Doubles Chiropractor’s Income

MEDICALLY ESTABLISHED AXON-II TEST PROVES CHIROPRACTIC SUBLUXATIONS


Journal of Pain Symptom Control & Palliative Care: Louisiana State Uni. Pain Center study finds AXON-II test has 100% statistical accuracy detecting and quantifying nerve injuries.

Journal of Practical Pain Management: Neurosurgeon reports the AXON-II prevents incorrect treatment caused by referred pain in 56% of 151 spine patients.

American College of Surgeons: Researchers using the AXON-II find L5-S1 lesions, undetectable by MRI or EMG, to cause pelvic inflammation (autonomic imbalance).

More studies & videos: www.deltapain.com

Reimbursement: Group, WorkersComp and PI

AXON-II Software report eliminates the need for testimony. Doctors using the AXON-II scripts and charts have never been cross examined. Judges, juries and insurance lawyers understand the evidence and cross examination would only strengthen the proof in the juror's minds.

ABNORMAL C8 NERVE FUNCTION CAUSES REVERSE SPINOUS ROTATION

One daily 15 minute painless test performed by doctor or staff returns the AXON-II investment in less than 40 days

INDEPENDENT DISTRIBUTOR – MAURICE WOODARD (404) 309-5200
PAINDX, INC. (800) 766-0884 www.deltapain.com
Re: National Institute of Health & Chiropractic Scientific Proof

Dear Colleague,

The National Institute of Health - National Library of Medicine Clinical Trials recently began using the Axon-II to evaluate the effectiveness of spinal injections. I had to wait until the Axon-II attained this highest level of medical acceptance before sharing the fact that the Axon-II scientifically proves chiropractic with objective evidence.

Facts:
- Axon-II - FDA Class-II (Safe % Effective)
- Peer-reviewed 100% accuracy locating & quantifying radiculopathy
- 15 minute painless exam a staff member can perform for the doctor
- $450 to over $1400 reimbursement (CA & NY)

The American Association of Sensory Electro-Diagnostic Medicine is the sponsor of the Clinical Trials. The AASEM was founded in 2002 by medical researchers studying the Axon-II. It now has over 1000 members including neuro-surgeons, orthopedic surgeons, pain mgmt, family practice and other specialists. www.aasem.org

The enclosed PI Report was generated with the Axon-II Analysis Software. It explains how the Axon-II proves chiropractic. Call and learn how easy it is to stop cutting PI bills, increase referrals and improve results 100% using a medial device that pays for itself in less than 3 months.

Sincerely,

James Hedgecock, DC, PhD (404) 309-5200 www.deltapain.com jimhedgecock@gmail.com

Brief CV:
INITIAL REPORT OF INJURY
Date: 02/23/2015
Re: Mary Jones
DOB: 04/06/1989
DOI: 02/15/2015
Examination date: 02/17/2015

To Whom It May Concern:

On 02/17/2015 Mary Jones was first seen for complaints associated with a 02/15/2015 vehicular accident. The complaints include neck and right shoulder pain radiating into the thumb side of the right arm.

SUBJECTIVE HISTORY & PHYSICAL FINDINGS
The history is negative for similar previous injuries or symptoms. Based on the description of the accident and physical, orthopedic and neurologic findings, which are detailed in the patient’s file, Ms. Jones has suffered a cervical spinal injury.

OBJECTIVE EVIDENCE
Rather than enumerate the substantially subjective findings of the history and physical examination, in the interest of brevity, this report focuses on the objective evidence presented by the electrodiagnostic and spinal imaging examinations.

OBJECTIVE NEURO-ELECTRODIAGNOSTIC EXAMINATION
Pain Fiber Nerve Conduction Study (pf-NCS)
The pf-NCS is the first new electrodiagnostic examination (EDX) to be introduced in nearly 60 years. It detects acute and chronic functional changes in small pain fibers, which allows it to locate and quantify nerve root pathology (radiculopathy) with 100% peer-reviewed statistical accuracy.1 The unique ability of pf-NCS to assess pain fibers has resulted in it being used in National Library of Medicine Clinical Trials through a division of the National Institute of Health, sponsored by the American Association of Sensory Electrodiagnostic Medicine (https://clinicaltrials.gov/ct2/show/NCT01979367). The AASEM is the medical organization through which I am certified in the pf-NCS.

By comparison, the battery of EMG tests developed between 1918 and 1945, have become so obsolete that no new textbooks on neurology or pain management mention them as diagnostic alternatives. Specifically dealing with the diagnosis of radiculopathy, EMG tests require gross degenerative changes of multiple nerve roots before they can begin to detect any change that suggests the presence of radiculopathy.2

Acute & Chronic Radiculopathy
Neuroscientists have applied the term Epicritic Phase to the nervous system’s immediate reaction to injury. This initial acute stage of injury is characterized by the A-delta pain fibers signaling sharp pain, and localizing it so well that we instantly identify its location and pull away from its cause. Within hours the Protopathic Phase begins with increasing
deep pain from the C-fibers, while simultaneously the excellent localizing A-delta fibers become progressively less responsive. This state of poor localizing C-fiber dominance persists as long the injury remains unresolved, which presents a diagnostic dilemma. Patients complaining of the worst subjective pain are those most likely to be misdirecting treatment and interventions. In this regard an example of the practical application of the pf-NCS was recently published in a major pain management journal. A neurosurgeon reported that the pf-NCS improved outcomes in 56% of 151 patients where it correctly redirecting spinal interventions. In 35% the pf-NCS confirmed the subjective findings, and in 8% it found the pain generating lesion to be on the side opposite from the patient’s symptoms.

