Case report cont.

Conclusion

The patient was making consistent progress with reduced neck pain, antalgia, and significantly improved cervical ranges of motion so at that time was referred to have the splint digitally equilibrated after the third visit and noted at that time a 70% reduction in diplopia. By the fifth dental visit on April 2, 2015 he stopped needing prism glasses. Follow-up ophthalmology exam in May of 2015 found no evidence of diplopia.

Discussion (Continued)

With cases that do not have a discrete relationship it is difficult to explain what were the specific mechanisms that affected improved ocular function following a chiropractic intervention. Many types of possibilities relating to chiropractic manipulative therapy and its affect on visual fields, vision, and optic nerve function have been discussed by Gorman et al in the literature.1-4

References


Discussion

There is not much in the literature regarding chiropractic and optometric or ophthalmological co-treatment of patients. One study by Tymms discussed a 13-year-old male with intermittent diplopia referred for chiropractic care by his optometrist. In this case only one treatment achieved a full resolution of the patients symptoms with the optometrist finding on re-examination a correction of the over-convergence 1.

Methods

A 56-year-old female patient presented for chiropractic and dental care with persistent symptoms of sleep apnea, excessive daytime sleepiness, short-term memory loss, foggy-headedness, TMJ pain, chronic myofascial neck and shoulder pain, fatigue, and vertigo.

Cranial palpation was noted at the right zygomaticomaxillary joint, upper medial orbit, sphenoid wing, coronal and squamosal sutures, and an occipital extension cranial distortion pattern. Pelvic torsion with sacroiliac joint hypermobility was noted on the left (category two). Palpation pain and hypermobility of right sub occipital muscles was noted along with palpation pain from C-1-6. He had cervical spine antalgia with decreased rotation range of motion to 25°.

The patient was treated for a total of six visits between February and April that were directed at stabilizing the sacroiliac instability SOT blocks and sacroiliac support belt. Spheno-maxillary cranial adjustments were administered to the maxilla and zygomatic bones along with intraoral cranial therapy for the occipital extension cranial distortion. Cranial dental co-treatment consisted of a lower occlusal splint, which involved one-visit per week three-weeks in a row, with the splint equilibrated immediately after cranial treatment.

Introduction

A 59-year-old male began to experience intermittent diplopia 50% of the time, which after three-days became constant. Over the previous 30 years it was not uncommon for him to initial awaken with “double vision” but after a few minutes it would go away. When his condition became constant he consulted with an ophthalmologist who diagnosed him with a fourth cranial nerve palsy causing a vertical displacement of his eye. He was given prism glasses to correct the displacement. He presented on February 17, 2015 for an assessment and treatment at this clinic.