

Although there is no standardized method of writing a working diagnosis, there are certain concepts that are universal in the iteration of a useful diagnosis. In both the old Practice Review process and the newer Practice Review Self-Submission model, the written working diagnosis is an element of record keeping that regularly requires coaching for members. As there may be some confusion about what this element of record keeping entails, this article hopes to bring clarity to the matter of CCOA expectations in the context of Practice Review.

The most common concerns addressed in Practice Reviews are a diagnosis that either simply reiterates the patient's presenting complaint, or diagnoses that are so generic as to provide little or no information regarding the patient's condition. Diagnoses of cervicgia or lumbago for patients that present with neck pain or low back pain do not meet the CCOA Standards of record keeping. Similarly, diagnoses that contain only an ICD-9 code also do not meet the Standard.

In chiropractic college, we were taught that a more descriptive diagnosis method is required when dealing with musculoskeletal conditions. This article is an attempt to describe this method in order to give a fresh perspective to clinicians.

While considerations regarding the effectiveness and validity of certain physical examination tests and procedures comes into question from time to time, the rationale of providing a sufficiently detailed description of the result of the assessment process remains the goal of providing a written working diagnosis.

The following is the recommended format taught at Western States Chiropractic College. Thanks to Dr. Ron Lefebvre at WSCC for his permission to provide this perspective.

- Pathoanatomical (orthopedic) component or named syndrome with specified neurological/radiating component
- Associated with biomechanical/soft tissue components (e.g., joint dysfunction) complicated by local complicators or major contributing factors
- Pathoanatomical (orthopedic) components or named syndromes

Anatomical or Orthopedic Component

The anatomical or orthopedic component is usually written first and is considered the primary diagnosis. This reflects the location of the structure (e.g., cervical, thoracic, thoracolumbar, lumbar, etc.) and the type of injury (e.g., sprain, strain, hyperflexion injury, etc.). Or it may reflect the presence of a certain type of headache (e.g., tension, cervicogenic, vascular, etc.), or it reflects the presence of a syndrome (e.g., cervicobrachial, thoracic outlet, etc.). A myofascial pain syndrome may be included here if it is the primary source of pain and there is no other anatomical lesion (e.g., piriformis syndrome, myofascial pain syndrome of rotator cuff, etc.); otherwise, myofascial syndromes properly belong under the biomechanical/soft tissue component.



Sample List of Anatomical or Orthopedic Components

Ankylosing spondylitis	Hyperextension-hyperflexion injury (acceleration-deceleration injury)
Brachial traction injury	Maigne syndrome
Cervical (lumbar) facet syndrome	Sacroiliac syndrome
Cervical (thoracic/lumbar) sprain/strain (note: sprains and strains must all be further differentiated as postural, traumatic, or accumulative, or repetitive, overuse)	
Cervical herniated disc	Sacroilitis
Cervical stenosis (when primary)	Spinal canal stenosis
Cervicobrachial syndrome	Spondylolisthesis (if considered primary cause)
Cervicocranial syndrome	T4 syndrome
Cervicogenic headache	Tension headache
Failed back syndrome (status post-surgical)	Thoracic Outlet Syndrome
Guillain Barre syndrome	Vascular headache

Neurological/Radiating Component

This component is utilized whenever there is radiating pain or neurologic signs or symptoms, especially into a related extremity. Include the nature of radiation (e.g., deep referred pain, radicular pain, radiculitis, radicular syndrome, paresthesia, etc.) as well as location (into right foot, to the left posterior thigh, grade 2 radiculitis, etc.).

Sample List of Neurological/Radiating Components

deep referred pain (sclerotogenous) into posterior thigh	myofascial pain referral over right eye
left foot paresthesia left foot paresthesia	S1 radicular pain into right foot

Biomechanical/Soft Tissue Component (Joint Dysfunction and Soft Tissue Lesions)

This component is the most classically chiropractic portion of the evaluation. It presents a diagnosis based on joint dysfunction and/or major soft tissue lesions. The sequence of joint dysfunction diagnoses will be in order of importance determined by the chiropractor; otherwise, as a matter of form, joint dysfunction will be cited first.

Joint Dysfunction will include:

- location (degree of specificity at doctor's discretion) – e.g., upper cervical, C2, cervical, thoracic, lumbosacral, etc.
- an acceptable term for joint dysfunction (choice at doctors discretion; specificity also at doctor's discretion) – e.g., segmental dysfunction, joint dysfunction, or subluxation syndrome.

