers

Commonly used non-steroidal anti-inflammatory drugs used to treat back pain provide little benefit, but cause side effects, according to new research from *The George Institute for Global Health*.

The findings of the systematic review, published in them*Annals of the Rheumatic Diseases*, reveal only one in six patients treated with the pills, also known as NSAIDs, achieve any significant reduction in pain.

The study is the latest work from *The George Institute* questioning the effectiveness of existing medicines for treating back pain. Earlier research has already demonstrated paracetamol is ineffective and *opioids provide minimal benefit over placebo*.

Lead author *Associate Professor Manuela Ferreira* says the study highlights an urgent need to develop new therapies to treat back pain which affects 80% of Australians during their lifetime.

Prof Ferreira, Senior Research Fellow at *The George Institute* and at the I*nstitute of Bone and Joint Research,* said: '*Back pain is the leading cause of disability worldwide and is commonly*

managed by prescribing medicines such as anti-inflammatories. But our results show anti-inflammatory drugs actually only provide very limited short term pain relief. They do reduce the level of pain, but only very slightly, and arguably not of any clinical significance'.

Prof Ferreira added '*When you factor in the side effects which are very common, it becomes clear that these drugs are not the answer to providing pain relief to the many millions of Australians who suffer from this debilitating condition every year*'.

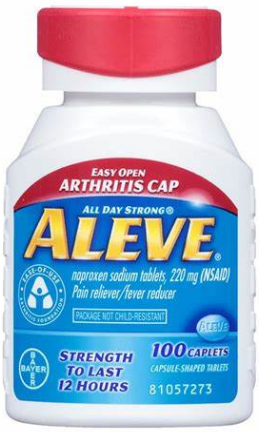
The team at *The George Institute*, which examined 35 trials involving more than 6000 people, also found patients taking anti-inflammatories were 2.5 times more likely to suffer from gastro-intestinal problems such as stomach ulcers and bleeding.

Research Fellow *Gustavo Machado*, of *The George Institute* and the *School of Medicine* at the *University of Sydney*, said: '*Millions of Australians are taking drugs that not only don't work very well, they're causing harm. We need treatments that will actually provide substantial relief of these people's symptoms*'.

Better still '*we need a stronger focus on preventing back pain in the first place. We know that education and exercise programs can substantially reduce the risk of developing low back pain*'.

Most clinical guidelines currently recommend NSAIDs as the second line analgesics after paracetamol, with opioids coming as third choice.

Aleve



Not only are OTC meds toxic and no better than placebo, but naproxen manufacturers have also failed to convince the FDA of its alleged safety. According to a report in Clinical Pain Medicine in February, *FDA Advisory Committees Vote Down Lower CV Risk Claim for Naproxen,* a panel of two FDA advisory committees voted against asserting that naproxen has a lower risk for cardiovascular (CV) thrombotic events than other NSAIDs.

Robert G Lahita, MD, PhD, said the most important outcome of the meeting '*was clearly the Aleve story. Aleve had gotten a lot of good press regarding its being the least effective of hypertension and cardiotoxicity of all the nonsteroidals … We felt that there was still a risk and it was sort of painting something over with a patina that really didn't apply*'. (14)

Dr. Lahita added '*We can't control what the public does with over-the-counter medications. We all know that patients take these things like candy when they buy them in the drugstore*'.

Flexeril

14. *FDA Advisory Committees Vote Down Lower CV Risk Claim for Naproxen*, Clinical Pain Medicinek, April 2014, vol 12(4)

Typically, the common medical misdiagnosis for back pain is 'pulled muscles' routinely treated with pain pills and muscle relaxants in 63% of cases. Despite the widespread use of muscle relaxers, an article in *Spine* found in patients with severe acute LBP, muscle relaxant use was associated with a statistically significant increase in time to recovery, 32.4 days compared to 16.2 days in the placebo group, due to the sedative effect upon patients. The researchers concluded there was '*no demonstrable effect from muscle relaxant use*'. (15)

In a similar comparison in 2004 between muscle relaxants and chiropractic care, *A Randomized Clinical Trial Comparing Chiropractic Adjustments to Muscle Relaxants for Subacute Low Back Pain*, this study found '*Chiropractic was more beneficial than placebo in reducing pain and more beneficial than either placebo or muscle relaxants in reducing GIS (Global Impression of Severity Scale)*'.

A commonly prescribed med for CLBP is *Flexeril*, aka, *cyclobenzaprine*, a muscle relaxant commonly prescribed for myofascial pain (MP), injuries, and sprains. As everyone knows, this is the standard entry-level med prescribed by MDs for anyone with muscle aches and pain.

In 2012, over 26 million prescriptions made it widely available. The DEA lists it as '*a drug of concern*' that is used to enhance the effect of mind-altering drugs or combined with alcohol and other depressants to induce deep states of relaxation.

According to the Cochrane Review, '*Cyclobenzaprine for the Treatment of Myofascial Pain in Adults*', the authors concluded '*There was insufficient evidence to support the use of cyclobenzaprine in the treatment of MP*'. (16)

Obviously, there is no drug solution to chronic LPB, whether OTC or prescription medications; at best meds simply mask the problem temporarily and at the worst they destroy your liver, heart, intestines, and may eventually kill you, the ultimate side effect.

Dr. Sanford Roth was spot on when he admitted: '*In the practical world, it's industry and not the government that brings us these drugs. It's completely skewed by the fact that profit influences where the interest and studies go. It goes ultimately to marketing potential*'.

2nd stop: Inept MDs

After the first stop at the local pharmacy and self-administered OTC meds fail to stop back pain and the inevitable side effects become overbearing, patients then go to their family doctor seeking stronger meds. This is a mistake on two levels:

1. their primary care providers are proven by leading medical spokesmen to be inept in spine care and,
2. the stronger prescription opioid painkillers also have a placebo effect although no stronger than OTC meds, but they do get patients 'high'.

Indeed, the facts are clear: updated spine care is not routinely taught in medical schools and surveys of physicians' knowledge of pain management principles find significant shortcomings,

15. Bernstein, E, Carey TS, Garrett JM (2004) The use of muscle relaxant medications in acute low back pain. Spine 2004:29(12):1346-51.
16. Leite FM, Atallah AN, El Dib R, Grossmann E, Januzzi E, Andriolo RB, da Silva EM, *Cyclobenzaprine for the treatment of myofascial pain in adults.* Cochrane Database Syst Rev. 2009 Jul 8;(3):CD006830. DOI 10.1002/14651858.CD006830.pub3

certainly concerning non-drug methods are now recommended such as Chiropractic and other CAM treatments. (17, 18)

In other words, don't expect a pharmacist or a general medical practitioner to give a patient the full story or guideline recommendations that include Chiropractic care as a frontline treatment. It is also unlikely any mention of the *Doctrine of Informed Consent* to tell patients alternatives to drugs or surgery. What they are taught by the AMA party line is to promote drugs, epidural shots, spine surgery and never refer to Chiropractors. (19)

Less than half of 122 US medical schools require a preclinical course in musculoskeletal medicine, less than one-fourth require a clinical course, and nearly half have no required preclinical or clinical course. (20) Another study confirms that both orthopaedic surgeons' and family physicians' knowledge of treating low back pain is deficient. In fact, orthopaedic surgeons were found to be less aware of current non-drug treatments than family practitioners and less likely to refer to Chiropractors. (21)Indeed, another example how they put medical politics above patient care.

Not only are MDs poorly educated in MSDs and responsible for the 'disastrous effects' of the opioid crisis, this inter-professional conflict is an example of an '*overlapping occupation*' working far over the top of its Scope of Practice when the *National Pain Strategy* admitted MDs were a poor choice to manage chronic pain cases:

'*Physicians are not adequately prepared and require greater knowledge and skills to contribute to the cultural transformation in the perception and treatment of people with pain*'. (22)

Most MDs deceived patients by not confessing spinal problems are outside their scope of expertise because, in fact, most MDs are inept according to many medical experts themselves.

Mark Schoene, editor of an international spine research journal, *The BACK Letter*, also commented on the buffoonery to use MDs as the POE for chronic pain patients considering they created this terrible opioid epidemic in the first place. He commented on this quandary in his article 'Why Should the National Pain Strategy Be MD-Centric?' (23)

'*Primary care physicians and pain specialists don't have unimpeachable backgrounds in the management of chronic pain in the U.S. These are the medical professions primarily responsible for the opioid over-treatment crisis. Are the two professions that helped create the worst pain management crisis in the history of modern medicine capable of leading the way forward? That remains to be seen*'.

17. Lebovits AH, Florence I, Bathina R, Hunko V, Fox MT, Bramble CY. Pain knowledge and attitudes of healthcare providers: practice characteristic differences. Clin J Pain. 1997;13:237-43.
18. Wolfert MZ, Gilson AM, Dahl JL, Cleary JF. Opioid analgesics for pain control: Wisconsin physicians' knowledge, beliefs, attitudes, and prescribing practices. Pain Med. 2010;11:425-34.
19. I've never forgotten at a high school reunion a rather awkward conversation with one of my best friends who had become a very successful pharmacist. When we shook hands, he told me, '*We're now enemies*'. A few years later he was in jail for trading prescription opioids for street drugs, lost his license, and spent years in prison.
20. Day C., Yeh A., Franko O., Ramirez M., Krupat E. (2007) Musculoskeletal Medicine: An Assessment of the Attitudes of Medical Students at Harvard Medical School, Academic Medicine 82: 452-7.
21. Finestone AS, Raveh A, Mirovsky Y, Lahad A, Milgrom C. Orthopaedists' and family practitioners' knowledge of simple low back pain management.Spine (Phila Pa 1976) 2009 Jul 1;34(15):1600-3.
22. http://iom.nationalacademies.org/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming Prevention-Care-Education-Research.aspx, pp.5.
23. Why Should the National Pain Strategy Be MD-Centric? BackLetter: February 2016 - Volume 31 - Issue 2 - p 16

Today the consensus opinion agrees medical primary care physicians lack training in musculoskeletal disorders (MSDs), (24) are more prone to ignore recent guidelines, (25) more likely to suggest spine surgery than surgeons themselves, (26) and only 2% of primary care physicians (PCPs) refer to DCs as a non-drug treatment despite our superior training and clinical results. (27)

An important finding from one study, *Interprofessional referral patterns in an integrated medical system*, found when PCPs were asked by patients to recommend Chiropractic care their PCP became reluctant and uncooperative. Close to 88% of MDs preferred self-referral where patients contact a chiropractor on their own, another sign of '*chirophobia*', the fear of being caught socialising with Chiropractors as the AMA demanded enforced by the *Committee on Quackery*. This is just another sign of medical supremacy just as the same white male orthopaedists who will not refer to chiropractors probably are members of exclusive all-white golf clubs too.

A 2024 study '*Healthcare provider perspectives on integrating a comprehensive spine care model in an academic health system: a cross-sectional survey*', by Christine Goertz et al at *Duke* found similar hesitation among respondents for the need for guidelines and referrals in a multidisciplinary setting, but seemed tentative to do so:

> Background:
>
> Healthcare systems (HCS) are challenged in adopting and sustaining comprehensive approaches to spine care that require coordination and collaboration among multiple service units. The integration of clinicians who provide first line, evidence-based, non-pharmacological therapies further complicates adoption of these care pathways.
>
> Respondents reported that guidelines were:
>
> - implementable within DUHS, but no spine care guideline was used consistently across provider types.
> - Guideline access and integration with electronic records were barriers to use.
> - Respondents (81%) agreed most patients would benefit from non-pharmacological therapies such as physical therapy or chiropractic before receiving specialty referrals.
> - Providers perceived spine patients expected diagnostic imaging (81%) and medication (70%) over non-pharmacological therapies. Providers agreed that receiving imaging (63%) and opioids (59%) benchmarks could be helpful but might not change their ordering practice, even if nudged by best practice advisories.
> - Participants felt that an optimal spine care workforce would require more chiropractors and primary care providers and fewer neurosurgeons and orthopedists.
>
> Conclusions:
>
> Spine care clinicians had positive support for current tenets of guideline-concordant spine care for low back pain patients. However, significant barriers to implementation were

24. Elizabeth A. Joy, MD; Sonja Van Hala, MD, MPH. Musculoskeletal Curricula in Medical Education - Filling In the Missing Pieces. The Physician And Sports Medicine. 32/ 11 (November 2004).
25. PB Bishop et al, The C.H.I.R.O. (Chiropractic Hospital-Based Interventions Research Outcomes) part I: A Randomized Controlled Trial On The Effectiveness Of Clinical Practice Guidelines In The Medical And Chiropractic Management Of Patients With Acute Mechanical Low Back Pain," presented at the annual meeting of the International Society for the Study of the Lumbar Spine Hong Kong, 2007; presented at the annual meeting of the North American Spine Society, Austin, Texas, 2007; Spine, in press.
26. SS Bederman, NN Mahomed, HJ Kreder, et al. In the Eye of the Beholder: Preferences Of Patients, Family Physicians, and Surgeons for Lumbar Spinal Surgery," Spine 135/1 (2010):108-15.
27. Matzkin E, Smith MD, Freccero DC, Richardson AB, Adequacy of education in musculoskeletal medicine. J Bone Joint Surg Am 2005, 87-A:310-314

identified, including mixed opinions about integration of non-pharmacological therapies, referral pathways, and best practices for imaging and opioid use.

Let me add an observation of the *Duke University* physicians confessing to '*significant barriers*' and their '*mixed opinions about integration*' of guidelines. Undoubtedly they were speaking of those dreaded chiropractors who they were taught to scorn, aka, '*chirophobia*', in their medical indoctrination explains their reluctance and why improvement in spine care is more than scientific studies alone can accomplish especially in light of their realisation that '*Participants felt that an optimal spine care workforce would require more Chiropractors and primary care providers and fewer neurosurgeons and orthopedists*'. (28)

Some PCPs mention that they do not know enough about chiropractic to have an opinion. This excuse is rather odd considering chiropractic is the 3rd largest physician-level health profession after medicine and dentistry. Back pain is the second leading cause of all physician visits in the US. In fact, half of all working Americans admit to having back pain each year, yet these MDs put on the '*willful ignorance*' excuse suggesting they have no opinion about chiropractic is very odd, isn't it, because as highly educated people they had to have known.

Replacing primary care physicians with doctors of chiropractic as the Primary Spine Care Providers is essential if the US is to solve this opioid and back pain pandemic.

Mark Schoene warned patients:

> 'Back care in the United States has been heavily oriented around opioids, excessive imaging, and early referrals to surgeons. So, in this area of medicine, patients would be well advised to take their doctors' diagnostic and treatment recommendations with a large grain of salt'. (29)

Dr Marc Siegel on FOX News also admitted primary care providers have only 9 hours of education on "'the back' and he blamed the opioid epidemic on his colleagues and pharmacists. '*We're getting a growing awareness of two things: the abuse of back surgery and the abuse of opioids*'. (30)

Richard Deyo, MD, MPH, author of '*Watch Your Back*!'also mentioned the problems with medical treatments and physician incompetence in diagnosis and treatment of low back treatments:

> 'Calling a [medical] physician a back pain expert, therefore, is perhaps faint praise, medicine has at best a limited understanding of the condition. In fact, medicine's reliance on outdated ideas may have actually contributed to the problem' (31)

Scott Boden, MD, currently director of the *Emory Orthopaedic and Spine Center* in Atlanta, also warned of this fiasco years ago in 2003 in an article in *Spine* when he admitted:

> 'Many, if not most, primary care providers have little training in how to manage musculoskeletal disorders'. (32)

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28. This quandary reminds me of an essay I wrote, Jackie Robinson, DC. Although he was great at every level of baseball from high school to UCLA where he was the only athlete to ever letter in four sports, people questioned whether he could cut it on the major league level due to racism. Finally, when given a chance, Jackie proved them wrong although he was still subjected to the wrath of racist fans and players alike. The same will be said when guidelines call for chiropractors to supplant PCPs and spine surgeons in the *"white only" American orthopedic system* we now have.
29. *Massive Wave of Unregulated Medical Marketing Putting Patients and Providers in Peril'*
30. Dynamic Chiro, May, 2017
31. Deyo, RA. Low -back pain. Scientific American, pp. 49-53, August 1998.
32. S Boden, et al. Emerging Techniques For Treatment Of Degenerative Lumbar Disc Disease. Spine 28 (2003):524-5.

