sented in Table 2. Figure 1 presents the corresponding radar plots that illustrate the relationship between proportional agreement and kappa.

Prevalence of osteopathic palpatory findings

The number of subjects with and without positive osteopathic palpatory findings according to element of somatic dysfunction, spinal segmental level, and laterality is presented in Table 3. The prevalence of these osteopathic palpatory findings (i.e., the proportion of subjects with positive osteopathic palpatory findings) is depicted in Figure 2. Immobility and tissue changes were the most common osteopathic palpatory findings.

Associations between type 2 diabetes mellitus and osteopathic palpatory findings

The osteopathic palpatory findings according to element of somatic dysfunction, spinal segmental level, and laterality are presented along with the corresponding crude ORs and 95% CIs in Table 4. Type 2 diabetes mellitus was significantly associated with three osteopathic palpatory findings: tissue changes at T11-L2 on the right side (OR, 4.44; 95% CI, 1.73–11.37; P = .002); tenderness at T11-L2 on the left side (OR, 4.00; 95% CI, 1.08–14.86; P = .04); and immobility at T5–T7 on the right side (OR, 2.56; 95% CI, 1.05–6.25; P = .04).

As shown in Table 5, the three significant associations between type 2 diabetes mellitus and osteopathic palpatory findings persisted in the partially-adjusted logistic regression models that controlled for age and sex: tissue changes at T11-L2 on the right side (OR, 4.49; 95% CI, 1.69–11.96; P = .003); tenderness at T11-L2 on the left side (OR, 4.28; 95% CI, 1.13–16.20; P = .03); and immobility at T5–T7 on the right side (OR, 2.71; 95% CI, 1.09–6.75; P = .03).

The fully-adjusted logistic regression models that controlled for age, sex, hypertension, and clinical depression are presented in Table 6. The only significant result in these analyses was an association between type 2 diabetes mellitus and tissue changes at T11-L2 on the right side (OR, 5.54; 95% CI, 1.76–17.47; P = .003). We subsequently performed a series of *post-hoc* subgroup analyses to explore whether tissue changes at the T11-L2 segmental level may be manifestations of a viscerosomatic reflex involving the kidney because its segmental sympathetic nerve supply closely corresponds to T11-L2 [4] and it is

Table 2: Interexaminer reliability of osteopathic palpatory findings according to element of somatic dysfunction, spinal segmental level, and laterality.*

Element of Somatic Dysfunction	Spinal Segmental Level	Laterality	
		Left	Right
Skin changes			
	T5–T7	0.67 (0.13)	0.73 (0.26)
	T8–T10	0.66 (0.21)	0.58 (0.03)
	T11-L2	0.76 (0.02)	0.78 (0.20)
Trophic changes			
	T5–T7	0.61 (0.23)	0.66 (0.32)
	T8–T10	0.66 (0.30)	0.62 (0.16)
	T11-L2	0.71 (0.32)	0.71 (0.31)
Tissue changes			
	T5–T7	0.55 (0.05)	0.63 (0.21)
	T8–T10	0.55 (-0.07)	0.66 (0.13)
	T11-L2	0.50 (-0.20)	0.59 (0.09)
Tenderness			
	T5–T7	0.87 (0.58)	0.86 (0.56)
	T8–T10	0.85 (0.56)	0.84 (0.51)
	T11-L2	0.78 (0.40)	0.85 (0.60)
Immobility			
	T5–T7	0.60 (-0.06)	0.57 (0.07)
	T8–T10	0.69 (-0.01)	0.65 (0.07)
	T11-L2	0.66 (0.23)	0.56 (0.06)

*Table entries are for proportional agreement (and kappa).