

1 **Clinical Practice Guideline: Drop Table Assisted Manipulation**

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3 **Date of Implementation: July 13, 2006**

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5 **Product: Specialty**

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8 **GUIDELINES**

9 American Specialty Health – Specialty (ASH) considers Drop Table Assisted Manipulation
10 as medically necessary when used to assist in administering a high-velocity, low-amplitude
11 (HVLA) spinal adjustment. As such, the base of peer-reviewed published literature
12 supporting HVLA can be used to support the efficacy and favorable benefit: risk profile of
13 drop table assisted manipulation.

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15 **DESCRIPTION/BACKGROUND**

16 There are several different manufacturers and commonly used drop table models, but they
17 all have a common purpose and mode of action. The drop table is used to assist in
18 administering a high-velocity, low-amplitude (HVLA) spinal adjustment (Cooperstein &
19 Gleberzon, 2004). The therapeutic procedure begins with a downward pressure over the
20 appropriate vertebral segment or contact point to adjust the involved joint of the patient
21 positioned on the drop table. This section of the table will release or “drop” from one to
22 several centimeters. This abrupt stop at the “terminal point” and the practitioner’s
23 continued downward pressure results in inter-vertebral motion and/or joint cavitation.

24
25 **EVIDENCE REVIEW**

26 Oh et al. (2018) examined the effects of flexion-distraction and drop techniques on
27 disorders and Ferguson's angle in female patients with lumbar intervertebral disc
28 herniation. Thirty female patients with lumbar intervertebral disc herniation were divided
29 into an experimental group ($n=15$) treated with flexion-distraction and drop techniques and
30 a control group ($n=15$) treated with spinal decompression therapy. Both groups were
31 treated three times a week over an eight-week period. Results demonstrated that both
32 groups showed statistically significant decreases in disorders and in Ferguson's angle.
33 Authors concluded that flexion-distraction and drop techniques may be an effective
34 intervention to improve disorders and Ferguson's angle in female patients with lumbar
35 intervertebral disc herniation. Oh et al. (2019) performed a similar study looking at the
36 effects of flexion-distraction technique and drop techniques on straight leg raising angle
37 and intervertebral disc height of patients with lumbar intervertebral disc herniation. Thirty
38 female patients between the ages of 20 to 60 years of age were assigned to the experimental
39 group ($n=15$) treated with flexion-distraction and drop techniques or to the control group
40 ($n=15$) treated with spinal decompression therapy. Both groups were treated three times a
41 week for 8 weeks. Both groups had a significant increase in straight leg raising angle and
42 intervertebral disc height. The authors concluded that flexion-distraction technique and the

1 drop technique may be effective interventions for straight leg raising angle and
2 intervertebral disc height in patients with intervertebral disc herniations.

3
4 There is no specific evidence of safety concerns using a drop table. It has been suggested
5 that the drop table method may have a more benign safety profile, but this hypothesis has
6 not been verified.

7 8 **PRACTITIONER SCOPE AND TRAINING**

9 Practitioners should practice only in the areas in which they are competent based on their
10 education training and experience. Levels of education, experience, and proficiency may
11 vary among individual practitioners. It is ethically and legally incumbent on a practitioner
12 to determine where they have the knowledge and skills necessary to perform such services.

13
14 It is best practice for the practitioner to appropriately render services to a patient only if
15 they are trained, equally skilled, and adequately competent to deliver a service compared
16 to others trained to perform the same procedure. If the service would be most competently
17 delivered by another health care practitioner who has more skill and expert training, it
18 would be best practice to refer the patient to the more expert practitioner.

19
20 Best practice can be defined as a clinical, scientific, or professional technique, method, or
21 process that is typically evidence-based and consensus driven and is recognized by a
22 majority of professionals in a particular field as more effective at delivering a particular
23 outcome than any other practice (Joint Commission International Accreditation Standards
24 for Hospitals, 2020).

25
26 Depending on the practitioner's scope of practice, training, and experience, a member's
27 condition and/or symptoms during examination or the course of treatment may indicate the
28 need for referral to another practitioner or even emergency care. In such cases it is prudent
29 for the practitioner to refer the member for appropriate co-management (e.g., to their
30 primary care physician) or if immediate emergency care is warranted, to contact 911 as
31 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice
32 guideline for information.

33 34 **References**

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