Fortunately, experts are now speaking out against such as editor Mark Schoene of the BACKLetter, an international spine research journal:

> 'As anyone who follows medical news is aware, excessive prescription of opioids for back and other forms of chronic pain has prompted a destructive epidemic of overdoses and deaths, with more than 17,000 deaths per year. And the opioid over-treatment epidemic has in turn kicked off a terrible wave of heroin addiction and overdose deaths.
>
> 'Low back pain has helped trigger a lethal and growing heroin addiction epidemic in the United States. How could that be? Unfortunately, it is easy to connect the dots', (33)

More dots

Let me add a few more dangerous 'dots' in spine care, such as the diagnosis for most neck or back pain. If your physician says you have a 'bad disc' causing your pain, this is an admission of his/her ignorance.

Subsequent studies from around the world have also debunked the discogenic theory that back pain was mainly due to herniated, bulging, or degenerated discs, (34) but this 'bad disc' diagnosis remains as medical folklore as the basis of most back surgeries today only to deceive the gullible patients.

Even when there is nerve root pressure such as sciatica, that does not relate to the need for surgery as many are led to believe when their PCP says '*You've got a ruptured disc*', a debatable term aimed to frighten patients similar to a *ruptured appendix*, which is a serious problem requiring immediate action. But that is not the case with most '*back attacks*'.

The issue of immediate spine surgery is not a new revelation considering in 1994 the *Agency for Health Care Policy & Research* (AHCPR) mentioned no need to rush into fusions:

> 'Even having a lot of back pain does not by itself mean you need surgery. Surgery has been found to be helpful in only 1 in 100 cases of low back problems. In some people, surgery can even cause more problems. This is especially true if your only symptom is back pain'. (35)

Plus, surgery is not the only solution to an acute '*back attack*'. In 2012 the North American Spine Society also published *What Is The Role Of Spinal Manipulation In The Treatment Of Lumbar Disc Herniation With Radiculopathy*?

The authors concluded that of patients with sciatica that fail three months of medical management, 60% will benefit from spinal manipulation to the same degree as if they undergo surgical intervention. For the 40% that are unsatisfied, surgery providers an excellent outcome. Although this study is a randomised controlled trial, it provides case series (Level IV) therapeutic evidence that spinal manipulation is beneficial in treating patients with lumbar disc herniation with radiculopathy.

Indeed, the 'bad disc' concept has been dispelled over the last three decades, but the medical profession has been strangely mute telling their patients of this monumental paradigm shift in spine care diagnosis despite the admissions of the leaders in spine research such as Mayo.

Schoene also mentioned the intransigence of the medical status quo:

> 'Multiple evidence reviews and guidelines have recommended a major paradigm shift in the management of low back pain in the United States and other countries. However, the

33. The BACK Letter, Volume 30, Number 10, 2015
34. SD Boden, DO Davis, TS Dina, NJ Patronas, SW Wiesel. Abnormal Magnetic-Resonance Scans Of The Lumbar Spine In Asymptomatic Subjects: A Prospective Investigation'. J Bone Joint Surg Am. 72 (1990):403-8.
35. *Acute low back problems in adults: assessment and treatment. Agency for Health Care Policy and Research*

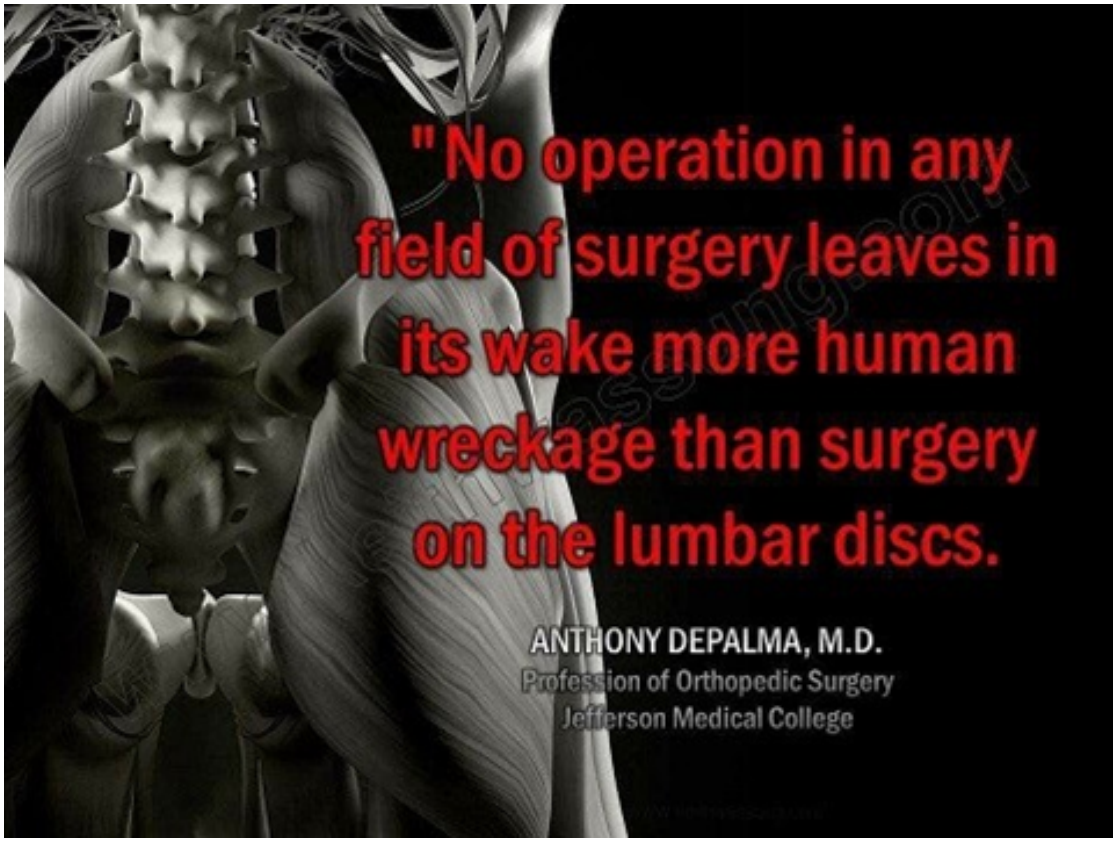
US medical system has been slow to adopt these recommendations on a national basis'. (36)

The paradigm shift in spine diagnosis and treatment began in 1990 with MRI research by Scott Boden MD, that was followed in 1994 by a supportive study by Maureen Jensen et al (37) who found no clear correlation between disc abnormalities and back pain.

'*It should be emphasised that back pain is not necessarily correlated or associated with morphologic or biomechanical changes in the disc*', according to Dr Scott Boden. '*The vast majority of people with back pain aren't candidates for disc surgery*'. (38)

Agreeing with Boden is another leading spine researcher, Richard Deyo MD, MPH, who criticised these '*old concepts supported only by weak evidence*' and the over-reliance on MRI exams to infer disc abnormalities as the main cause of back pain and justification for back surgery.

Deyo also confirmed that '*many of these abnormalities are trivial, harmless, and irrelevant, so he recently dubbed them as "incidentalomas" because they may be incidental to your pain as he explains: 'And we know that bulging, degenerated, and even herniated discs in the spine are common among healthy people with no symptoms. When doctors find such discs in people with back pain, the discs may be irrelevant, but they are likely to lead to more tests, patient anxiety, and perhaps even unnecessary surgery*'. (39)



36. Unsavory Publicity for U.S. Spine Surgeons, The BACKLetter, Volume 22, Number 2, 2007
37. MC Jensen, MN Brant-Zawadzki, N Obuchowski, MT Modic, D Malkasian, JS Ross, "Magnetic Resonance Imaging Of The Lumbar Spine In People Without Back Pain," N Engl J Med. 331 (1994):69-73.
38. Boden, S et al. (2003) Emerging techniques for treatment of degenerative lumbar disc disease, Spine 28:524-525.
39. Richard A. Deyo, MD, MPH and Donald L. Patrick, PhD, MSPH, Hope or Hype: The Obsession with Medical Advances and the High Cost of False Promises, AMACOM books, (2005): 36-37

The Mayo Clinic research also found 'bad discs' in pain-free people. In November, 2014, the Mayo Clinic released its review by Waleed Brinjikji, MD, and his colleagues, *Systematic Literature Review of Imaging Features of Spinal Degeneration in Asymptomatic Populations*. This Mayo review found a consensus among 33 MRI studies from around the world that undermines the rationale for fusion surgery based solely on this 'bad disc' idea that is used to lure unsuspecting patients into disc fusion surgery.

The following 'Table 2' shows by age 50 in pain-free (asymptomatic) people, there is an 80% chance of degenerative disc disease. However, surgeons fail to mention this is part of the normal aging process to patients thereby leading them to unnecessary disc fusion. This is another reason why Informed Consent is necessary to warn all patients of this scam and to urge them to try conservative care before drugs, shots, or surgery as the guidelines recommend.

Table 2: Age-specific prevalence estimates of degenerative spine imaging findings in asymptomatic patients[a]

	Age (yr)						
Imaging Finding	20	30	40	50	60	70	80
Disk degeneration	37%	52%	68%	80%	88%	93%	96%
Disk signal loss	17%	33%	54%	73%	86%	94%	97%
Disk height loss	24%	34%	45%	56%	67%	76%	84%
Disk bulge	30%	40%	50%	60%	69%	77%	84%
Disk protrusion	29%	31%	33%	36%	38%	40%	43%
Annular fissure	19%	20%	22%	23%	25%	27%	29%
Facet degeneration	4%	9%	18%	32%	50%	69%	83%
Spondylolisthesis	3%	5%	8%	14%	23%	35%	50%

The 'bad disc' diagnosis has become the biggest scam in spine care as Deyo suggests '*It's easy to be fooled into thinking these incidentalomas are the cause of their pain*'. Since spine surgeons still use this debunked '*bone on bone*' sales pitch as the need for surgery and they are making millions by keeping this hoax alive.

It is past time to listen to the many spine surgery whistleblowers warning the public about the outdated models of care shown to be ineffective, dangerous, and costly that are based on widespread misconceptions such as the 'bad disc' diagnosis still in use despite being disproven by 33 studies including the Mayo Clinic. This resistance explains the high failure rates, repeat surgeries, and readmission rates that are shocking.

The *North American Spine Society* (NASS) published online a Public Education Series that includes '*Spinal Fusion*'. Remarkably, this explanation proved to be very accurate, including the opinion that '*Fusion under these conditions is usually viewed as a last resort and should be considered only after other conservative (nonsurgical) measures have failed*'.

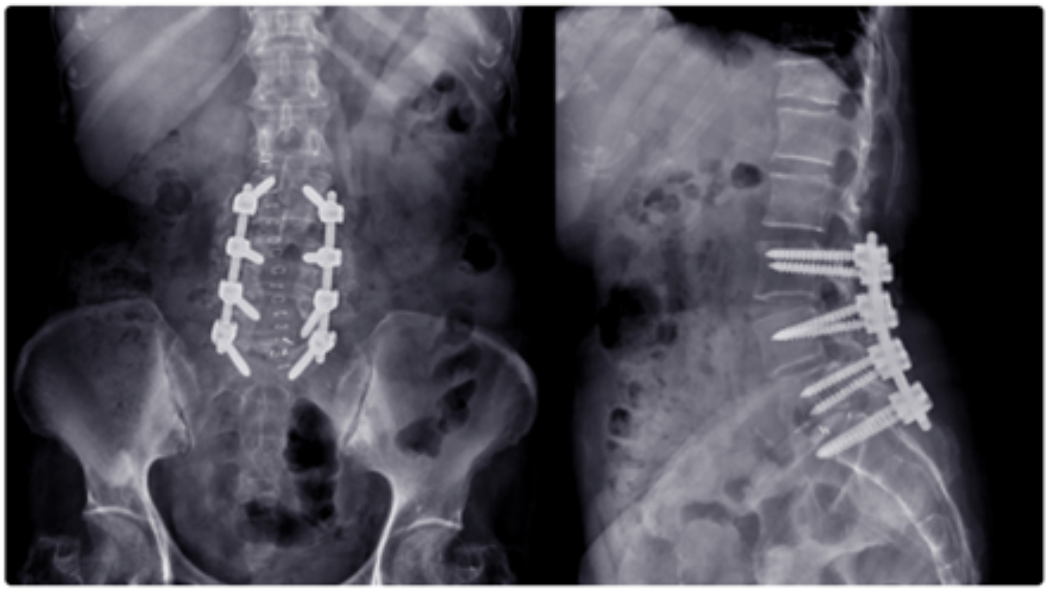
The NASS stated:

> A major obstacle to the successful treatment of spine pain by fusion is the difficulty in accurately identifying the source of a patient's pain. The theory is that pain can originate from painful spinal motion, and fusing the vertebrae together to eliminate the motion will get rid of the pain.
>
> Unfortunately, current techniques to precisely identify which of the many structures in the spine could be the source of a patient's back or neck pain are not perfect. Because it can be so hard to locate the source of pain, treatment of back or neck pain alone by spinal fusion

is somewhat controversial. Fusion under these conditions is usually viewed as a last resort and should be considered only after other conservative (nonsurgical) measures have failed. (40)

The admission by NASS that fusion should be a last resort is a huge warning that has been unheard by the public and ignored by the medical professionals. My intention is to save those patients with common back pain and/or bad discs from the ravages of outdated medical spine care, prescription opioid painkillers, epidural steroid injections, and most of all, spine surgery. Not only do patients fail to realise the 'bad disc' premise is a false-positive diagnosis, but they also certainly have no idea what a spine fusion does to them.

In my office I kept on-hand an x-ray image of a lumbar fusion to show them and ask '*Is this what you want before trying chiropractic care?*' because no one is ever shown the results of a surgeon's handiwork …



Deyo acknowledged in his article, '*Low Back Pain*' that abnormal anatomy like a 'bad disc' was the cause in '*about 1%*' of most back pain cases. He then suggested '*Perhaps 85% of patients with isolated low back pain cannot be given a precise pathoanatomical diagnosis*'. He mentioned most back pain is '*mechanical*' in nature, aka, pathophysiological disorders, not bad anatomical problems

- '*Mechanical Low Back or Leg Pain*' constituted 97 percent of these cases, of which '*lumbar strain, sprain*' accounted for 70% of these cases. (41)
- '*Non-mechanical Spinal Conditions* [disc, fractures, infections]' accounted for about 1%
- '*Visceral Disease*' as referred pain accounted for 2%.

