

Ambulatory Traction: An Adjunct to Chiropractic Care

By Richard Carpenos, D.C.

By decreasing the intradiscal pressure, walking traction enables the herniated disc material to be sucked back into place between the vertebral discs.

The Vertetrac is a form of ambulatory traction developed more than 2-1/2 decades ago by the Polish physician Dr. Ludvig M. Stabholz, who now lives in Israel. He studied various forms of traction (hanging weights, traction table, friction-free couch) and ultimately decided their shortcomings were caused by the techniques used to produce the traction — not by a shortcoming in the principles of traction itself.

As a result, Stabholz persisted and eventually succeeded in finding a technique capable of giving the principles of traction their due. That technique is ambulatory traction, using the Vertetrac that Stabholz created.

APPLICATION OF FORCES

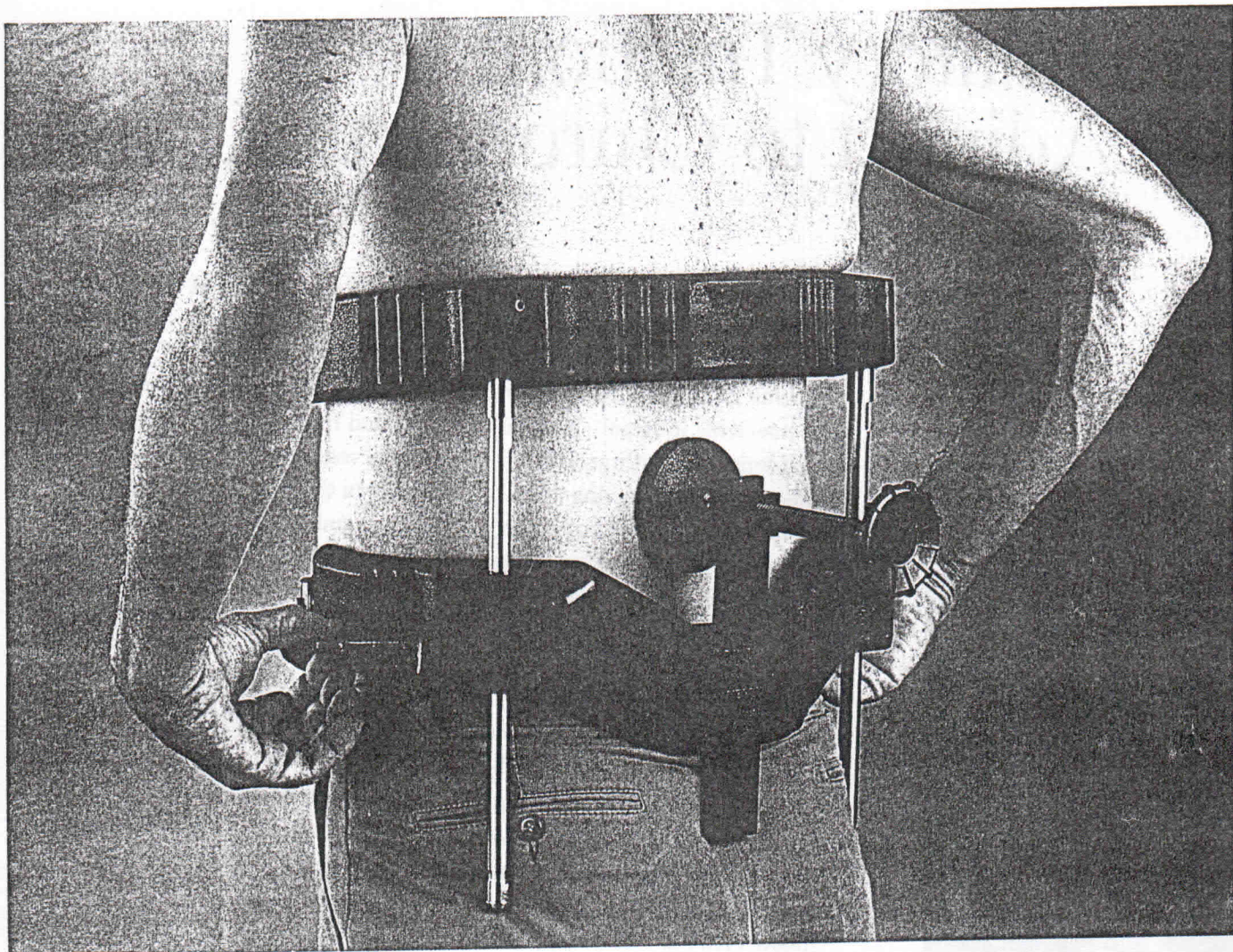
The Vertetrac is a fairly simple and relatively inexpensive instrument that applies a vertical, upward-thrusting distraction force to the lumbar spine, greater than the weight-bearing force. It also applies a horizontal force simultaneously, to complete the function of the traction. Because the Vertetrac is strapped onto the torso, it allows the patient full movement and mobility during utilization — a condition that tends

to have a positive psychological effect.

The instrument itself is composed of two U-shaped, flexible, padded frames connected by two metal rods. The bottom frame rests on the iliac crests of the pelvis and is not movable. The top frame, strapped to the thorax, is movable, producing a vertical, upward-thrusting force. Both frames have a front belt assembly with a ratchet mechanism for tightening and quick release. There is a leverage mechanism that moves the top frame up, while allowing additional traction pressure on either side (useful for sciatic scoliosis cases).

