Chris Kemper, D.C.
C.V. Current 2010

1. Graduate Palmer College of Chiropractic 1978
2. Director of product development Kemper Support Surfaces
3. Director of Physician Services, Kemper Tailbone Injury Foundation (KTIF)

Current Projects

- Offering continuing education for Doctors of Chiropractic and Medicine
- Provides private consultation services to assist medical physicians, surgeons and chiropractors in integration of diagnosis and treatment of the SacroCoccygeal syndrome into their specialty practices
- Advocating the direct role coccyx function plays in normal child birth and vaginal birth after C-section (VBAC). Helping to define the role coccygeal dysfunction evidently plays in the need for surgical delivery.
- Continuing discussions with researchers on how to design investigational studies to better understand the impact coccyx dysfunction evidently has on pelvic floor mechanics and spinal neurodynamics
- Development of an online database to enable coccyx care specialists to upload simple intake and outcome data sets to enable eventual large scale meta-analysis of orthopedic, neurologic, obstetric and pain conditions stemming directly or indirectly from the SacroCoccygeal syndrome.

Research:

1. Kemper C., Wooley J. Hypothesis: Is Sacrococcygeal Hypomobility related to chronic low back pain and stiffness? J. Orthopaedic Medicine. 1998: Vol. 20, No. 3, 17-20.
2. Wooley J, Kemper C. Hypothesis: Is sacrococcygeal hypomobility related to chronic low back pain and stiffness. J orthopaedic medicine 1998; 20:17-20.
3. Is Sacrococcygeal Hypomobility related to chronic low back pain and stiffness? In: University of California San Diego proceedings of the 3rd International Congress on low back and pelvic pain. Vienna: Third Interdisciplinary World Congress on Low Back and Pelvic Pain; 1998. P. 222-224.
4. Kohlbeck FJ, Haldeman S, Hurwitz E, Dagenais S. Supplemental Care with Medicine-Assisted Manipulation Versus Spinal Manipulation With Chronic Low Back Pain. J Manipulative Physiol Ther 2005: 245-52.

   This prospective cohort was conducted in 2000-2001 by Kohlbeck & Haldeman et al. with Jim Wooley, D.C. and Chris Kemper, D.C. providing clinical services. The study looked at chronic low back pain in patients suspected to have coccyx dysfunction. Sixty eight patients participated with 26 receiving only massage, assisted stretching, supervised therapeutic exercise and spinal manipulative therapy. Forty-two comprised the medicine-assisted group that received the same physical therapeutics as the control group but also received coccygeal manipulation according to the clinician’s standard protocol. Patient selection was not limited to pain or deviant intercoccygeal angles but included objective signs of impairment believed to be associated with coccyx dysfunction including: palpable impairment of coccygeal range of motion; impaired lumbopelvic flexion and; impaired thigh strength. The group that received the medicine-assisted coccyx manipulation with the Wooley-Kemper procedure initially had both higher levels of pain and greater overall improvement in pain and disability at 3 months and 1-year after treatment was concluded. Unfortunately, the study was not randomized or blinded. In addtion, only pain and subjective factors of disability were measured. More research is needed to shed light on why the experimental group that was treated for coccygeal hypomobility improved the most.

Papers under submission:

- Radiology: Outlet Anterior Posterior Diameter (APD): Are now reference points needed for Anterior Posterior Diameter measurment in obstetrical pelvimetry?
- Obstetrics: Can increase in coccygeal extension increase physician-maternal confidence in vaginal deliver after Cesarean section.
- Orthopedics and Pain: Coccyx dysfunction: An objective clinical profile.

Professional Goals:

- To contribute to the body of evidence related to chronic pelvic pain (CPP), particularly that which is associated with coccyx angulation and hypomobility-induced pelvic floor deformity.
- Establish the role of coccygeal dysfunction may play in neuromusculoskeletal conditions. Pose potentially critical questions for each medical specialty that diagnoses and treats the spine:
  - **Pain:** The role coccyx angulation, dislocation and hypomobility plays in CPP.
  - **Neurologic:** Can spinal cord & thecal sac tension be induced at the dysfunctional coccyx. Is it possible that coccyx dysfunction could inhibit pelvic muscles and excite lumbar tone at the same time? If coccyx dysfunction can induce abnormal dural tension, what neurologic signs are reflective of such a condition?
  - **Orthopedic:** Can observed coccyx dysfunction-induced loss of lumbopelvic flexion & straight leg raise (SLR) induce excessive axial compression and lead to discopathy?
  - **Obstetrical:** To what extent does coccygeal dysfunction, characterized by anterior angulation and segmental hypomobility, affect birth canal pelvimetry? What percentages of Caesarian sections are performed primarily due to inadequate pelvimetry?
  - **Physiatry:** How many spine-related disabilities occur directly as the result of idiopathic CPP for which coccyx dysfunction has not been assessed?

- Help bridge the gap between allied and primary care providers. Advocate further cooperation in the formation of multidisciplinary care facilities.

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