The 1979 New Zealand Inquiry (42) remarked about this dilemma when it suggests they may be looking for the wrong thing:

The problem is a functional not a structural one; the medical profession simply fails to see the direction and subtlety of the chiropractic approach towards spinal dysfunction. Because the

40. Spinal Fusion. North American Spine Society Public Education Series, www.spine.org/documents/fusion
41. Deyo RA, Weinstein JN. Low back pain. N Engl J Med 2001 Feb 1;344(5):363-70.
42. BD Inglis, B Fraser, BR Penfold, Commissioners, Chiropractic in New Zealand Report 1979, PD Hasselberg, Government Printer, Wellington, New Zealand, (1979): p. 55.

Chiropractor uses x-ray extensively the medical practitioner thinks he is looking for a gross bony change, and when the medical practitioner cannot see this on the x-ray the Chiropractor is using, he immediately becomes skeptical. He might as well expect to see a limp, or a headache or any other functional problem on x-ray.

How the spine functions and not only how it looks requires more than looking at an image on and MRI or x-ray overlooked concept of joint motion.

These topics, debunked 'bad discs' and inept MDs, have been controversial in the media as well as among spine researchers/editors.

> But the elephant in the Spine Cartel is the fact spine surgeons are the highest paid surgeons but have a failure rate of at least 50%. Can anyone name another profession with such statistics, the highest paid with the lowest success rate?

Researchers now agree the image of medical competency in musculoskeletal disorders, mainly back and neck pain, which are the main causes of opioid painkiller usage, (43) is an illusion if not a fraud as Schoene suggests. But the refusal to refer to chiropractors is both unethical and illegal regarding the Informed Consent laws.

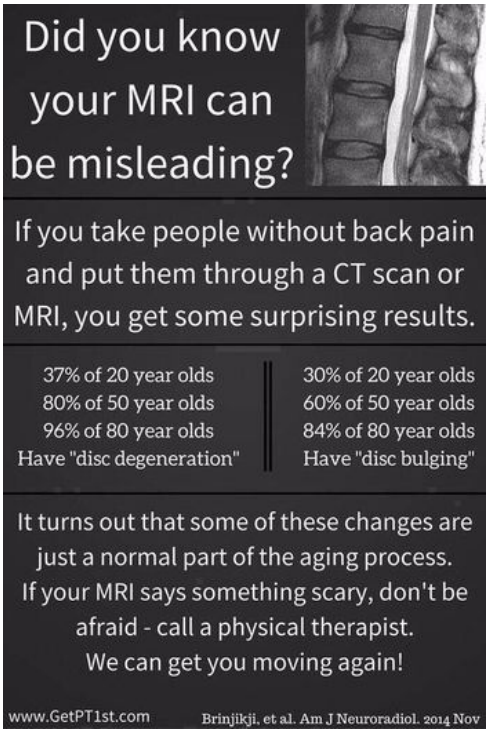
Medical liability can occur due to a flawed diagnosis, improper treatment, or even treating a patient without proper permission, such as the lack of a thorough Informed Consent. In my four decades of practice, I find it is a rare patient, especially those with failed back surgery syndrome, who were given a legitimate Informed Consent where Chiropractic care was mentioned as a frontline 'practical alternative' treatment before surgery. This is undoubtedly the biggest illegality by surgeons and hospitals that defraud patients by trafficking patients into unnecessary spine surgery by not informing patients of the current law or scientific research.

This should be considered entrapment of gullible patients in pain via inveiglement when surgeons also use false pretences to lure them into a spine surgery that most patients do not need. This conscious pattern to persuade gullible patients becomes a crime that includes the obvious defrauding and swindling of patients, which also may be a violation of *18 U.S. Code § 1341 - Frauds and Swindles*:

> …to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises…

The Spine Cartel ignores the research studies and expert opinions while convincing millions of people with misleading MRI scans detecting 'bad discs' and making billions of dollars deceiving patients despite the accumulating research showing the weak correlation between spine pathoanatomy (such as 'bad discs', arthritis, stenosis) and pain. (44)

43. Denise Boudreau, PhD, Michael Von Korff, ScD, Carolyn M. Rutter, PhD, Kathleen Saunders, G. Thomas Ray, Mark D. Sullivan, MD, PhD, Cynthia Campbell, PhD, Joseph O. Merrill, MD, MPH, Michael J. Silverberg, PhD, MPH, Caleb Banta-Green, and Constance Weisner, DrPH, MSW. "Trends in De-facto Long-term Opioid Therapy for Chronic Non-Cancer Pain," Pharmacoepidemiol Drug Saf. 2009 December ; 18(12): 1166–1175. DOI 10.1002/pds.1833.
44. *W. Brinjikji, et al, Systematic Literature Review of Imaging Features of Spinal Degeneration in Asymptomatic Populations, American Journal of Neuroradiology April 2015, 36 (4) 811-816;*



Dr Toad's wild ride on this medical train went from one scary destination of pharmaceutical drugs (OTC meds, muscle relaxants, depressants, prescription opioid painkillers) to the next destination of 'underwhelming' epidural steroid injections, and when all that fails, they end up at the final destination, a variety of spine surgery from disc fusion to newer concepts like minimally-invasive spine surgery to total disc replacement. As you will learn, Dr Toad does not forewarn passengers that most of these stop destinations are deemed placebo, very ineffective, temporary for most, or extremely dangerous and expensive.

For too many passengers their final destination is America's *Double Crisis* of opioid abuse and unrelenting back pain as the NIH decreed in 2018.

When passengers do experience side effects, Dr Toad then simply changes drug prescription to a stronger dosage or takes them to the next stop of invasive nerve blocks, spinal injections, or another spine surgery instead of letting them change tracks to complementary and alternative (CAM) treatments such as Chiropractic, acupuncture, yoga as guidelines suggest. (45)

Research shows even when disc bulges and herniations were confirmed that discs do often move back, and do so to a significant degree (70 percent or more). (46, 47, 48) Additional research now shows non-surgical spinal decompression (NSSD) also has a very high success rate (86% in one study,(49)) for confirmed disc problems without the need for drugs or surgery, but Dr Toad is reluctant to tell passengers that either NSSD or *chiropractic spinal care reduces the need for surgery* and *reduces opioid* consumption risks and abuse.

Instead, Dr. Toad recommends another ride to the surgical operating room because approximately 15%-20% of passengers who had a spinal fusion procedure for degenerative disease of the lumbar spine during the ensuing *3 - 5 years will require revision lumbar surgery*. And within 5 to 8 years, 30 to 40 percent of fusion them will develop *adjacent segment disease*

45 *Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians*

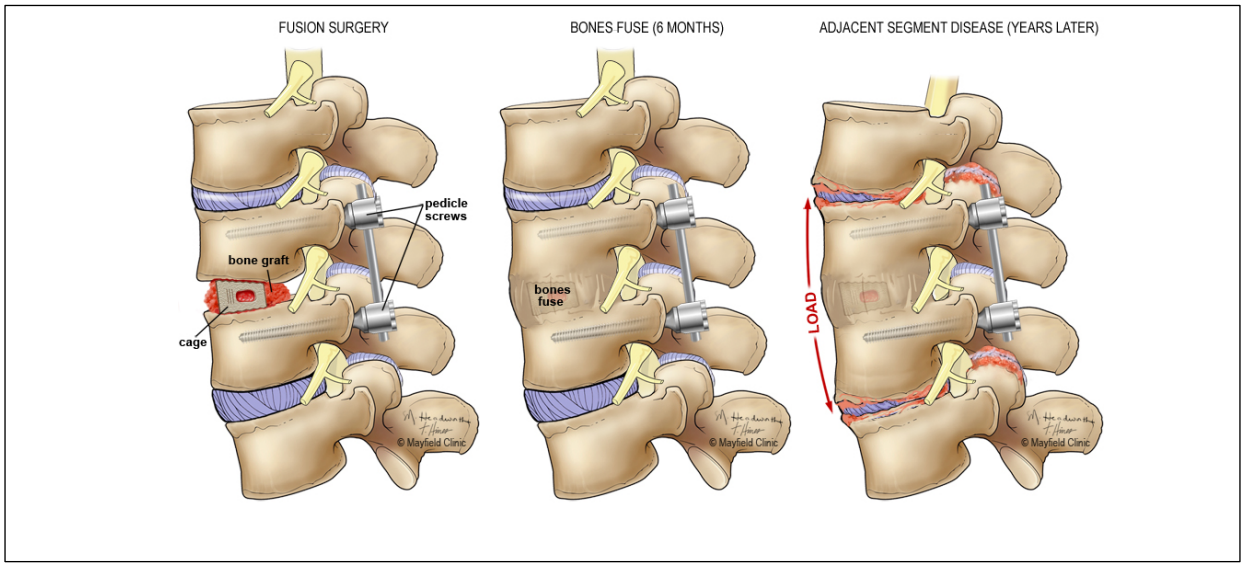
46. E Ilkko, S Lahde, ER Heikkinen. Late CT Findings In Nonsurgically Treated Lumbar Disc Herniations. Eur J Radiol. 16/3 (1993):186-189.

47. MR Ellenberg, ML Ross, JC Honet, et al. Prospective Evaluation Of The Course Of Disc Herniations In Patients With Proven Radiculopathy. Arch Phys Med Rehab 74/1 (1993):3-10,

48. K Bush, N Cowan, DE Katz, et al. The Natural History Of Sciatica Associated With Disc Pathology. Spine 17/10 (1992):1205-1212.

49. Non-Surgical Spinal Decompression Study in Japan Utilizing the DRX9000®

requiring many to undergo additional fusions. Once a passenger has one surgery, it becomes a vicious loop they undergo again. A patient in Florida was subjected to a staggering number of operations (27 on the spine and 3 on various other joints) within the space of only 2 years. The term multiple operations on the same patient (MOSP) was coined to describe this entity. Even after adjustments and global write-offs, the patient subsequently estimated her total cost for 27 spine operations at approximately $800,000, all of which were paid in cash.



Instead of redirecting passengers to another and safer nonsurgical track, some passengers may also be lured into repeat spinal fusions with diminishing returns. (50) Some are convinced by slick television ads to a new gimmick 'minimally invasive' laser spine surgery. While they had hoped for a quick fix became a quick con as Jack Stern MD, PhD, FACS, wrote in his article *Lasers in Spine Surgery: A Review* '*To date, laser discectomy may be more effective in attracting patients than in treating them*'.

Indeed, there are always new, risky, expensive, and controversial surgeries to tempt gullible passengers in pain, but the medical conductors fail to mention the risks along this wild ride. Nor does Dr. Toad mention practical alternatives as the Doctrine of Informed Consent demands.

For most passengers on Dr Toad's Wild Ride, their ending wasn't fun and passengers ended up right where they began at the start, still in pain according to Harvard Medical School article, *Back Surgery Success Rate & Failure Rate: Statistics*.

Despite the *high number of back surgeries*, unfortunately, many people don't get better after back surgery.

In fact, up to *74.6% of low back spine surgeries fail* to alleviate back pain, according to a 2016 review in the *Journal of Pain Research*.

The number is so high, there's an official medical term for this, *failed back surgery syndrome*. FBSS, as it is often called for short, refers to chronic back pain following back surgery.

How's that for failed back surgery statistics? According to *another research study*, it's estimated that around 80,000 people yearly are suffering due to back surgery failure. Failed back surgery statistics show that anywhere from *10-40% of FBSS patients* are affected.

50. *Failed Back Surgery Syndrome: A Review Article*

Another alarming stat, most patients who take opioids narcotics for chronic pain before lumbar fusion surgery *continue taking them long-term after surgery*.

According to Steven Atlas, an associate professor of medicine at *Harvard Medical School*, '*Based on the evidence, the indications for fusion are few and far between, but that doesn't stop surgeons from doing them or patients from getting them*'.

'*As a result, fusion has become the poster child for expensive, risky, and unnecessary back surgery. Your pain is typically decreased by 50%*'. Atlas says, '*but there are very few people who really have no pain after spinal fusion. The relief may last only a few years before the condition worsens again*'. (51)

Although some may have gotten temporary relief by masking pain with strong narcotics, researchers now show it wasn't long-lasting because most passengers were misdiagnosed, mistreated, and misinformed about practical alternatives. Literally, these passengers in pain were 'railroaded' by unethical conductors for a wild ride they will never forget and never got them where they needed to go.

As the latest research now shows, most passengers do not have '*pulled muscles*' or '*slipped discs*' as they are mistakenly told by inept medical conductors. Those are '*widespread misconceptions*' that lead to '*outdated models of care*' and the present 'Double Crisis' we now have with opioid abuse and unrelenting chronic back pain.

Today the most knowledgeable explanation basically states the underlying cause of back pain is 'joint dysfunction' and the lack of 'joint play'. Simply, approximate 70% of back pain (52) stems not from the discs, but joints. The *fallacy of bad discs* as the causative factor has long been debunked by the Mayo Clinic as the wrong track to take.

Alf L. Nachemson, MD, regarded as the godfather of the evidence-based spine care movement, also admits a disdain for surgery:

> 'Fusion surgery is typically not a cure and should not be presented as such. Few patients experience complete relief of back pain following surgery. Only one in five patients in these studies became pain-free'. (53)

Nachemson spoke on the dilemma on the aetiology of low back pain and concluded joint motion as the primary problem:

> 'Many people have focused on the disc as the potential cause of pain. But its role in back pain causation is no more proven than those of other structures. Our knowledge of back pain causation remains poor. We still do not have diagnostic techniques that can link structural abnormalities to symptoms with any accuracy … I continue to believe that the origin of nonspecific back pain lies in the motion segment'. (54)

Many became permanently disabled, many left broke, and hopeless living in unrelenting pain from failed disc surgery on post-surgical opioid therapy, especially those who had multiple re-surgeries of diminishing returns that also failed. (55)

The NIH in 2018 described this sad situation as a *Double Crisis*:

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51. *Back Surgery Success Rate & Failure Rate: Statistics*
52. Drs. Richard Deyo and James Winterstein acknowledged this in their article, *Low Back Pain*.
53 RA Deyo, A Nachemson, SK Mirza. Spinal-Fusion Surgery - The Case for Restraint. New England Journal of Medicine 350/7 (February 12, 2004):643-644
54. A Tribute to Alf Nachemson: The Spine Interview, The BACKLetter, Volume 22, Number 2, 2007
55. *Failed Back Surgery Syndrome: A Review Article*

> 'The United States is facing a double crisis: opioid addiction and unrelieved pain. An estimated two million Americans are addicted to opioids; overdose fatality rates rose more than 20 percent in the past two years. Some 25 million Americans suffer from daily chronic pain and lack effective non-opioid treatments to manage that pain'.

The Washington Post also has '*blown the whistle*' on this '*slippery slope*' in spine care as they called the descent from drugs to surgery.

I tease my patients who initially went to their primary care provider for spine care treatment because they could have gotten the same bad advice at their hair salon (plus they would leave prettier and without narcotics in their purses or screws in their spines).

Nor do they realise their primary care providers are as inept in spine care as Dr Toad was at conducting the wild train. Schoene makes the case primary care practitioners are dangerous to patients: '*One can make the argument that the most perilous setting for the treatment of low back pain in the United States is currently the offices of primary care medical practitioners, primary care MDs. This is simply because of the high rates of opioid prescription in these settings*'. (56)

Many primary care physicians resemble 'Dr Toad' willing to take their patients on his wild ride on the medical railroad although the warning signs are posted everywhere, but once his passengers become addicted to opioids, they cannot stop. Many then face their next challenged because even tapering down this narcotic painkiller is dangerous.

