Five Clinical Tips That I Learned from Dr. Troxell

By: Peter T. DeLoe, D.C.

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It seems that a day doesn't go by that I don't think of, or reflect on, Dr. Larry Troxell, and what he taught us. This does nothing to diminish the magnitude of his passing. I can't help but wonder what else I could have learned from him. But what I did learn from him seems astonishing not only in its volume but also in the incredible relevance when helping sick people get well. I am sure there are many of you who have had one of those, "Gee, T was right," moments in practice. It is doubtful that we will find someone who had such a huge influence on our professional lives as Dr. T did.

I feel fortunate and grateful for having had a professional and personal relationship with Dr. T. All of us have benefited from his tireless and selfless commitment to teaching Gonstead chiropractic. We all tried to pull one more piece of knowledge out of him when we were with him. For me, some of the best tidbits of information came when I was working with him, or during social time, just by ourselves. I can recall one specific time when we were riding up a chairlift in Vermont, and he just started talking about the pelvis. Another time, while we sat at the kitchen table getting our daily 'supplement' of ice cream, he let out a few more 'pieces to the puzzle.'

I feel compelled to write down and share with you a few of my favorite lessons from Dr. T. Some are obvious; others are small pointers that make all the difference to achieve rapid success. Some are things he said, but others are observations that I made.

1) "Chiropractic always works! When it seems not to, re-evaluate its application." Dr. T would often share this quote from Dr. Gonstead. I find it so important in my practice. Gonstead chiropractors are somewhat isolated from one another, and thus, are devoid of a constant support system.

What would Dr. T do? That is a question that we often ask ourselves, and I personally have had more success with that thought process than with any other that I can think of. When difficult cases arise, the exceptional doctor figures out the 'missing link' to success. I remember a Bells Palsy case that Dr. T and I shared. It was slower to respond than the typical two-to-five adjustments. Dr. T enthusiastically pulled me aside and said, "Hey, you know what fixed that case? The patient's TMJ was subluxated!"

2) When you have a difficult case or a patient with increased pain after an adjustment, look lower in the spine for the primary subluxation. A good example of this would be the cervicals. Let's say you start adjusting a patient at the sixth cervical, and they get more neck pain or a headache. Recheck your x-ray, palpation, and especially, your instrumentation. Chances are you will need to look one or more vertebrae lower. Sometimes, it can be much lower.

I recall adjusting a patient that Dr. T and I shared. She began having pain over her left atlas after I had adjusted her lower cervicals. So, being the new Dr. that knows everything, I talked myself into a

reading at the atlas and made an adjustment. It seemed like a good set until she came in the next day with left jaw pain, acute neck pain and a headache! Well, with my sweaty palms, I was able to detect a reading at the axis. Another adjustment. No change! She felt just as much pain as before. Surprisingly, she returned for another appointment. I suggested that Dr. T come in and have a look. She thought that was a good idea. I explained to Dr. T what I had done. He grimaced a bit and proceeded to run the instrument from about T2 down through her thoracics. I felt like saying to Dr. T, "I told you that her pain was in her upper left cervicals and jaw"!!!!!! Instead, I kept my tail between my legs and my mouth shut. After his analysis, he said, much to my surprise, adjust the fifth thoracic!!! The next day, he was not a little better. She was 100% better!! Lesson learned!

3) There are multiple reasons why Dr. T was a superior adjuster. After observing him for over fifteen years, one thing stands out in my mind as one of the primary reasons why. You may find this trivial, but I feel his line-of-correction was incredibly accurate and consistent. When observing Dr. T adjust, you knew the plane-line of the joint to be adjusted by looking at his forearm. During the adjustment, that forearm did not waver off target. Once he was set up, it was as if he was locked on the target. Then, BOOM! It was fast and efficient and rarely did he need to "try again." Watching him adjust (and watching ourselves) on tape is certainly one of the great tools we have to improve our skills.

4) The "five-to-two" rule. Yes, of course, there is the "five-to-two" rule as it applies to the pelvis and its effect on leg length, but Dr. T once shared with me another "5-to-2" rule that he used with low back cases. The classic case-in-point would be a fifth lumbar as a primary subluxation and one of the sacroiliacs as a secondary problem. Dr. T would often do five adjustments on the primary, then two adjustments to the secondary subluxation. He would also do the opposite: two adjustments on the secondary, then five on the primary. Of course, five-to-two is not set in stone, but it seems to be the ratio that is most often appropriate. Maybe it could be three-to-one for some or ten-to-three, etc. But, what makes the great ones great is not only knowing where and how to adjust, but also, how many times to adjust before moving onto a secondary or tertiary subluxation.

5) I can't write an article about Dr. T without mentioning something about the posterior second sacral tubercle subluxation. He continually taught us to double-check for this elusive subluxation on all of our patients, especially, the ones we were having difficulty with. He would constantly point to the patient's lateral x-ray, and show us how the remnant disc was open in the back, an indication of a posterior subluxation of that segment. It could also be the third or fourth sacral segment, but the second is the most prevalent. Instrumentation will show a 'break' at the involved level. Static palpation will reveal a very tender tubercle, and motion palpation will feel like the entire low back is tight or fixated. Very often, the site of pain will be right over the involved segment, but in many cases – such as, when the patient is not responding like you know they should and regardless of where the pain is – check for the elusive sacral tubercle.

Well, that's just the tip of the iceberg, but these are probably my top five lessons from Dr. T. I could write a book on half of what he taught me. Wait, did I just say that? Maybe a couple more articles

instead! Please feel free to e-mail me (drdeloe@yahoo.com) with your favorite lessons from Dr. T. I would love to hear from you. In good health!

Editor: I feel blessed as well that I was given the opportunity to intern at Dr. Troxell's V Points Clinics and was able to receive so many valuable clinical lessons. Thanks Dr. T!

If you have had a chiropractor mentor who gave you some valuable clinical tips, please share them with us. The practice of chiropractic continues and advances with what is passed onto us and what we do with the hard-won knowledge.