



Clinical Weekly - 184th Edition

#JOURNALTUESDAY - by Abi Peck

A systematic review of potential long term effects of sports related concussion. [Download here](#)

1. Did the review address a clearly focused question?
2. Did the authors look for the right type of papers?
3. Do you think all the important, relevant studies were included?
4. Did the review's authors do enough to assess the quality of the included studies?
5. If the results of the review have been combined, was it reasonable to do so?
6. What are the overall results of the review?
7. How precise are the results?
8. Can the results be applied to the local population?
9. Were all important outcomes considered?
10. Are the benefits worth the harms and costs?

#NEWSOFTHEWEEK - by Liz Wright

1. GLA:D (Good life with osteoarthritis in Denmark)

An initiative from the research unit for musculoskeletal function and physiotherapy at the university of south Denmark. It presents an evidence based treatment plan for knee and hip OA, consisting of

patient education and neuromuscular exercise. The aims of GLA:D are to allow equal access for all OA patients to evidence-based patient education and exercise irrespective of place of residence and financial situation. Highlighting surgery is indicated only when non operative treatment fails. Key elements of GLA:D include: education of physical therapists in delivering patient education and neuromuscular exercise training and 2 sessions of patient education and a minimum of 6 weeks of neuromuscular exercise for patients.

National clinical guidelines for treatment of knee/hip osteoarthritis:

All patients should be offered the first line treatment, some may need supplementary treatment, while only 10-15 % need surgery in the form of joint replacement.





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#NEWSOFTHEWEEK - by Liz Wright

1. Continued

Patients participating in the programme aim to have increased physical function, reduced pain, reduced intake of painkillers and improved quality of life. The aim is that this will result in a decrease in health care visits and thus lower costs for the individual patient and society.

<https://bit.ly/2jiR6xB>

2. Achilles Tendon Differential Diagnosis by Peter Malliaras & Carly Johnson

Many of us will jump straight to a tendinopathy diagnosis. Here, Peter and Carly reason what else is possible; highlighting the signs and symptoms of common differential diagnoses in Achilles, and how ultrasound imaging can help (it can never make a diagnosis, though is excellent for confirming many conditions that present in a similar way to Achilles tendinopathy).

MIDPORTION TENDINOPATHY- localised tendon pain that 'warms up' with activity, worse in the morning, improves after 5-10mins, usually history of overload. London hospital test =palpation tenderness in a stretched position vs a relaxed position (if the tendon is more painful in a relaxed position its more likely tendon pain rather than pain from the surrounding tissues). Careful with end range loading.

INSERTIONAL TENDINOPATHY-distal insertion (superior calcaneum tuberosity or low at the distal calcaneum). Similar pain behaviours/morning stiffness and 'warming up' to midportion. The high insertion pain needs to be differentiated from a retrocalcaneal bursa whereas the low insertional pain is often from the tendon.

RETROCALCANEAL BURSA-can present with symptoms in exactly the same location as insertional tendinopathy however they may be more diffuse. One of the clues to differentiate is irritable pain and symptoms on low load activities such as heel raises or end range compression in dorsiflexion. Differential palpation of the two tissues can also be very helpful. If there is a lot of fluid or thickening of the bursa on imaging it very likely to be a pain generator and should be treated. Conversely, a little fluid on imaging is normal in active populations.

PARATENON- paratenon (the areolar tissue filling the space between a tendon and its sheath) inflammation which often presents with a reactive or irritable pain that flares for days after activity and can also be painful with low load activities such as calf raises. Often the patient will localise to the medial or lateral side of the Achilles. When localised to the medial side there needs to be some suspicion of plantaris.

PLANTARIS TENDON- Not common. Can be typical Achilles symptoms but more likely medially localised pain and medially localised Achilles pathology. Symptoms can come on in end range dorsiflexion from compression of the tendon. May be associated with increased foot pronation in function.

TRUE PARTIAL TEAR- Need to have the key diagnostic signs for a partial tear – 1) definite incident, 2) acute pain/definite change in pain following the incident, 3) acute and major loss of strength, related to pain inhibition. i.e. this is a major change in pain and function.

<https://bit.ly/2HFVDD>





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#FRACTUREFRIDAY BY SCOTT ROWBOTHAM

Weber Ankle Fracture

Also known as Danis-Weber classification it is a system of diagnosing lateral malleolar fractures. It is also a clinical indicator for appropriate management.

Type A

Fracture of the lateral malleolus distal to the syndesmosis. Typical components:

- below level of the ankle joint
- tibiofibular syndesmosis intact
- deltoid ligament intact
- medial malleolus often fractured

Type B

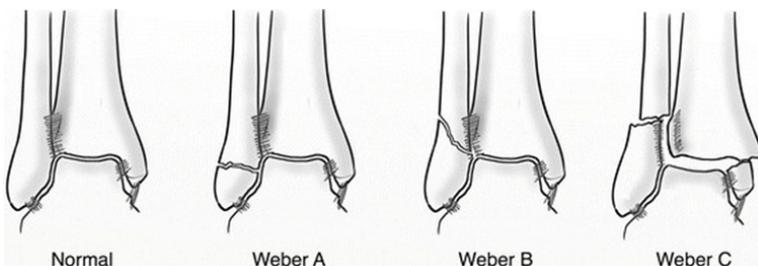
Includes fracture of the fibula at the level of the syndesmosis. Typical components:

- fracture at the level of the ankle joint, extending superiorly and laterally up the fibula
- tibiofibular syndesmosis intact or only partially torn, but no widening of the distal tibiofibular articulation
- medial malleolus may be fractured or deltoid ligament may be torn

Type C

Fracture of the fibula proximal to the syndesmosis. Typical components:

- above the level of the ankle joint
- tibiofibular syndesmosis disrupted with widening of the distal tibiofibular articulation
- medial malleolus fracture or deltoid ligament injury present



Imaging

Type B and C fractures involve damage to the syndesmosis itself which cannot be visualised on X-ray).

Management

Type B and C are unstable and are more likely to require operative management to achieve a successful outcome. Type A fractures are usually stable and are manageable through appropriate immobilisation and physiotherapy intervention.

<https://radiopaedia.org/articles/weber-classification-of-ankle-fractures>

https://en.wikipedia.org/wiki/Danis%E2%80%93Weber_classification