Passengers believe Dr Toad knows what he's doing, but not so according to studies. First of all, MDs are not trained in the latest spine care guidelines or treatments. The British medical journal, *The Lancet*, in a 2018 comprehensive 3-part review, *Low back pain: a call for action*, described this massive worldwide pandemic has been compounded by '*outdated models of care*' based on "*widespread misconceptions, inappropriate tests, risky surgeries, and painkillers, often against treatment guidelines*'. (57)

Indeed, the major obstacle to overcome on this wild ride begins with the poor training by Dr Toad in spine care and procedures of medical conductors themselves.58 Consequently, at the urging of their medical conductor, many people take the medical train grasping with white knuckles at the medical straws of quick-fix chemical and surgical procedures that have now proven mostly placebo in most cases. (59)

To make matters worse, there were no guardrails insight, no Informed Consent alerts, and no warnings of possible failed surgery or doctor malpractice from unsuccessful spine surgery with the likelihood of permanent side effects such as opioid addiction or disability from repeated surgeries. Despite 'best practices' guidelines and the *Doctrine of Informed Consent*, passengers are misled to medical conductors who *had to have known* their '*outdated models of care*' were based on '*widespread misconceptions*'. They had to have known spine surgery has a history of failure and diminishing returns60, but fail to warn their passenger patients on the wild ride.

Before departure on Dr Toad's Wild Ride, the train station master should have announced these warnings about their MDs or surgeons, a case can be made these ill-informed, misguided patients are 'trafficked' by MDs onto the medical fast track because in the majority of 'nonspecific'

56. The BackLetter, volume 30, number 10, 2015
57. *Low back pain: a call for action*
58. Boden S, et al. Emerging techniques for treatment of degenerative lumbar disc disease. Spine, 2003;28:524-5.
59. Of course, there are caveats, the very small percentage (5-7%) of red flag cases consisting of fracture, cancer, serious infections, *cauda equina*, and the rare and unusual congenital cases that do need appropriate medical spine care. But, for most commonplace mechanical/pathophysiological in nature, not pathoanatomical, the chiropractic brand of non-invasive 'hands-on' spine care is rated among the best care.
60. *Failed Back Surgery Syndrome: A Review Article*

low back pain cases, none of the medical treatments correct the underlying functional problem with the spinal joints, called vertebral subluxations. Chiropractors have 'adjusted' these 'dysfunctional joints' since 1895 with good results to stay in business despite the medical genocidal war to 'contain and eliminate' this healing art.

So, for these misguided patients on Dr Toad's Wild Ride who pray the spine surgeon will help as they buy an expensive ticket to the final destination, never understanding the fraud of disc fusion nor the likelihood more than half will suffer failed back surgeries and go on more wild rides. For too many of these desperate patients, estimates suggest 50% will end up with failed back surgery syndrome (61) that results in spine re-surgery with a diminishing success rates, no more than 30%, 15%, and 5% of the patients experience a successful outcome after the second, third, and fourth surgeries, respectively, according to research by Alf Nachemson.62

Doctor, heal thyself

Another under-reported problem about Dr Toad's Wild Ride is the fact that Dr Toad may be stoned himself. His Wild Ride may be explained by the finding that '*69% of the physicians had misused prescription drugs sometime in the past*' according to an article in Medscape, *Why MDs Abuse Prescription Drugs*. Maybe these Dr Toads were taking a test drive before patients to check out the potency.

Dr Thomas Frieden, past Director of the CDC, mentioned this problem when he said, '*physicians have supplanted street corner drug pushers as the most important suppliers of illicit narcotics*'. (63)

Pain clinics have also added to what became known as the '*Hillbilly Heroin*' epidemic because Pharma focused on West Virginia, Ohio, and other Appalachian states. To better understand the damage of this Hillbilly Heroin epidemic, enjoy *INTERVENTION IN-DEPTH: HILLBILLY HEROIN*: The story of Jon Riley Hays, MD:

> '*Just because you're a physician, you don't automatically become immune to addiction*', Hays said. '*Maybe you're a little more highly educated. But as in my case, yeah, I knew I was addicted. I knew the warning signs for everything, but it didn't prevent it*'.

Ironically, the reason given why many MDs abuse prescription drugs sounds painfully similar to what most patients might say, too: '*Several of the physicians who said that they misused drugs reported that it was because they had trouble trusting the recommendations from their treating provider*'. (64)

Indeed, someone is asleep at the wheel of the Hillbilly Heroin train when both patients and physicians alike are addicted and the prevailing mantra by the shills for Big Pharma ridicule cautious MDs accusing them of '*opioid phobia*'.

Apparently, these pain management specialists (PMR) operating 'pill mills' and Big Pharma reps have adopted folk singer Bob Dylan's popular song, '*Everybody Must Get Stoned*', originally known as, '*Rainy Day Woman*', as their theme song.

A June 2015 survey published in Pain Medicine revealed the dangers Dr Toad faces in his own office. (65) In fact, the highest situation for violence involved opioids (89.9%). The survey found more than 8% of chronic pain care providers (CPCPs) now carry a gun for protection. The

61. *Failed Back Surgery Syndrome: A Review Article*
62. Nachemson AL. Evaluation of results in lumbar spine surgery. Acta Orthop Scand Suppl. 1993;251:130-33.
63. Centers for Disease Control and Prevention Press Release, CDC Vital Signs: Overdose of Prescription Opioid Pain Relievers—United States, 1999-2008; 2011: www.cdc.gov/media/releases/2011/t1101_presecription_pain_relievers.html.
64. Veterans Kick The Prescription Pill Habit, Against Doctors' Orders, by Quil Lawrence, All Things Considered. NPR, July 11, 2014
65. Kim David, MD, Daftari Anuj, and Sibai Nabil. Violence Toward Chronic Pain Care Providers: A national survey. Pain Medicine, June 2, 2015.

researchers found that 64% of CPCPs have called security and 51% had received threats. Discharging a patient was the most common risk (85%). Apparently, once a patient gets hooked on opioid painkillers, they resent being denied access to more drugs.

Once the prescription painkillers are depleted, it creates a 'gateway' situation where addicted patients turn to the street for more, creating a new set of problems. According to the National Institute of Drug Abuse, 80% of all heroin users begin using the drug after they have used opioid painkillers. (66)

Undoubtedly, the DEA's heightened restriction for opioid painkillers will have little impact as long as pain management conductors ignore the restrictions and believe pushing narcotics is fulfilling the Oath of Hippocrates, but instead of '*To Do No Harm*' the new Hippocratic Oath seems to say '*To Get Them High*'.

The size of this drug train is bigger than passengers realise according to the 2013 article in *Medscape.com* '*Many Docs Still Don't Understand Opioid Dependence*' that revealed opioid addiction is actually now more pervasive than those patients suffering from diabetes and cancer:

> 'Results showed that 12% of the adults reported personally struggling with opioid dependence, which the surveyors point out is more than those who struggle with diabetes (7%) or cancer (3%)' (67)

This survey of opioid addiction found it was compounded by shame, embarrassment, fear, and the delusion that patients and doctors alike think they can get off the drug train and stop their addiction anytime on their own:

> 'The survey also found that 77% of the adult participants and 93% of the clinicians said that shame, embarrassment, or fear that others would find out are among the main reasons why those with the addiction might not seek treatment.
>
> 'Although 71% of the adults and 85% of the clinicians said that many of these people think they can stop their addiction on their own, 83% and 92% agreed that a long-term combination of medication and behavioral changes is needed for successful treatment'.

In a NPR segment on opioid abuse in the military and DVA programs, 'Veterans Kick the Prescription Pill Habit, Against Doctors' Orders' Dr Richard Friedman, director of the *Psychopharmacology Clinic* at *Weill Cornell Medical College*, spoke of this prescription painkiller abuse:

> 'It's like giving a football player painkillers so he can finish the game. It gets him back on the field, but might hurt him worse in the long term'. (68)

Even our veterans cannot escape Dr Toad's Wild Ride to narcotic painkillers. In this case, however, boarding this drug train does not begin as a voluntary choice by veterans, but the mistreatment starts when VA doctors force patients with CLBP to take narcotic painkillers and epidural steroid injections before they will be referred to chiropractors for non-drug care as I have witnessed working with veterans referred from the Dublin (GA.) VA hospital.

Ironically, if these veterans using narcotics and steroids were in the NFL, Olympics, or college football, they would be banned from playing if caught.

Whether in private practice, the VA or military healthcare, or in sports, Dr Toad's Wild Ride is running wild out of control. Recently news articles have disclosed Dr Toad's Wild Ride includes NFL players where opioid painkillers were dispensed indiscriminately to enable them to continue

66. Donna Leinwand Leger, "OxyContin a Gateway to Heroin for Upper-Income Addicts," USA TODAY, June 28, 2013

20. Deborah Brauser, Deborah Brauser, Many Docs Still Don't Understand Opioid Dependence, www.medscape.com Jun 14, 2013

68 Veterans Kick The Prescription Pill Habit, Against Doctors' Orders, by Quil Lawrence, All Things Considered, NPR, July 11, 2014

their playing careers. On July 12, 2014, journalist Michael O'Keeffe of *The New York Daily News* revealed this 'pill mill' painkiller problem in his exposé, '*EXCLUSIVE: Feds quietly investigating prescription drug abuse in NFL locker rooms, sources say*'.

The *Drug Enforcement Administration's* probe began after attorneys representing about 1,300 NFL retirees filed a lawsuit accusing the league of illegally handing out painkillers, sleeping pills, and other drugs without informing players of the risks of health problems and addiction.

Former Chicago Bears quarterback Jim McMahon and other plaintiffs accuse the NFL of illegally providing prescription drugs without telling players about the risks. McMahon says he became hooked on pain pills, at one point gulping down more than 100 *Percocets* each month. (69)

Just like their fans, little do these NFL players realise the long-term risks far outweigh the short-term high of opioids that actually remain unproven for treatment of chronic pain since they do not correct the underlying structural problems. (70)

Not only is Dr Toad's Wild Ride addictive, but it is also deadly for some passengers. Roughly one in five deaths after lumbar fusion surgery is related to analgesic use, according to a report in Spine. The results indicate that the risk of such deaths is particularly high in young and middle-aged workers with degenerative disc disease. The investigators concluded:

> 'The most important finding of this study was that analgesic-related deaths, both suicidal and accidental, claimed the highest potential life lost (31.4%), more than heart disease (9.2%), cancer (9.1%), and liver disease (5.1%), combined'. (71)

Dr Chapo

Most Americans realise we have a huge opioid crisis, but they also do not understand this did not begin with the illegal drug cartel from Mexico. It came from the American Spine Cartel, (72) the medical-industrial enterprise comprised of the spine surgeons/orthopedists with other members of the AMA and Big Pharma, initially *Purdue Pharma* headed by the infamous Sackler family.

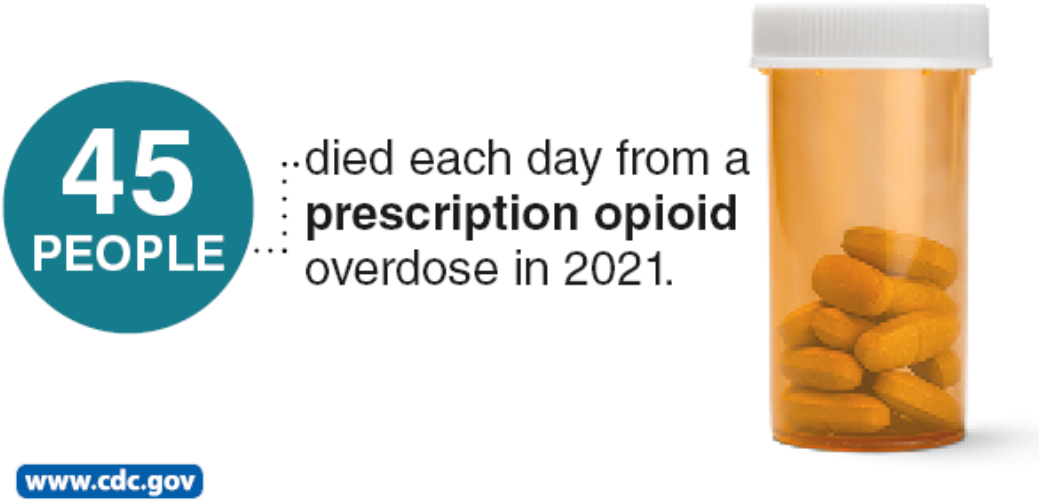
Indeed, this opioid crisis was not brought to middle America by the Mexican drug lord, '*El Chap*' but it was your favourite family physician '*Dr Chapo*, according to a study from *Stanford University* researchers:

> 'Opioid prescriptions are dominated by general practitioners, the family doctors, internists, nurse practitioners and physician assistants that most patients see for common problems, and not by a small cadre of high volume 'pill mill' prescribers once thought to be fuelling this epidemic'. (73)

Today the US has a widespread opioid distribution network that is killing 45 people daily according to the CDC but is perfectly legal. This conspiracy is reminiscent of the AMA in cahoots

69. Michael O'Keeffe, EXCLUSIVE: Feds quietly investigating prescription drug abuse in NFL locker rooms, sources say, NEW YORK DAILY NEWS, Saturday, July 12, 2014
70. Luis Enrique Chaparro, MD, Andrea D. Furlan, MD, PhD, Amol Deshpande, MD, Angela Mailis-Gagnon, MD, MSc, FRCPC, Steven Atlas, MD, Dennis C. Turk, PhD, *Opioids Compared With Placebo or Other Treatments for Chronic Low Back Pain*, An Update of the Cochrane Review, Spine. 2014;39(7):556-563
71. Deaths After Back Surgery Often Related to Analgesics by *California Spinal Rehab Clinic*, May 31, 2009 Reuters Health Information 2009. © 2009 Reuters Ltd
72. Members of the Spine Cartel enterprise include primary care '*promiscuous prescriber'* physicians, pain management '*needle jockeys'*, spine surgeons using '*outdated models of care*', *medical Bastille* hospitals, device manufacturers, radiologists, pharmacists, Big Pharma, all in cahoots with managed care organizations to boycott chiropractors to maintain its medical monopoly.
73. Jonathan Chen, *Overprescribing of opioids is not limited to a few bad apples*, Stanford Medicine News Center, Dec 14 2015

with *Big Tobacco* who convinced the gullible public that smoking cigarettes was safe from 1930 to 1986 when a class action lawsuit exposed this medical gang of imposters for what they were.



Thomas Frieden, past Director of the CDC, mentioned this problem when he said, 'physicians have supplanted street corner drug pushers as the most important suppliers of illicit narcotics'. (74)

The role of Chiropractors

This report will show the answer to this dilemma begins with Doctors of Chiropractic as the Primary Spine Care Providers (75) (PSCP) acting as the Portal of Entry (76) (POE) for all nonspecific neck and low back pain cases due to better education in spine care, *superior clinical results*, (77) *reduced costs*, *reduced opioid consumption risks and opioid abuse* (since back pain is the leading reason for opioid painkiller prescription (78)), and the research showing *chiropractic reduces spine surgery.*

The bottom line in this opioid crisis is simple: Chiropractic patients do not leave our offices suffering from failed back surgery in half the cases with screws in their spines and a prescription for opioids in their hands.

Not only are opioids dangerous, but they are also ineffective for low back pain (LBP) cases:

- 2007: *Relationship Between Early Opioid Prescribing For Acute Occupational Low Back Pain And Disability Duration, Medical Costs, Subsequent Surgery And Late Opioid Use*: Given the negative association between receipt of early opioids for acute LBP and outcomes, it is suggested that the use of opioids for the management of acute LBP may be counterproductive to recovery.