The thrusting force (20 to 40 kg on both sides) produced by the Vertetrac is strong enough to eliminate all, or nearly all, lower back and sciatic pain when it is strapped to the patient's torso. This force, controlled on each side by a power indicator etched into the metal rods, effectively counteracts the weight loading while tightening longitudinal ligaments.

Horizontal force is, meanwhile, applied with a pressure pad tightened by a knob that screws in or out; the pad puts pressure directly onto the spinous processes



Designed to fit the patient's torso, the Vertetrac provides traction to help correct herniated disc conditions.

(L3, L4, L5). As a result, additional tightening of the longitudinal ligaments over the discs occurs. This produces centripetal pressure on the disc and eases reposition, particularly of the annulus fibrosus.

When Stabholz reports in his 1992 book, *Low Back Disorders: Innovative Ambulatory Treatment, Self-Treatment and Prophylaxis*, that "over 10,000 patients have been treated with Vertetrac" for lumbar disc disorders of primary and secondary origin, my own experience indicates that the device can be an important

adjunct to chiropractic care.

Five years ago, suffering from a herniated lumbar disc myself, I ordered a Vertetrac after reading about it in a chiropractic magazine. Its design made sense to me; I had hoped to develop something similar, in fact, for patients who had lower back problems. Because the results I obtained in my own case — full recovery in two weeks, using the Vertetrac daily, in combination with chiropractic adjustments — were so dramatic, I began adding the device to my care plan for patients with herniated lumbar discs.

CASE STUDY ONE

Patient Deborah Daren, a 38-year-old dentist, is a good example of the kind of care the Vertetrac makes possible. She was told by her radiologist that she had the largest herniated disc he had ever seen. Her CAT scan revealed severe herniation in L5, S-1, on the left.

When Daren called me in February 1994, she had lower back, leg and buttock pain which made it difficult for her to sit. Her pain was so intractable, in fact, she was unable to get out of bed. For the first care session, I

went to Daren's home, taking the Vertetrac with me. Once I did some preliminary adjustments, I got Daren into the Vertetrac and she responded positively. Her pain immediately decreased, and she said, "This thing feels like it's doing something."

For the next session, she was driven to my office while lying down in the back seat of the car. In the interim, however, she had seen a neurologist, who had recommended that she continue her care plan with me; he said that the device sounded interesting and noted a slight improvement.

Daren came to the office for care three times a week, with the visits decreasing as the healing progressed. My in-office care plan was to begin with flexion-distraction adjustments on the table, continue with specific diversified spinal adjustments (anterior dorsal and side posture lumbar) as indicated and conclude with her walking around 30 to 45 minutes with other patients, all wearing the Vertetrac. (I've learned that the camaraderie and encouragement that occurs in a group adds a significant intangible benefit to the healing process.)

Three months after my initial care provision, Daren had a follow-up MRI which revealed that her herniation had decreased on the left when compared with her earlier CAT scan. This constitutes objective "proof" that the Vertetrac, in combination with chiropractic adjustments, creates real change in disc herniation. At this point, Daren, who had been working part-time throughout her care plan, was able to return to work full-time with only slight discomfort and some restrictions. In an additional three months, all discomfort disappeared.

Daren continues to come in for monthly "healthy visits," which consist of adjustments and ambulatory traction. And the "largest herniated disc" ever seen by her radiologist is a thing of the past.

CASE STUDY TWO

Another patient of mine, 45-year-old Ed Simonelli, had similar results in a much shorter period of time. He tends the roadways, shoveling salt and sand to prevent accidents when it's icy in winter and marking potholes for repair at other times of the year. He was moving a box in

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the back of his truck from a twisted position when he felt his back go out in the first week of January.

In severe, right-sided lower back pain, Simonelli also had great difficulty getting out of bed. When I did a home visit — as I did with Daren — I first completed some standing dorsal adjustments and minor stretching before getting him into the Vertetrac. Once it was on, Simonelli, who had been antalgic by about 25 degrees, was able to stand up straight while feeling an immediate relief of his pain.

I worked with him three times a week for three weeks, using flexion-distraction adjustments and ambulatory traction, and Simonelli was able to return to work by the end of the month. There has been no relapse, though the city worker, like the dentist, continues to come in for monthly healthy visits.

The success of the healing process can be attributed to overall good chiropractic care, including the use of ambulatory traction, and a supportive environment.

As an important adjunct to chiropractic care, the Vertetrac ambulatory traction device offers both "instant relief" to patients in severe lumbar disc pain, as well as long-term assistance in resolving the herniation resulting in that pain. By decreasing the intradiscal pressure, walking traction enables the herniated disc material to be sucked back into place between the vertebral discs. At that point, the spine can gradually heal itself, if given continuous and ongoing chiropractic support and follow-up.

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About the author: Richard Carpenos, D.C., a 1984 graduate of National College of Chiropractic, has been in private practice for more than nine years in West Haven, Conn. He is a member of the International Chiropractors Association and serves as public relations director for the Connecticut Chiropractic Association. Inquiries should be directed to him at 666 Campbell Ave., West Haven, CT 06516; or call (203) 934-6066.