Note: avoid using the term “joint restriction”, since restriction is simply a physical exam finding that supports the diagnosis of subluxation. It is not a diagnosis itself.



Sample List of Joint Dysfunction Diagnoses

Cervical (thoracic/lumbar) joint dysfunction	Lumbosacral subluxation syndrome
Upper cervical joint dysfunction	

Soft Tissue Lesion will include:

- location (specificity at doctor's discretion – e.g., paraspinal, quadratus lumborum, pelvic stabilizers, etc.
- type – e.g., myospasms, myofascial trigger point, myofibrosis, etc.

Sample List of Soft Tissue Lesion Diagnoses

... and attendant shoulder girdle hypertonicity	... and paraspinal myospasm
... and cervical myofascial pain syndrome	... and TFL myofascial trigger point

Local Structural Complicators

This component cites any local complicating features that may affect expected outcome (prognosis) or overall management. Which particular anomalies or factors should be considered in this list is at the discretion of the doctor. Other types of contributing or underlying factors may be better cited as a separate problem or be reserved for discussion in the clinical impression. For example, while diabetes may be seen to be complicating a patient's lumbar sprain, it is better cited as a separate problem and the connection could be suggested in the case discussion. An over-pronation syndrome may ultimately be responsible for the above mentioned lumbar sprain, but since it is not really a local complicating feature, it too might be better seen as a separate problem, again reserving the clinical impression as a place for speculating on cause and effect. Ergonomic considerations should be discussed in the clinical impression.

Sample List of Local Structural Complicators

bony anomalies and significant structural changes such as C3-C4 block vertebrae, tropism, transitional segment, spondylolisthesis (if not primary lesion), scoliosis	DJD or DDD
central canal (lateral recess stenosis) if relative	ligamentous instability

Note: other modifiers may be used at doctor's discretion (mild, moderate, severe; acute, chronic, subacute, chronic recurrent). Other pertinent discussion should be included in the written case summary (a.k.a. clinical impression).

Sample Diagnosis

Let us put it all together with examples:

- Acute traumatic lumbosacral facet syndrome
 - with deep referred pain into right posterior thigh
 - associated with multiple lumbar subluxations and paraspinal spasms
 - complicated by relative spinal stenosis
- Postural cervical sprain



- associated with cervical joint dysfunction and suboccipital
- 3. Myofascial pain
 - complicated by C1 ligamentous instability
- 4. L5-S1 medial disc protrusion
 - with S1 radicular syndrome into left foot
 - associated with thoracolumbar subluxation and myospasm
- 5. Lumbar subluxation complex
 - with attendant quadratus lumborum myofascitis
 - complicated by L5-S1 tropism
- 6. Cervicogenic headache
 - with deep referred pain over right eye
 - associated with upper cervical segmental joint dysfunctions

Another method of diagnosis for musculoskeletal conditions could take into account many of the above recommendations, but perhaps in a simpler form.

For example, if we observed a musculoskeletal condition as a diagnosis that contains the following:

- a timeline (acute, sub-acute, chronic)
- severity (mild, moderate, severe)
- mechanism (traumatic, repetitive strain, cumulative micro-trauma etc.)
- involved tissue/location (anatomical structure(s)), and
- injury type (sprain, strain, joint dysfunction, subluxation, etc.)

we can come up with a very descriptive diagnosis that provides significant information.

Consider a situation where a patient presents with neck pain three days after a motor vehicle accident. Your history, examination, and ancillary studies point to a sprain/strain in the patient's cervical spine. When we consider the above factors, this patient's descriptive diagnosis may read, "Mild to moderate, acute, traumatic, cervical sprain/strain."

We could also include any type of associated or complicating factors at this point as well, for example, "with associated cervicogenic headache, complicated by moderate osteoarthritis at C5-6."

Both methods provide very detailed and descriptive diagnosis for musculoskeletal conditions that would be seen in any chiropractic office in Alberta. As there are no hard and fast guidelines or standardized methods of writing diagnosis, consider a more descriptive approach.

Remember that the objective of a written diagnosis is to inform the reader of the clinical conclusion reached by the writer. It should be descriptive enough that the reader can then look to the treatment plan and see that there is a rational link between the two.