74. Centers for Disease Control and Prevention Press Release, CDC Vital Signs: Overdose of Prescription Opioid Pain Relievers—United States, 1999-2008; 2011: www.cdc.gov/media/releases/2011/t1101_presecription_pain_relievers.html.
75. *Chiropractors as primary care provider on the increase*
76. *Conservative Spine Care: The State of the Marketplace and Opportunities for Improvement*.
77. excluding Red Flags of cancer, fracture, infections, cauda equina, severe scoliosis
78. Denise Boudreau, PhD, Michael Von Korff, ScD, Carolyn M. Rutter, PhD, Kathleen Saunders, G. Thomas Ray, Mark D. Sullivan, MD, PhD, Cynthia Campbell, PhD, Joseph O. Merrill, MD, MPH, Michael J. Silverberg, PhD, MPH, Caleb Banta-Green, and Constance Weisner, DrPH, MSW. "Trends in De-facto Long-term Opioid Therapy for Chronic Non-Cancer Pain," Pharmacoepidemiol Drug Saf. 2009 December ; 18(12): 1166–1175. DOI 10.1002/pds.1833.

- 2018:*Treatment of Low Back Pain with Opioids and Nonpharmacologic Treatment Modalities for Army Veterans*: In the Veterans Health Administration (VHA) there is growing interest in the use of nonpharmacologic treatment (NPT) for low back pain (LBP) as pain intensity and interference do not decrease with opioid use.
- 2015: *Chronic Opioid Therapy After Lumbar Fusion Surgery for Degenerative Disc Disease in a Workers' Compensation Setting*: The majority of the study population was on chronic opioid therapy (COT) after fusion. COT was associated with considerably worse outcomes. The poor outcomes of this study could suggest a more limited role for discogenic fusion among WC patients.79

Today the research also clearly shows that chiropractic reduces both opioid consumption and *reduces spine surgery*. If the medical profession had anything as cost and clinically effective in this era of evidence-based medicine, they would be touting it across the nation as a 'wonder treatment' for this scourge. But when this revolutionary research promotes its chiropractic rivals, it has been ignored by the medical profession and government health agencies like the NIH study on *Double Crisis*. Instead of following science, the medical professionals follow the money.

Let me present upfront the research studies from the PubMed.gov website that reveals plenty of evidence that chiropractors can rescue this situation.

3rd stop:'modest' physical therapy

Since the guidelines all recommend using conservative (non-drug, nonsurgical) care initially, to avoid referring to DCs, most MDs may refer LBP patients to their local physical therapists (PT) for '*conservative care*', but research has found their brand of physical medicine to be modestly effective, it is not equivalent to chiropractic for spine care. Legally, PTs are not licensed or qualified by Medicare law to render the Chiropractic benefit to Medicare patients by adjusting '*vertebral subluxations*'.

Don't take it wrong because PTs do best with rehabbing football knees, helping stroke victims, post-surgical rehab, but they get poor results with backs. Standard physical therapy consisting of ultrasound, hot packs, and other physiotherapeutic modalities have not proven effective because PTs treating symptoms is different than correcting / adjusting the underlying cause, namely dysfunctional joint problems in spine injuries as chiropractors aim to do.

- 2015: Early Physical Therapy vs Usual Care in Patients With Recent-Onset Low Back Pain: A Randomized Clinical Trial.

  Conclusions and relevance:

  Among adults with recent-onset LBP, early physical therapy resulted in statistically significant improvement in disability, but the improvement was modest and did not achieve the minimum clinically important difference compared with usual care.
- 2018: McKenzie Method of Mechanical Diagnosis and Therapy was slightly more effective than placebo for pain, but not for disability, in patients with chronic non-specific low back pain: a randomised placebo controlled trial with short and longer term follow-up.

  Background:

79. Anderson, Joshua T. BS; Haas, Arnold R. BS, BA; Percy, Rick PhD; Woods, Stephen T. MD; Ahn, Uri M. MD; Ahn, Nicholas U. MD, "Chronic Opioid Therapy After Lumbar Fusion Surgery for Degenerative Disc Disease in a Workers' Compensation Setting," Spine, November 2015 - Volume 40 - Issue 22 - p 1775–1784

The McKenzie Method of Mechanical Diagnosis and Therapy (MDT) is one of the exercise approaches recommended by low back pain (LBP) guidelines. We investigated the efficacy of MDT compared with placebo in patients with chronic LBP.

Conclusion:

We found a small and likely not clinically relevant difference in pain intensity favouring the MDT method immediately at the end of 5 weeks of treatment but not for disability. No other difference was found for any of the primary or secondary outcomes at any follow-up times.

- 2018: Effectiveness of classic physical therapy proposals for chronic non-specific low back pain: a literature review.

  Conclusions:

  Based on the data obtained, classical physiotherapy proposals show ineffectiveness in the treatment of chronic non-specific low back pain.

  Despite the modest clinical effectiveness for physical therapy for LBP, the Georgia State Board of Workers Comp spent $27,404,501 during the 3-year span of 2013-2015 while spending only $420,095 for chiropractic services, clearly showing the systemic barrier to chiropractic care due to medical gatekeepers.

- 2018: Effectiveness of classic physical therapy proposals for chronic non-specific low back pain: a literature review: Ferran Cuenca-Martínez, PhD, Sara Cortés-Amador, PhD, and Gemma Victoria Espí-López, PhD, Department of Physiotherapy, Faculty of Physiotherapy, University of Valencia, Spain.

  Conclusions:

  Back School exercises and McKenzie's method were all ineffective. Osteopathic spinal manipulation proved effective when performed on the lower back and the thoracic area but only immediately after it was received, and not in the medium or long term. Massages proved effective in the short term too, as well as global postural reeducation although ultimately this study can be considered of a low methodological quality.

  Based on the data obtained, classical physiotherapy proposals show ineffectiveness in the treatment of chronic non-specific low back pain.

4th stop: Say no to pain clinics and needle jockeys

Not only are spine surgeries and opioids under attack, so are other standard medical treatments for back pain, such as epidural steroid injections in Washington state where a committee is considering whether state healthcare programs should continue to pay for spinal injection treatments for neck and back pain. According to March 18, 2011, newspaper report, '*State May Stop Funding For Spinal Injections*', a review of medical literature found there was '*little or no benefit to patients from the use of spinal injections, such as epidurals, to manage back and neck pain*'. (80)

After OTC and muscle relaxers fail, patients are referred to '*needle jockeys*' in pain management clinics for '*underwhelming*' steroid injections (81) that lead to a new set of problems with '*pill mills*' working under the guise of '*pain management*' clinics that are exploding.

The US Attorney's office in Atlanta says six times the number of people died of prescription drug abuse in Georgia last year than from all other illegal drugs combined.

80. Michelle Dupler, "State may stop funding for spinal injections," 03/18/2011, The News Tribune.com
81. Major Review Finds Scant Evidence to Support Spinal Injections as Treatments for Back and Leg Pain, BackLetter: June 2015 - Volume 30 - Issue 6 - p 64–65

Dr Barry Straus with the North Georgia Pain Clinic says weak laws and lack oversight has sent a flood of illegal clinics and operators to his state.

> 'Much of the problem is the physicians who don't really know how to treat chronic pain but are viewing this as a quick buck and an easy way to get rich and prescribe out medicines—essentially being a legal drug dealer'. (82)

Instead of acknowledging the latest research and evidence-based guidelines, the Spine Cartel had to have known its 'outdated models of care' were proven to be deceptions:

- opioid painkillers (83) were shown to be no better than NSAIDs
- epidural steroid injections were deemed '*underwhelming*' (84)
- spinal cord stimulators (85) '*raise more doubt than substance*'.

Dr Roger Chou et al found in his 2015 study in the *Annals of Internal Medicine*, *Epidural corticosteroid injections for radiculopathy and spinal stenosis: a systematic review and meta-analysis*: Epidural corticosteroid injections for radiculopathy were associated with immediate reductions in pain and function. However, benefits were small and not sustained, and there was no effect on long-term surgery risk. Limited evidence suggested no effectiveness for spinal stenosis.

- *Epidural corticosteroid injections for lumbosacral radicular pain*

Authors' conclusions: This study found that epidural corticosteroid injections probably slightly reduced leg pain and disability at short-term follow-up in people with lumbosacral radicular pain. In addition, no minor or major adverse events were reported at short-term follow-up after epidural corticosteroid injections or placebo injection. Although the current review identified additional clinical trials, the available evidence still provides only limited support for the use of epidural corticosteroid injections in people with lumbosacral radicular pain as the treatment effects are small, mainly evident at short-term follow-up and may not be considered clinically important by patients and clinicians (i.e. mean difference lower than 10%).

- *Lack of Superiority of Epidural Injections with Lidocaine with Steroids Compared to Without Steroids in Spinal Pain: A Systematic Review and Meta-Analysis*

  > Conclusion: Overall, the present meta-analysis shows moderate (Level II) evidence for epidural injections with lidocaine with or without steroids in managing spinal pain secondary to disc herniation, spinal stenosis, discogenic pain, and post-surgery syndrome based on relevant, high-quality RCTs. Results were similar for lidocaine, with or without steroids.

When in dire pain, patients often fail to realise how dangerous the wild ride can be. According to a 2014 study by the *Centers for Disease Control* (CDC) of data from 2012, *Opioid Painkiller Prescribing,* (86) MDs prescribed 259 million prescriptions for opioids, nearly one for every American adult. Each day, 46 people die from an overdose of prescription painkillers in the US, killing nearly as many people annually as all car wrecks combined. (87)

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82. Edgar Treiguts, "State's Prescription Drug Abuse 'Epidemic'," Georgia Public Broadcasting, March 2, 2011
83. Department of the Veterans Administration researcher Dr. Erin Krebs, "*Opioids are no better than NSAIDs for chronic back or arthritis pain*"
84. Epidural steroid injections also proven to be "underwhelming" in a *Major Review Finds Scant Evidence to Support Spinal Injections as Treatments for Back and Leg Pain*, sponsored by the U.S. Agency for Healthcare Research and Quality (AHRQ).
85. "Renewed doubt about spinal cord stimulation for chronic pain—as its popularity soars," The BACKLetter, vol.37, No. 12, December 2022.
86. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, *www.cdc.gov/vitalsigns/*, July 2014.
87. CDC Vital Signs, *http://www.cdc.gov/vitalsigns/pdf/2014-07-vitalsigns.pdf*.

This locomotor of narcotics painkillers recently hit a speed bump on August 21, 2014, when the DEA published its *Final Rule* heightening restriction of hydrocodone-combination products (HCPs). Pure hydrocodone drugs are listed as Schedule II drugs but HCPs, those made with other non-narcotic ingredients like acetaminophen or aspirin, were listed as the less-restrictive Schedule III. The DEA is now putting HCPs on par with powerful illegal narcotics including heroin and methamphetamine, as well as commonly abused medications *Adderall* and *Ritalin*.

DEA Administrator Michele Leonhart commented '*Today's action recognizes that these products are some of the most addictive and potentially dangerous prescription medications available*'. (88)

No other class of drugs, pushed or prescribed, is responsible for as many deaths according to the CDC. (89) Deaths increased to almost 17,000 people per year, up more than 400% from 1999. And for every death, more than 30 people are admitted to the emergency room because of opioid complications. (90)

Comments in The New York Times on the DEA Ruling '*In Move to Curb Drug Abuse, D.E.A. Tightens Rule on Widely Prescribed Painkiller*' emphasize the dangers of this out-of-control medical train:

> 'Abuse of painkillers now claims the lives of more Americans than heroin and cocaine combined, according to federal data, and the number of Americans who die from prescription drug overdoses has more than tripled since the late 1990s. Prescription drugs account for the majority of all drug overdose deaths in the United States. In all, drug-induced deaths have outstripped those from traffic accidents'. (91)

The rescheduling means people will be able to receive the drugs for only up to 90 days without obtaining a new prescription in person, no longer able to phone or fax-in one, yet a small hurdle to overcome for pill mill MDs or anyone addicted to painkillers.

5th stop: MRI cascade of waste

Not only has opioid abuse escalated, but so has the overuse of MRIs. A 2009 study found the abundance of MRI scans lead to excessive back surgeries. According to *Stanford University Medical Center*, patients who live in areas with more MRI scanners are more likely to undergo spine surgery. (92) '*The worry is that many people will not benefit from the surgery, so heading in this direction is concerning*', said senior author Laurence Baker, PhD. (93)

Without question, the MRI scan to locate disc abnormalities has been the best sales pitch by surgeons to convince patients of surgery when, in effect, these '*incidentalomas*' are commonplace. (94) Like grey hair, disc abnormalities are now viewed as a normal part of the aging process and may have nothing to do with back pain.

Researchers now recognise a lesser-known fact that disc bulges and herniations often undergo some degree of regression without surgery, but this finding has also been ignored by spine

88. *DEA to Publish Final Rule Rescheduling Hydrocodone Combination Products*
89. Louise Radnofsky and Joseph Walker, *Clampdown on Popular Painkillers*, WSJ, 8/22/2014.
90. Special report: The dangers of painkillers, Consumers Report, July 2014
91. Sabrina Tavernise, *In Move to Curb Drug Abuse, D.E.A. Tightens Rule on Widely Prescribed Painkiller*, NY Times, AUG. 21, 2014
92. M Brandt, Stanford University Medical Center, "*MRI Abundance May Lead To Excess In Back Surgery*," (Oct. 14, 2009)
93. JD Baras and LC Baker, "*Magnetic Resonance Imaging And Low Back Pain Care For Medicare Patients*," Health Aff (Millwood) 28/6 (2009):1133–40.
94. Richard A. Deyo, MD, MPH and Donald L. Patrick, PhD, MSPH, *Hope or Hype: The Obsession with Medical Advances and the High Cost of False* Promises, AMACOM books, (2005): 36-37

surgeons. In the past decade, research has shown that discs do, in fact, move back, and do so to a significant degree (70 percent or more). (95, 96, 97)

Just like every destination along Dr Toad's Wild Ride, MRI imaging is another procedure that is very lucrative but often unnecessary without any indications of 'Red Flags'. Not only are MRIs costly, ranging from a cash price of $295 to $3,000 if billed to insurance, the global MRI market was valued at $3.9 billion in 2011 and expected to reach $4.8 billion by 2017. (98)

Not only misleading in most cases finding '*incidentalomas*', but recent research also conducted by the *Liberty Mutual Research Institute for Safety* found that inappropriate early use of MRI to diagnose work-related lower back pain correlates with higher medical costs, unnecessary and ineffective procedures, and prolonged disability. (99)

The 2014 study published in *Spine* found these early MRIs led to a '*cascade of medical services*' in the six-month period post-MRI that included electromyography, nerve conduction testing, advanced imaging, injections, or surgery. These procedures often occurred soon after the MRI and were 17 to nearly 55 times more likely to occur than in similar claims without MRI. (100)

According to Deyo, the '*cascade effect*' in medical care refers to 'a chain of events initiated by an unnecessary test … which results in ill-advised tests or treatments that may cause avoidable adverse effects and/or morbidity'. (101) and is well documented across other specialties of medical care. Electronic foetal monitoring has been associated with a 40% higher Cesarean section rate without foetal outcome improvement. (102) Unnecessary cardiac stress tests generating false-positive results lead to significant morbidity and mortality due to unnecessary invasive testing and surgery. (103)

Today '*best practices' guidelines* question whether or not scans are necessary in light of the cost and ubiquitous nature of disc abnormalities in pain-free people. Apparently disc degeneration is like finding grey hair and just another part of the aging process. But Dr Toad will use any abnormality as reasons to do surgery and the gullible patient is scammed.