Pf-NCS Examination Protocol
The pf-NCS precisely gauges A-delta fiber function by detecting changes in their sensitivity. All the major regional nerves, whose origins are from specific nerve roots, are bilaterally tested. In a cervical study 9 nerves are tested bilaterally for a total of 18 nerves. All the measurements are averaged and nerves requiring stronger than the average stimulation to cause an action potential (nerve signals) suggests pathology. Nerves requiring less than the average strength stimulation suggests the presence of a nearby process causing irritation, such as vertebral joint inflammation. Measurements are objectively verified by detecting the increase in electrical amplitude that accompanies the action potential. The 100% peer-reviewed statistical accuracy of the pf-NCS is independent of variations associate with race, age or gender, since the patient acts as his own control. If the measurements were compared to population averages on a bell-shaped curve, as used in EMG, accuracy would drop to around 65%.

A-delta pf-NCS Deviation Index
A-delta measures are rated in a Deviation Index ranging from +1 (mild – 27 to 31 on the graph scale) to +5 (very severe – over 40 on the graph scale). Graph scale numbers are for relative comparison and do not coincide with actual measurements.

Diagnostic Summary
The right C6 is seen in the graphic Deviation Index to be rated +5 Very Severe making it the major dysfunction.

OBJECTIVE RADIOGRAPHIC EXAMINATION
Anatomical/Structural Findings
Bone density appears normal.  
The anterior curve is within normal range.  
Disc spacing is normal.  
Bony spurring is not noted.

**Lateral Bending Radiograph Studies**  
**Proprioception Physiology**  
During the Protopathic Phase, as A-delta signals decrease, there is a corresponding decrease in pressure and stretch (proprioception) signals to the spinal cord from the joints, muscles and ligaments of vertebrae adjacent to the injured nerve root. This decrease in proprioceptive signals impairs the ability of spinal cord reflexes to control precise vertebral motion. Even slightly aberrant motion can traumatize the nerve root, which results in a vicious cycle. The greatest degree of vertebral rotation is well established in the literature to take place at the limit of lateral bending. It is also well established that since vertebral rotation is under the control of spinal cord reflexes, and not under voluntary control, no one can willingly make her/his vertebrae rotate in the wrong direction.  

**Lateral Bending Findings**  
The patient’s cervical lateral bending view demonstrates normal and abnormal cervical rotation (white arrows). The two dash lines form the right and left boundaries of the mass of the vertebral bodies. It can be seen that relative to the center of the body mass the upper three spinous processes rotate in the correct direction, which is away from the side of bending. The spinous of the C6 vertebra, immediately below, is abnormally centered in that it failed to rotate in the correct direction, while C7 spinous rotates in the wrong direction some 11 millimeters from its normal position.

**EVIDENCE BASED DIAGNOSIS**  
The objective correlation of the pf-NCS and the radiographic imaging represents irrefutable evidence of the presence of nerve root injury. These findings show that the neurologic trauma has resulted in a proprioceptive imbalance of the local spinal cord segment. This is causing abnormal vertebral motion with recurring nerve root injury. If such a vicious cycle were to be left untreated it would certainly result in chronic spinal degeneration and advancing neurological damage.

**Treatment Prescription**  
Ameliorating nerve root pain is important, but alone will not result in a positive outcome. Palliative therapies cannot break the vicious cycle involved here. Therefore, treatment must include techniques to both restore normal vertebral motion and accelerate nerve recovery. When indicated, the A-delta pf-NCS and lateral bending radiographic studies will be repeated to objectively assess progress.
Sincerely,

Dr. James L Mason, DC

References

1 R Cork et al Predicting Nerve Root Pathology Jo. Pain, Symptom Control and Palliative Care Vol 2 #2
3 Hedgecock, Textbook of Pain Electrodagnosis, 2 Ed. 2013
4 Multicenter Study Paradoxical Relationship – A-delta Function & VAS, Jo. AASEM 2012
5 P. Carney (Neurosurgeon) Practical Pain Management Vol. 12 #5 June 2012
6 Punjabi & White, Spinal Mechanics, Lippincott 2 Ed. 1998

Date: 07/12/2015
Patient: Mary Jones

ADDENDUM REPORT

The patient has been seen on a reduced frequency basis, from daily for 5 weeks down to once per week during the last month.

Treatment Regimen
Besides palliative physical therapy modalities, treatment has been focused on restoring normal spinal motion and supporting the repair processes by increasing blood flow and electro-stimulation.

COMPARATIVE ELECTRODIAGNOSTIC STUDY pf-NCS
Seen here is the most recent A-delta graph. In comparing it to the initial graph it is noted there is an estimated 100% reduction is severity.

COMPARATIVE RADIOGRAPHIC STUDY
The recent radiographic study shows a corresponding 95% improvement in rotation of the C7 vertebra. This seems to be the maximum improvement that can be expected. Though this is an excellent improvement, unfortunately, there may be some weakness that will predispose the patient to future recurrences that may be caused by relatively minor strains, such as lifting associated with daily activity.

Prognosis
Though the findings suggest an excellent recovery, based on severity of the injury and its location the patient can expect to have some recurrences that can be caused by daily activity, such as lifting. Over time as she returns to normal activity she can expect to gain strength and stability, which means she may well fully recover at some point.

Ms. Jones has been instructed on how to check her ranges of motion. She is released from active care and instructed to return upon any recurrence of symptoms or return of limited motion, since limited motion may be the first sign of a instability.
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![Graph Image](image)

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