In The New England Journal of Medicine, Dr. Deyo debunked the reliance on MRI exams to infer disc abnormalities were the cause of back pain that often lead to a "false positive" misdiagnosis. This term means that a bad disc may appear on an image, but it has nothing to do with the pain:

> 'Early or frequent use of these tests [CT and MRI] is discouraged, however, because disc and other abnormalities are common among asymptomatic adults. Degenerated, bulging, and herniated discs are frequently incidental findings, even among patients with

95. E Ilkko, S Lahde, ER Heikkinen, " Late CT Findings In Nonsurgically Treated Lumbar Disc Herniations," Eur J Radiol. 16/3 (1993):186-189.
96. MR Ellenberg, ML Ross, JC Honet, et al. "Prospective Evaluation Of The Course Of Disc Herniations In Patients With Proven Radiculopathy," Arch Phys Med Rehab 74/1 (1993):3-10,
97. K Bush, N Cowan, DE Katz, et al. "The Natural History Of Sciatica Associated With Disc Pathology," Spine 17/10 (1992):1205-1212.
98 . Transparency Market Research, "*Magnetic Resonance Imaging (MRI) Market: Global Market Analysis, Size, Share & Forecast (2011 – 2017)*
99. "*Studies Find Early MRI for Lower Back Pain Often Yield Expensive, Unnecessary Treatment and Longer Disability Periods*," Liberty Mutual Research Institute for Safety, August 20, 2014
100. The cascade of medical services and associated longitudinal costs due to nonadherent magnetic resonance imaging for low back pain, Webster, Barbara S. BSPT, PA; Choi, YoonSun MA; Bauer, Ann Z. MPH; Cifuentes, Manuel MD, MPH, ScD; Pransky, Glenn MD, MOccH, The Cascade of Medical Services and Associated Longitudinal Costs Due to Nonadherent Magnetic Resonance Imaging for Low Back Pain, Spine: *01 August 2014 - Volume 39 - Issue 17 - p 1433–1440*
101 Deyo RA. Cascade effects of medical technology. Ann Rev Public Health 2002;23:23–44.
102. Shy KK, Luthy DA, Bennett F, et al. Effects of electronic fetal-heart-rate monitoring, as compared with periodic auscultation, on the neurologic development of premature infants. N Engl J Med 1990;322:588–93.
103. Banerjee A, Newman DR, Van den Bruel A, et al. Diagnostic accuracy of exercise stress testing for coronary artery disease: a systematic review and meta-analysis of prospective studies. Int J Clin Pract 2012;66:477–92.

low back pain, and may be misleading. Detecting a herniated disc on an imaging test therefore proves only one thing conclusively: the patient has a herniated disc'. (104)

'*Being a highly sensitive test, MRI will quite often reveal common age-related changes that have no correlation to the anatomical source of the lower back pain*', said Glenn S Pransky MD, *Center for Disability Research*.

'*Leading evidence-based practice guidelines for lower back pain recommend against early MRI except for "red flag" indications, such as severe trauma, infection, or cancer. These guidelines suggest that, following a month trial of conservative treatment, MRI may then be considered if symptoms of sciatica/radiculopathy persist, but only to guide epidural steroid injections, or to provide more information if surgery is being considered. Because of a lack of evidence for improving care, the guidelines recommend that MRI is not indicated for non-radicular, non-specific back pain*'. (105)

Another study conducted by Deyo and Daniel Cherkin in 1994 compared international rates of back surgeries and found the startling fact that the rate of American surgery is unusually excessive and directly attributed to the supply of spine surgeons.

The rate of back surgery in the United States was at least 40% higher than any other country and was more than five-times those in England and Scotland. Back surgery rates increased almost linearly with the per capita supply of orthopaedic and neurosurgeons in that country. (106)

Today there are 25,500 orthopaedic/spine surgeons (107) many of whom are routinely performing unnecessary spine surgeries in America on uninformed patients without giving them any '*black box warnings*' including the actual costs, failure rates of fusions, the repeat surgeries rates, alternatives like Chiropractic, or told realistically of the adverse side effects. Patients are blind to the reality of back surgery and suffer consequences when they are not given Informed Consent or Buyer Beware warnings nor told Chiropractic care is a non-drug, nonsurgical alternative as guidelines across the world confirm.

Researchers now recognise a lesser-known fact that disc bulges and herniations often undergo some degree of regression without surgery, but this finding has also been ignored by spine surgeons. In the past decade, research has shown that discs do, in fact, move back, and do so to a significant degree (70% or more). (108, 109, 110)

Last stop: Surgery, the ultimate placebo

Yet another shot across the bow for spine surgeons occurred when spine surgery was deemed *the ultimate placebo* by a mutinous *Australian spine surgeon Ian Harris* in his book, *Surgery, The Ultimate Placebo: A surgeon cuts through the evidence*.

According to Dr. Harris, spine fusion is not only ineffective but often leads to complications and, even when it appears

104. Deyo RA, Weinstein JN. Low back pain. N Engl J Med 2001 Feb 1;344(5):363-70.

105. "Studies Find Early MRI for Lower Back Pain Often Yield Expensive, Unnecessary Treatment and Longer Disability Periods," Liberty Mutual Research Institute for Safety, August 20, 2014.

106. DC Cherkin, RA Deyo, et al. "An International Comparison Of Back Surgery Rates," Spine, 19/11 (June 2004):1201-1206.

107. *11 Statistics and Facts About Orthopedics and Orthopedic Practices*

108. E Ilkko, S Lahde, ER Heikkinen, " Late CT Findings In Nonsurgically Treated Lumbar Disc Herniations," Eur J Radiol. 16/3 (1993):186-9.

109. MR Ellenberg, ML Ross, JC Honet, et al. "Prospective Evaluation Of The Course Of Disc Herniations In Patients With Proven Radiculopathy," Arch Phys Med Rehab 74/1 (1993):3-10,

110. K Bush, N Cowan, DE Katz, et al. "The Natural History Of Sciatica Associated With Disc Pathology," Spine 17/10 (1992):1205-1212.

to work, it's usually because of the *placebo effect*:

> 'Millions of people have had spine fusions for back pain and I am not at all convinced that the benefits of this surgery outweigh the considerable harms. Spine fusion (getting two neighbouring vertebral bodies to heal together) can be done for many reasons, but the most common reason is degenerative conditions (wear and tear, arthritis, spondylosis) in the lumbar spine.
>
> "Yet there is very little evidence that spine fusion surgery for back pain is effective. It is very expensive (the implants alone are often tens of thousands of dollars per case), often leads to complications, often requires further surgery, is associated with increased mortality, and often does not even result in the spine being fused.
>
> "The rate of spine fusion surgery is increasing and has been increasing for many years. The rate in the US has gone way past the rate of one spine fusion per 1000 population per year. It has overtaken hip replacement surgery and continues to rise. The rates of surgery vary widely across the US, where back fusion is associated with a high degree of practice variation'.

While there are clinical indications for lumbar fusion in the Red Flag cases, they may be as little as 5% to 7% of all LBP cases according to orthopaedist KS Dhillon MD:

> 'Chronic low back pain is a common, disabling and costly health problem. The treatment of chronic low back is difficult and is often ineffective. For treatment to be effective the cause of the pain has to be established but unfortunately in 80% to 95% of the patients the cause cannot be determined despite the existence of modern imaging techniques. A pathoanatomical diagnosis which fits into a classical disease model where successful treatment can be carried out, can only be made in 5% to 7% of the patients. The back pain in the rest of the patients where no pathoanatomical diagnosis can be made is often labelled, unscientifically, as chronic low back pain'.

Another study by Richard A Deyo, MD, MPH and Sohail K Mirza MD, MPH, *Trends and Variations in the Use of Spine Surgery*, reveals the ugly truth about American spine surgeons:

> 'Rates of spine surgery vary approximately fivefold among industrialized countries. The spine surgery rate in the U.S. is the highest in the world, and is approximately five times greater than the rate in England and Scotland. The U.S. rate is double that of most countries, including Australia, Canada, and Scandinavian counties'. (6)

Deyo also commented on the sudden increase in spine surgery:

> 'It is unclear why more complex operations are increasing. It seems implausible that the number of patients with the most complex spinal pathology increased 15-fold in just 6 years. The introduction and marketing of new surgical devices and the influence of key opinion leaders may stimulate more invasive surgery, even in the absence of new indications.111 Surgeons may believe more aggressive intervention produces better outcomes. Improvements in surgical technique, anesthetic technique, and supportive care may make more invasive surgery feasible when risks formerly would have been prohibitive. Financial incentives to hospitals and surgeons for more complex procedures may play a role, as may desires of surgeons to be local innovators… Adjusted mean hospital charges for complex fusion procedures were $80,888 compared to $23,724 for decompression alone.112 The cost to Medicare, just for the hospital charges for the

111. Deyo RA, Gray DT, Kreuter W, Mirza S, Martin BI. United States trends in lumbar fusion surgery for degenerative conditions. Spine. 2005;30:1441–1445.

112. *Trends, Major Medical Complications, and Charges Associated with Surgery for Lumbar Spinal Stenosis in Older Adults*

> three types of back surgery reviewed is about $1.65 billion a year. It certainly looks like there's more complex surgery being done than we have very good evidence to support'. (113)

In 1994 the *Agency for Health Care Policy and Research* (AHCPR), a 23-member panel headed by orthopaedist Stanley Bigos MD, unquestionably the most in-depth meta-analysis of acute LBP, confirmed the rare need for surgery:

> 'Surgery has been found to be helpful in only 1 in 100 cases of low back problems. In some people, surgery can even cause more problems. This is especially true if your only symptom is back pain'. (114)

This guideline fell on deaf ears considering just a few years later between 2002 and 2007, passengers on the medical train destined to spine fusions actually increased 15-fold (115) despite the research debunking the 'bad disc' theory based on '*incidentalomas*' because these also are found in pain-free people. (116)

In spite of the proof of the many placebo treatments in medical spine care, these treatments makes too much money for the medical train to change tracks and follow the *evidence-based guidelines* in this era of healthcare reform whose goal is to improve outcomes and lower costs.

Sham surgeries

There are also ethical quandaries when it comes to sham treatments, especially those that are invasive. However, when researchers look at improvement rates, both subjective and objective, they found that sham surgery 'works' in at the same levels of surgery. (117) Placebo effect was observed in nearly half of the patients during the first 6 months following a sham spine procedure. (118)

- In a meta-analysis involving 2902 patients, it was found that the mean improvement for sham groups vis-a-vis active treatment was 78% in pain-related conditions.
- Sham Surgery in Orthopedics: A Systematic Review of the Literature

  Conclusions. This review suggests that sham surgery has shown to be just as effective as actual surgery in reducing pain and disability; however, care should be taken to generalize findings because of the limited number of studies.
- A Randomized Trial of Vertebroplasty for Painful Osteoporotic Vertebral Fractures, N Engl J Med 2009; 361:557-568, August 6, 2009,

  Conclusions

  We found no beneficial effect of vertebroplasty as compared with a sham procedure in patients with painful osteoporotic vertebral fractures, at 1 week or at 1, 3, or 6 months after treatment.

113 *Unneeded, riskier spinal fusion surgery on rise*

114. Bigos S. et al. US Dept. of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, Clinical Practice Guideline, Number 14: Acute Low Back Problems in Adults AHCPR Publication No. 95-0642, December 1994.

115. RA Deyo, "Conservative Therapy for Low Back Pain: Distinguishing Useful From Useless Therapy," JAMA 250 (1983):1057-62

116. Deyo, ibid.

117 *46 PLACEBO EFFECT STATISTICS: 2020/2021 DATA, EXAMPLES & IMPLICATIONS* by Arthur Zuckerman May 27, 2020

118. *Placebo Effect of Sham Spine Procedures in Chronic Low Back Pain: A Systematic Review*.

Surgeon's secret

Clearly Dr Toad's Wild Ride on the medical train has had many casualties due to misdiagnosis, mistreatments, and misinformation about alternative destinations, which explains the critical comment of Mark Schoene, editor of *The BACKLETTER*:

> 'The world of spinal medicine, unfortunately, is producing patients with failed back surgery syndrome at an alarming rate … Despite a steady stream of technological innovations over the past 15 years, from pedicle screws to fusion cages to artificial discs, there is little evidence that patient outcomes have improved.' (119)

In 2010 the North American Spine Society journal published an article, '*NASS Contemporary Concepts in Spine Care: Spinal Manipulation Therapy For Acute Low Back Pain*', admitting spine fusion should be a last resort and recommended spinal manipulation, 5 to 10 sessions over 2 to 4 weeks, should be considered before surgery. (120) This study found superior improvement in pain and function when compared with other commonly used interventions, such as physical modalities, medication, education, or exercise, for short, intermediate, and long-term follow-up. Spine care clinicians should discuss the role of SMT as a treatment option for patients with acute LBP who do not find adequate symptomatic relief with self-care and education alone.

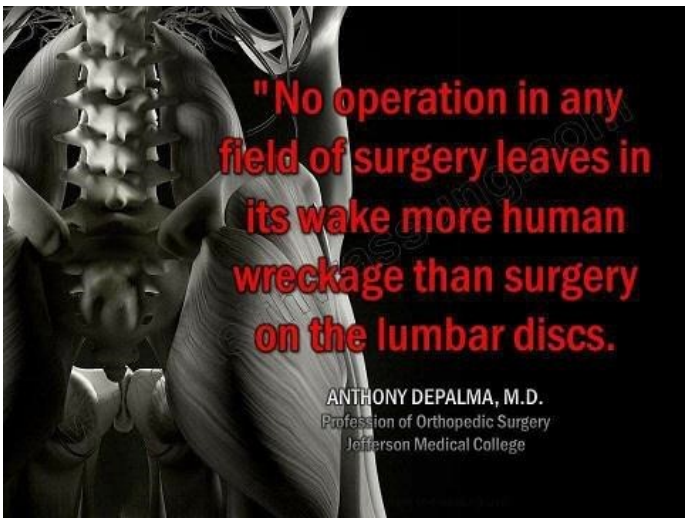
This study remains the untold Big Secret among MDs evident by the lack to inform patients as the *Doctrine of Informed Consent* requires to mention all '*practical alternatives*' even when the famed NASS publishes this revelation.

This 'bad disc' fiasco is promoted by MDs, hospitals, and surgeons who have significantly profited from this outdated concept. This is not a new issue, but it may be the best kept secret in medicine and must be understood to explain why disc fusions have high failure rates and why they are avoidable.

The Washington Post published whistleblowing articles on excessive spine surgery and heart surgery:

- *Stents and Bypass Surgery Are No More Effective Than Drugs*.
- *Spinal Fusions Serve as Case Study for Debate Over When Certain Surgeries Are Necessary*.

Indeed, this ruse is spine surgeons' dirty little secret that has now become an irreversible public nightmare and the biggest expense in spine care.



119. The BackLetter, vol.12, no. 7, pp.79 July, 2004. The BackPage editorial, The BackLetter, pp. 84, vol. 20, No. 7, 2005.

120. MD Freeman and JM Mayer "NASS Contemporary Concepts in Spine Care: Spinal Manipulation Therapy For Acute Low Back Pain," The Spine Journal 10/10 (October 2010):918-940

This fallacy was first debunked in 1990 by research done by Drs Scott Boden, now director at *Emory Spine Center* in Atlanta, and Sam W. Wiesel, MD, chair of Orthopaedic Surgery at *Georgetown University*, who conducted the first MRI analysis that found 'bad discs' in asymptomatic 'pain-free people:

- 1990: *Abnormal magnetic-resonance scans of the lumbar spine in asymptomatic subjects. A prospective investigation.*

  Abstract

  We performed magnetic resonance imaging on sixty-seven individuals who had never had low- back pain, sciatica, or neurogenic claudication. The scans were interpreted independently by three neuro-radiologists who had no knowledge about the presence or absence of clinical symptoms in the subjects. About one-third of the subjects were found to have a substantial abnormality.

  In view of these findings in asymptomatic subjects, we concluded that abnormalities on magnetic resonance images must be strictly correlated with age and any clinical signs and symptoms before operative treatment is contemplated.

- 1991: *Magnetic resonance imaging of the lumbar spine in asymptomatic adults. Cooperative study--American Society of Neuroimaging.*

  We performed magnetic resonance imaging of the lumbar spine on 66 asymptomatic subjects and found that 12 (18%) had either a disc protrusion or herniation. An additional 26 (39%) had a bulge that was associated with degenerative disc disease. We also found examples of spinal stenosis, narrowed nerve root canals, osteophytes, and vertebral body involvement with multiple myeloma.

Degenerative disc disease is a common finding in asymptomatic adults that increases in frequency with age. It occurs more frequently in men and usually involves more than one level. The most common location is L5-S1.

- 1994: *Magnetic resonance imaging of the lumbar spine in people without back pain*.

  Conclusions:

  On MRI examination of the lumbar spine, many people without back pain have disc bulges or protrusions but not extrusions. Given the high prevalence of these findings and of back pain, the discovery by MRI of bulges or protrusions in people with low back pain may frequently be coincidental.

- 1994: the US Public Health Service's *AHCPR guideline #14 on acute low back pain* also echoed Dr. Boden's finding:

  'Degenerative discs, bulging disc and even herniated discs are part of the aging process for the spine and may be irrelevant findings: they are seen on imaging tests of the lumbar spine in a significant percentage of subjects with no history of low back problems. Therefore, abnormal imaging findings seen in a patient with acute low back problems may or may not be related to that individual's symptoms'.

- 1995: Magnetic resonance imaging of the thoracic spine. Evaluation of asymptomatic individuals.

  This study documents the high prevalence of anatomical irregularities, including herniation of a disc and deformation of the spinal cord, on the magnetic resonance images of the thoracic spine in asymptomatic individuals.

- 2005: *Magnetic resonance imaging and low back pain in adults: a diagnostic imaging study of 40-year-old men and women* by Per Kjaer PT, PhD, performed a study of the link between MRI

findings and back pain and found more than half of 40-year olds have abnormalities on MRI scans. Interesting, none of the MRI findings was strongly associated with recent pain. Neither disc herniations nor nerve root compromise was associated with low back pain.

- 2014: the Mayo Clinic released its review by Waleed Brinjikji MD, et al, *Systematic Literature Review of Imaging Features of Spinal Degeneration in Asymptomatic Populations* found a consensus among 33 MRI studies from around the world that undermined the rationale for fusion surgery based solely on the 'bad disc' idea that is used to lure unsuspecting patients into disc fusion surgery. They found by the age of 50 at least 80% of patients will show 'bad discs' but they are asymptomatic, meaning they have no back pain or pinched nerves.

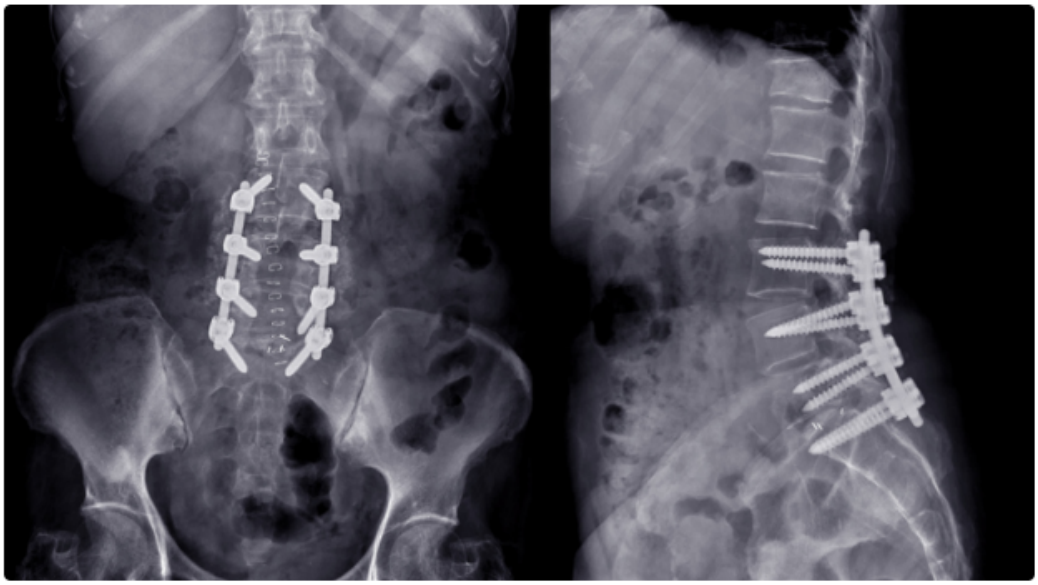
As you can see, there is abundant proof that 'bad discs' appear in pain-free people, but this research has never been told to the public by the medical media that perpetuates this widespread misconception. A good example was the Chief Medical Correspondent at CNN *Dr Sanjay Gupta* who is a neurosurgeon well aware of this research and he also worked at *Emory University* alongside Scott Boden, undoubtedly aware of Boden's work. Inexplicably, Gupta never told his viewers on CNN of Boden's research debunking the bad disc diagnosis. If he were to reveal this truth, Gupta would have been a very unpopular speaker at the next spine surgeons' conference.

Indeed, this 'bad disc' fiasco is medicine's dirty little secret that has now become an entrenched nightmare that has also added to the opioid crisis we now face considering LBP is among the leading reasons for prescription opioid painkillers among pre- and post-surgery victims.

Richard Deyo MD, MPH, co-author of *Hope or Hype: The Obsession with Medical Advances and the High Cost of False Promises*, undermines the false 'bad disc' premise used by all spine surgeons. Deyo acknowledged abnormal anatomy like bad discs was not the cause of most back pain: '*Perhaps 85% of patients with isolated low back pain cannot be given a precise pathoanatomical diagnosis*'. (121)

Deyo lamented the 'surgery first' attitude in medical spine care:

> 'People say, "I'm not going to put up with it", and we in the medical profession have turned to ever more aggressive medication, narcotic medication, and more invasive surgery'. (122)



121. Deyo RA, Weinstein JN. Low back pain. N Engl J Med 2001 Feb 1;344(5):363-70.

122. G Kolata, "With Costs Rising, Treating Back Pain Often Seems Futile," NY Times (February 9, 2004)

Spinal stenosis surgery

According to the *Mayo Clinic*:

> Spinal stenosis happens when the space inside the backbone is too small. This can put pressure on the spinal cord and nerves that travel through the spine. Spinal stenosis occurs most often in the lower back and the neck.
>
> Some people with spinal stenosis have no symptoms. Others may experience pain, tingling, numbness and muscle weakness. Symptoms can get worse over time.
>
> The most common cause of spinal stenosis is wear-and-tear changes in the spine related to arthritis. People who have severe cases of spinal stenosis may need surgery.
>
> Surgery can create more space inside the spine. This can ease the symptoms caused by pressure on the spinal cord or nerves. But surgery can't cure arthritis, so arthritis pain in the spine may continue.

Despite the Mayo explanation of spinal stenosis, research has not supported its hopeful prognosis:

- Effectiveness of surgery for lumbar spinal stenosis: a systematic review and meta-analysis

  > Background: The management of spinal stenosis by surgery has increased rapidly in the past two decades, however, there is still controversy regarding the efficacy of surgery for this condition. Our aim was to investigate the efficacy and comparative effectiveness of surgery in the management of patients with lumbar spinal stenosis.
  >
  > Conclusions: The relative efficacy of various surgical options for treatment of spinal stenosis remains uncertain. Decompression plus fusion is not more effective than decompression alone. Interspinous process spacer devices result in higher reoperation rates than bony decompression.

- *Surgical options for lumbar spinal stenosis*

  > Authors' conclusions: The results of this Cochrane review show a paucity of evidence on the efficacy of surgery for lumbar spinal stenosis, as to date no trials have compared surgery with no treatment, placebo or sham surgery. Placebo-controlled trials in surgery are feasible and needed in the field of lumbar spinal stenosis. Our results demonstrate that at present, decompression plus fusion and interspinous process spacers have not been shown to be superior to conventional decompression alone. More methodologically rigorous studies are needed in this field to confirm our results.

- *Surgical versus non-surgical treatment for lumbar spinal stenosis*

  > Authors' conclusions: We have very little confidence to conclude whether surgical treatment or a conservative approach is better for lumbar spinal stenosis, and we can provide no new recommendations to guide clinical practice. However, it should be noted that the rate of side effects ranged from 10% to 24% in surgical cases, and no side effects were reported for any conservative treatment. No clear benefits were observed with surgery versus non-surgical treatment. These findings suggest that clinicians should be very careful in informing patients about possible treatment options, especially given that conservative treatment options have resulted in no reported side effects. High-quality research is needed to compare surgical versus conservative care for individuals with lumbar spinal stenosis.

Regarding conservative treatments for spinal stenosis:

- *The effects of manual manipulation therapy on pain and dysfunction in patients with lumbar spinal stenosis*

Conclusion: The results of this study suggest that manual manipulation therapy is an effective intervention for treating pain and dysfunction in patients with lumbar spinal stenosis.

- *Effects of flexion-distraction manipulation therapy on pain and disability in patients with lumbar spinal stenosis*

  Conclusion: Flexion-distraction manipulation appears to be an effective intervention for pain and disability among patients with lumbar spinal stenosis.

With the research trend now critical of spine fusions for 'bad discs', spine surgeons seemingly simply changed their diagnosis. Since there are always some types of pathoanatomical incidentalomas to be found in unsuspecting older adults to warrant some type of surgery in the minds of spine surgeons, today lumbar spinal stenosis (LSS) has become the leading reason for spine surgery in patients over the age of 65 years. (123)

This NASS guideline mainly focuses on the standard surgical and pharmaceutical treatments, but on page 62 in the *North American Spine Society (NASS) study of lumbar spinal stenosis*, surprisingly included a 2006 study of SMT done by DCs for stenosis led by Donald Murphy DC, DACAN, Clinical Director, *Rhode Island Spine Center*.

Murphy is now involved with the *Primary Spine Provider Network, LLC*, to train DCs and DPTs to be front line providers inasmuch as medical PCPs are woefully ill-trained in MSDs. (124)

Murphy's study found that chiropractic offers a non-drug, non-surgical hope to many patients as evident by his patients who had a self-rated improvement of 75.6% overall. '*According to our data, there are things [SMT] that can be done to make actual long-term changes*'. (125)

Not only does this outcome encourage the use of SMT for this condition, it also raises the question: despite the 75% success rate, these patients still had the pathoanatomy of spinal stenosis, just like patients with degenerative disc disease who used chiropractic care improve.

This is more evidence that the pathoanatomical symptoms are secondary and can be improved by physiological interventions. The paradigm shift in spine care science continues to support the re-focus from pathoanatomical to pathophysiological issues. In other words, from detecting 'incidental' findings to detecting how well the spine functions. For example, chiropractors adjust a spine with stenosis or other arthritic issues, but most improve in terms of pain levels, but they still had their anatomical issues.

Murphy addressed this paradigm shift:

> 'Clearly the pathoanatomy did not change. We have this discussion frequently in Spine Conference in the neurosurgery department on Monday mornings when I make the point that the spine is capable of handling pathoanatomy as long as the physiology is right (and psychology of course).

123. James N. Weinstein, D.O, et al. Surgical versus Nonsurgical Therapy for Lumbar Spinal Stenosis, N Engl J Med 2008; 358:794-810 *February 21, 2008*

124. KB Freedman, J Bernstein, "The Adequacy Of Medical School Education In Musculoskeletal Medicine," J Bone Joint Surg Am. 80/10 (1998):1421-7

125. Murphy DR, Hurwitz EL, Gregory AA, Clary R. A non-surgical approach to the management of lumbar spinal stenosis: a prospective observational cohort study. BMC Musculoskelet Disord. 2006;7:16.

> 'Pathoanatomy only creates the potential for pain. Physiology is what determines whether pain actually occurs or not and psychology determines how much suffering results from that pain'. (126)

This dilemma over the various causes of back pain demands that medical primary care providers understand this complex problem without a bias against chiropractors or a chauvinist attitude about the sanctity of the disc theory, drugs, shots, and spine surgery.

Murphy says another problem is the prevailing medical bias against DCs:

> 'Many patients are told not to go to a chiropractor, told that their spine is degenerated and the last thing they want to do is to have someone move it. In my experience, having someone move the spine is the best thing. But the only way to change minds is to come up with credible evidence and substantive argument'. (127)

Murphy touts the benefit of chiropractic care:

> 'The advantage we have as nonsurgical spine specialists is when it's not clear whether a person will respond or not, there's no harm in giving it a try. The worst thing that can happen is that they don't respond. With surgery, if you're not sure whether the person is going to respond or not, it's a lot harder to just say, "Let's go for it and see what happens". You're making a permanent change in the structure of the spine'. (128)

The clinical-effectiveness of Chiropractic care to avoid surgery was also shown in a comparative *Washington State* workers' comp study that found for patients whose first provider was a chiropractor, only 1.5% had surgery in contrast to 42.7% of workers who went through the typical medical system inevitably had surgery. (129)

Fortunately, the guideline for LBP issued by the American Pain Society, '*Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society*'recommends CAM methods for LBP when self-care fails:

> '…clinicians should consider the addition of nonpharmacologic therapy with proven benefits for acute low back pain, spinal manipulation; for chronic or subacute low back pain, intensive interdisciplinary rehabilitation, exercise therapy, acupuncture, massage therapy, spinal manipulation, yoga'. (130)

It also mentioned grave concerns about the small improvement after back surgery: '*Some studies have shown no benefit of surgery compared with intensive interdisciplinary rehabilitation, with a significant proportion of patients experiencing suboptimal outcomes, including persistent pain or functional deficits after surgery*'.

On the basis of the evidence, Chou said, they were unable to give strong recommendations for surgery, '*but we think there may be some patients for whom surgery, fusion specifically, might be helpful, but it's really important for doctors to discuss the fact that surgery doesn't tend to lead to huge improvements on average. You're talking about a 10- to 20-point improvement in function on a*

126. Murphy DR, Hurwitz EL, Gregory AA, Clary R. A non-surgical approach to the management of lumbar spinal stenosis: a prospective observational cohort study. BMC Musculoskelet Disord. 2006;7:16.

127. Donald Murphy in private communication with JC Smith, July 20, 2012 \.

128. Chiropractic Approach to Lumbar Spinal Stenosis, Part II: Surgery and Treatments by Carol Marleigh Kline, JACA Online editor

129. Keeney BJ, Fulton-Kehoe D, Turner JA, Wickizer TM, Chan KC, Franklin GM., Early Predictors of Lumbar Spine Surgery after Occupational Back Injury: Results from a Prospective Study of Workers in Washington State.,Spine (Phila Pa 1976). 2012 Dec 12.

130. Low Back Pain Guidelines Expanded to Include Interventional Procedures, American Pain Society 27th Annual Scientific Meeting: Symposium 312. Presented May 8, 2008.

100-point scale, so that's pretty small, and a significant proportion of patients still need to take pain medication and don't return to full function'. (131)

To be sure, the spine surgeons are now squawking after decades atop the physician pecking order undeterred while making millions. A business website for orthopedists and spine physicians, *Becker's Orthopedic & Spine*, has published several articles relating to the recent attack on spine fusions, including '*Spine Fusions Face an Uncertain Future*'.132

The tone of these articles is one of disbelief that the sacrosanct surgeons were under attack rather than admitting to the overuse of surgery and advocating restraint. However, this website did admit:

> '… four years after surgery, the fusion patients were four times more likely to need additional surgery and half of those operations were necessary because of new disc complications occurring at adjacent levels to the fusion'. (133)

From a business viewpoint, however, re-operations were another source of income in the ruse of unnecessary fusions. Failed back surgery per se has yet to be viewed as malpractice nor does it fall under the Lemon Law statutes. Whereas every product has warranties or product liability, medicine does not.

New spine ruses: Artificial discs

To counteract the obvious failings of fusions, another rising spine surgery is artificial disc replacement that remains '*controversial*' according to Milliman. (134) Spine surgeons tout these as an improvement that aims at preserving the integrity of the spine by restoring the normal physiological motion. (135)

This procedure involves a technically demanding operation that requires disemboweling the patient and inserting the artificial disc through the patient's abdomen. According to Milliman, this eviscerating procedure creates '*potential complications including death, major bleeding, or severe nerve damage*'. Obviously this expensive and risky surgery remains '*experimental*' that most insurance and Medicare refuse to pay.

The '*motion preservation*' novelty of artificial disc replacement is ironic considering Chiropractic spinal adjustments do exactly the same without the need for surgery and at a fraction of the cost. Restoring spinal joint motion has been the clinical goal of chiropractors for over one hundred years, yet the spine care market acts as if this is a new concept and artificial discs replacement is the only answer, illustrating the adage, '*when in doubt, cut it out*'.

The Milliman guideline suggests at least six months of conservative treatment prior to fusion or artificial disc implantation. Regrettably, rather than referring such cases of spinal fixation to chiropractors, most spine surgeons jump to recommend artificial disc replacement instead, illustrating how the medical profession can justify another surgical overkill to exploit patients and payers.

In the United States, the cost of an artificial disc surgery alone averages upward of $50,000 or more, plus the cost for the replacement of a single artificial disc average $11,500 each, bringing

131. Low Back Pain Guidelines Expanded to Include Interventional Procedures, American Pain Society 27th Annual Scientific Meeting: Symposium 312. Presented May 8, 2008.

132. Miller L, Spine Fusions Face an Uncertain Future, Becker's Orthopedic & Spine.com, 2011 January 18

133. Miller L, Dr. Rick Delamarter: Artificial Disc Replacement Effective, Costs Less Than Spinal Fusions, Becker's Orthopaedic, Spine, and Pain Management, 2011 March 23

134. Milliman Care Guidelines for Lumbar Fusion, "Low Back Pain and Lumbar Spine Conditions—Referral Management, Clinical Indications for Referral," www.allmedmd.com

135. "U.S. Spinal Surgery Market Moving toward Motion Preservation," Business Wire, Sept 4, 2007

the cost to roughly $60,000 to $65,000, not including hospital stay costs that may spike the total cost to over $110,000. (136) According to *The Wall Street Journal*, by 2010 JP Morgan estimated the market for artificial discs could approach $1.7 billion a year. (137) This procedure was approved after a trial involving only 304 patients and only 36% of them fared well enough to get off narcotic painkillers. (138) For a serious surgical procedure that has a lesser chance of success than a flip of a coin, it is obvious why payers and guidelines do not endorse this expensive, risky surgery.

One thing is certain, spine surgeons love the trend to disc replacement according to Becker's Spine Review article, *Cost of total disc replacement in the 30 largest US cities*, as of Jan 17, 2024:

1. Columbus, Ohio: $45,901
2. Indianapolis: $41,367
3. Portland, Ore.: $40,177
4. San Jose, Calif.: $37,332
5. San Francisco: $37,332
6. Dallas: $37,278
7. Fort Worth, Texas: $37,278
8. Seattle: $35,185
9. Denver: $34,614
10. Charlotte, N.C.: $33,875

Spine surgeon André van Ooij of the Netherlands expressed his concern as someone who has observed significant numbers of post-artificial disc implants:

> 'Most patients will be happy for the first years, but the big problem will arise in later years. I am very negative about disc prostheses in general and the Charite disc in particular'. (139)
>
> 'These patients represent the most disabled group of patients that I have personally seen in 24 years of spine practice. The overload of the facet joints as a consequence of removal of the anterior longitudinal ligament and annulus fibrosis producing axial rotational instability and related progressive degeneration of the facet joints'. (140)

The public has been misled about artificial discs just as it was about spine fusions, for example, when one newspaper article touted artificial discs as the '*Holy Grail of spine fusions*'. (141) However, most are now less supportive. According to a *NY Times* article, '*When F.D.A. Says Yes, But Insurers Say No*', as far as insurers see it, the '*Charite device was no better than spinal fusion*' and '*many insurers consider the fusion surgery to be over-prescribed and of little long-term value*'. (142)

According to Aetna's Clinical Policy:

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136. Stephen Hochschuler, MD, "Issues to Consider Before Having Artificial Disc Surgery," www.spine-health.com

137 Rhonda L. Rundle and Scott Hensley, "Back Fire, J&J's New Device For Spine Surgery Raises Questions, Artificial Disc Aims to Help Body's Natural Movement; Some See Risk if It Slips, 'Big Money Riding on This'."The Wall Street Journal, June 7, 2005

138. Matthew Herper and Robert Langreth, "Dangerous Devices," Forbes.com (November.27, 2006); http://members.forbes.com/forbes/2006/1127/094.html (accessed February 23, 2010.

139. Rhonda L. Rundle and Scott Hensley, "Back Fire: J&J's New Device For Spine Surgery Raises Questions," The Wall Street Journal, June 7, 2005

140. Letters To The Editor, North American Spine Society Newsletter, SpineLine (Nov.-Dec. 2004)

141. Macon McGinley, "Artificial Disc Revolutionizes Back Surgery," Macon Telegraph, June 29, 2005.

142. "When F.D.A. Says Yes, but Insurers Say No," by Barnaby J. Feder, The New York Times, July 6, 2005.

> 'These procedures resulted in suboptimal long-term results … the Charite Artificial Disc should not be implanted in patients with isolated radicular compression syndromes, especially due to disc herniation … The FDA approved labelling also states that patients receiving the Charite Artificial Disc should have failed at least six months of conservative treatment prior to implantation of the Charite Artificial Disc'. (143)

Despite the cost, danger, and experimental nature of artificial discs, little mention of caution was made on spine surgery websites of the serious complications or failure rates when the artificial discs slip or further degeneration occurs at adjacent disc levels. Milliman states artificial discs '*may be appropriate for only a very limited group of patients*' and also points out that '*patients with multiple degenerating discs or who have had multiple failed back surgeries may not be candidates for artificial disc replacement*'.

Not only have spinal fusions and artificial disc replacements found few friends, so has another controversial spine surgery, vertebroplasty for spinal fractures at a cost of $2,530, which is done to 80,000 people yearly. In late September 2010, the *American Academy of Orthopaedic Surgeons* released new clinical practice guidelines that recommended against the use of vertebroplasty, the use of bone cement to fill fractured vertebrae, in the treatment of osteoporotic vertebral compression fractures. The guidelines were based primarily upon the evidence presented in two level 1 studies published in *The New England Journal of Medicine* that found '*vertebroplasty to be no more effective than sham procedures or placebo*'. (144, 145)

Minimally invasive laser surgery

Instead of redirecting passengers to another and safer nonsurgical track such as *nonsurgical spinal decompression* therapy, some passengers may also be lured into repeat spinal fusions with '*diminishing returns*'. (146)

'*Although slightly more than 50% of primary spinal surgeries are successful, no more than 30%, 15%, and 5% of the patients experience a successful outcome after the second, third, and fourth surgeries, respectively*'. (147)

Another element in the '*series of legal and ethical crimes*' in spine care is the array of spine surgeries that have proven to be ineffective and, too often, unsuccessful. A recent example was the charade of '*laser disc surgery*' that exemplified the deception some spine surgeons will go to make a lot of money off the backs of gullible patients. While they had hoped for a quick-fix became a quick-con as Jack Stern MD, PhD, FACS, wrote in his article *Lasers in Spine Surgery: A Review*.

According to investigative journalist and editor Mark Schoene of *The BACK Letter*, it's painfully obvious '*back care in the United States has been heavily oriented around opioids, excessive imaging, and early referrals to surgeons. There has been broad overuse of numerous, heavily marketed back pain treatments, from passive physical modalities to invasive pain interventions such as laser and open-spine fusion surgery*', a lucrative enticement that averages an estimated $77,500 at the Mayo Clinic, despite critics stating fusion surgery *has been abused*, often unnecessary, ineffective, and disabling.

'*So, in this area of medicine, patients would be well advised to take their doctors' diagnostic and treatment recommendations with a large grain of salt*', according to Schoene who wrote about the

143. Aetna Clinical Policy Bulletins Number: 0591 http://www.aetna.com/cpb/data/CPBA0591.html

144. R Buchbinder, et al. "A Randomized Trial Of Vertebroplasty For Painful Osteoporotic Vertebral Fractures," N Engl J Med. 361 (2009):557-68.

145. DF Kallmes, et al. "A Randomized Trial Of Vertebroplasty For Osteoporotic Spinal Fractures," N Engl J Med. 361 (2009):569-79.

146. Failed Back Surgery Syndrome: A Review Article

147. Failed Back Surgery, The BACKLetter, Vol. 33, No. 7, July 2018

inaccurate and aggressive marketing in '*Massive Wave of Unregulated Medical Marketing Putting Patients and Providers in Peril*':

> 'Regulators have not caught up with this tidal wave of marketing. And much of the information that goes out to physicians and patients in these marketing efforts is unregulated—and of questionable accuracy …'

Anyone familiar with the history of the spine field knows that there have been a series of controversies and scandals over the past few decades, in which inaccurate information and aggressive marketing have played major roles.

Some of these scandals and controversies include the *Vioxx* debacle, the overuse of the bone grafting agent *INFUSE (BMP-2)*, the excessive utilisation of spinal fusion for '*discogenic*' pain and other unvalidated indications, and the promotion of stem cell therapy for disc degeneration, to name a few.

Undoubtedly the *Laser Spine Institute* in Tampa, Florida ran the largest 'inaccurate information and aggressive' advertising promoting the 'bad disc' diagnosis as a sole criterion for surgery with its incessant TV ads promoting '*minimally-invasive*' laser spine surgery (MISS). In fact, it is well established that 'bad discs' appear in pain-free people As the facts will show, perhaps this type of disc surgery should be renamed 'evasive' laser surgery.

After deceiving the public with an onslaught of TV ads, these surgical con-artists finally met their fate. On March 1, 2019, the *Laser Spine Institute* (LSI) closed abruptly. (148) However, this closing did not undo the misconception millions of people around the world were imprinted with, namely the 'bad disc' causation of low back pain. Despite the closing of the LSI in Tampa, many other spine surgery clinics have continued misleading the public.

Hyperbolic TV ads have not gone unnoticed by a National Public Radio broadcast revealing in its investigation, *Laser Back Surgery Clinics Reap Profits, Complaints*:

> 'The surgery to relieve back pain hasn't been shown superior to laser-less versions and runs about $30,000, more than twice the amount insurer Aetna will pay for the old-fashioned approaches … One neurosurgeon who has treated former Laser Spine patients said, "It strikes me as somewhat of a scam".'

Bloomberg News reported that one laser surgery clinic had an annual profit margin of 34.3% from 2006 through 2009, higher than that of Google at 24.8%. One insurer paid Laser Spine $90,176 for an operation, a follow-up procedure, and some subsequent care. Laser Spine's surgeons, some of whom are investors in the company, performed as many as 5,000 operations a year, (149) which equates in a 50 working week year to be 20 surgeries daily. No wonder the Laser Spine Institute in Tampa employed 600 people.

Mark R. McLaughlin, MD, FACS, FAANS, was adamant about the myth of laser surgery when asked, '*Do you use a laser in your spinal surgeries*?' His position?

> '*That question makes the hair stand up on the back of my neck. I reply calmly and with authority, "No." I am trained in laser surgery. It has almost zero usefulness in your spine surgery and in fact may be harmful*.
>
> *'The truth is minimally invasive spine surgery, or MISS, can be performed as effectively, and probably more effectively, without a laser. In fact, more than 95% of minimally invasive spine procedures in the U.S. are done without laser. MISS is based upon the surgical approach to the spine, not what kind of scalpel a surgeon uses.*

148. *THE CLOSING OF THE LASER SPINE INSTITUTE*

149. David Armstrong, Laser Spine Surgery's Profits Beat Google's Amid Complaints, May 4, 2011; Bloomberg News.

> *'Some might argue that the laser is an appropriate (or ideal) tool for spine surgery, but this is not generally accepted within the neurosurgical spine community or among leading spine surgeons. The laser has been around spine surgery for more than twenty years. With the exception of lipomeningocele surgery, it has not gained mainstream acceptance. While any technology can be improved or in some way modified to work, at the present time I do not see that happening with laser spinal surgery.*
>
> *'One recent study published in 2016 found that not only were lasers significantly less effective than minimally invasive microdiscectomy, but that they also resulted in a near doubling of the need for a subsequent surgery. Certainly, these are not the kind of results that would lead me to change my thoughts on the use of lasers in spine surgery.'*

Another spine surgeon, *Peter F. Ullrich, Jr.,* suggests laser is mainly a marketing ploy in his article, *Laser Disc Decompression for Spinal Stenosis: Does it Work?*:

> '*It seems to me that the most practical use for lasers in spine surgery is for marketing. Like most businesses, spine surgery is very competitive, and having an edge in marketing can make a practice standout. I knew a spine surgeon who would tell his patients he could use a laser to do their surgery. He would cut the skin with a scalpel, then bring in a laser to cut the subcutaneous fat, then go back to electrocautery. However, since the laser was so slow, he would only use it for about thirty seconds before he went back to electrocautery. The laser performed no useful function during the surgery but helped him for marketing purposes*'.

As you can see, there are many deceptions in spine care that go unrecognised because the public is naïve about the science, legal, and ethical issues in spine care. Just as the scam of MISS came to light after many patients were exploited, upon further investigation, the facts will show the same deception occurs in nearly every step in the spine Cartel chain of events from initial visit with the primary care provider to pain management clinicians to spine surgeons.

Famed pro-wrestler Hulk Hogan has filed a multi-million-dollar medical malpractice lawsuit against Tampa, Fla.-based spine doctors, alleging he was the victim of unnecessary surgeries which '*severely damaged*' his career.

The lawsuit alleges that Hogan, '*due to LSI's monetary rather than medical motives, became the victim of multiple unnecessary endoscopic surgical procedures that further destabilised his already existing injured back ... during the last chapter of an internationally successful athletic and entertainment career*', the statement said.

The suit, which was filed in *Pinellas County Circuit Court,* alleges Hogan suffered lost income in excess of $50 million.

It accuses LSI of advertising endoscopic procedures as a less-intrusive alternative to traditional surgery *'through scare tactics*', while failing to inform patients that its procedures '*only temporarily treat symptoms and cannot treat and provide a long-term solution* ...' (150)

150. *Hulk Hogan sues spine clinic for millions, alleging unnecessary surgeries 'severely damaged' his career*.

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