



Clinical Weekly - 187th Edition

#JOURNALTUESDAY - by Abi Peck

Are corticosteroid injections more beneficial than anaesthetic injections alone in the management of rotator cuff-related shoulder pain? A

systematic review [Download here](#)

1. Did the review address a clearly focused question?

Yes, are corticosteroid injections more beneficial than anaesthetic injections in the management of rotator cuff related conditions?

Population: people with rotator cuff pathologies that underwent an injection

Outcomes: pain, function and ROM

2. Did the authors look for the right type of papers?

Yes, the search and exclusion criterion was very specific and all studies were RCT.

3. Do you think all the important, relevant studies were included?

Yes, they reviewed a wide range of papers. Not limited by time or language.

4. Did the review's authors do enough to assess the quality of the included studies?

Risk of bias was assessed by 2 authors using the domain-based Cochrane tool for RCTs.

5. If the results of the review have been combined, was it reasonable to do so?

Yes, results were combined by time scale of effect for treatment (short, mid and long term).

6. What are the overall results of the review?

Short term effects of corticosteroid injections are thought to be better than anaesthetic injections.

Midterm effects show no difference between the two injections. There is limited evidence to show no difference between the two injections in the long term.

7. How precise are the results?

Confidence intervals were not used to discuss results of the RCTs. The results do demonstrate that some of the RCTs used had statistically significant results referring to the P values.

8. Can the results be applied to the local population?

Yes, a lot patients seen in clinical practice are considering injections for rotator cuff related conditions that fail to manage conservative measures.

9. Were all important outcomes considered?

Yes pain, function and ROM were used as outcomes, however could of assessed biological changes through MRI scans or ultrasound

10. Are the benefits worth the harms and costs?

Yes, the study was useful to determine whether the NHS could be saving money using anaesthetic injections over corticosteroid injections. No adverse effects were reported for patients receiving the injections.





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#NEWSOFTHEWEEK - by Liz Wright

1. Clinical outcomes of arthroscopic repair of acetabular labral tears

This prospective study involved patients who had a preoperative diagnosis of labral tears, a lateral centre edge greater than 25° and a labral tear believed to be suturable during the intraoperative evaluation. All patients were evaluated using the modified Harris Hip Score (mHHS) during the final appointment before surgery, 4 months after surgery and at the final evaluation. Results found in patients with a mean age of 44 years, arthroscopic labral repair was associated with a clinically significant improvement in self-reported hip pain and function (modified Harris Hip Score) at both short-term (4 months) and medium-term (43 months) follow-up. Clinically, it was explained that patients should expect to feel an improvement in self-reported hip function by 4 months post-operatively. However, there are certain research limitations evident. For example, all interviews were conducted by the senior surgeon and response bias to the surgeon was found in other studies. Finally, questionnaires such as the Non-Arthritic Hip Score and the Hip Outcome Score could have been employed to measure the outcomes, but only mHHS was used.

<http://bmjopensem.bmj.com/content/4/1/e000328>

2. Risk factors and the associated cut-off values for failure of corticosteroid injection in treatment of Morton's neuroma

Understanding the risk factors that predict the prognosis of Morton's neuroma after corticosteroid injection would help clinicians determine the appropriate treatment protocol. However, the cut-off values for the risk factors are unknown. Therefore this study aimed to identify the risk factors and cut-off values that predict failure of corticosteroid injection in treatment of Morton's neuroma. Injection was performed with ultrasound guidance following ultrasound confirmation of the diagnosis. Demographic information, size of the neuroma, and other comorbidities between the patients who did and did not undergo further treatment after injection were compared in order to determine the risk factors of failure. The optimal cut-off value for the size of the neuroma was 6.3 mm (sensitivity, 81%; specificity, 95%) for predicting the failure of corticosteroid injection. Age was not associated with a specific cut-off value. Conclusions: This study found that, with a cut-off value of 6.3 mm, larger Morton's neuromas were associated with failure of corticosteroid injection.

<https://koreauniv.pure.elsevier.com/en/publications/risk-factors-and-the-associated-cutoff-values-for-failure-of-cort>

3. Managing hamstring injury in track and field by Stuart Butler

England Athletics Physio and Medical Lead Stuart Butler has shared a blog in which he provides a great overview of hamstring injury management, based on his extensive experience and recent research. 5 key treatment principles are discussed: 'Long and strong'; load eccentrically; load early; load often and 'run faster and fastest (often)'. The best present evidence suggests that there should be an eccentric component (this appears to help maintain strength and fascicle length) with regular consistent exposure, that it should involve both exercises with a hip and knee bias, and involve a gradual progressive high speed running plan. Don't be frightened to load eccentrically early, use double leg exercises (i.e. long lever bridging) with eccentric action and a bias to uninjured leg just to get some eccentric stimulus to posterior chain. Remember hamstring injuries are complex and involve multiple factors many of which we don't fully understand and need to be reviewed on a case by case nature with no definite one size fits all rehabilitation program.

<http://www.running-physio.com/hsi/>





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#FRACTUREFRIDAY BY SCOTT ROWBOTHAM

Jones fracture

A Jones fracture is an extra-articular transverse fracture at the base of the fifth metatarsal.

Mechanism

The fracture is believed to occur as a result of significant adduction force to the forefoot with the ankle in plantar flexion

Imaging

A plain X-Ray is normally sufficient but a CT may be warranted due to the likely non-union or for differential diagnosis to rule out surgical management.

Jones fracture is located at the metadiaphyseal junction, approximately 2 cm (1.5-3 cm) from the tip of the 5th metatarsal

For differential diagnosis it is important to note that it should not extend distally or involve the articular surfaces.

Rehabilitation

In contrast to avulsion fractures, Jones fractures are unfortunately prone to non-union. Rates of non-union have been reported as high as 50%.



Displacement of the fracture is significantly increased with weight bearing therefore immobilisation is recommended in a non-weight bearing for 8 weeks.

Surgical management may be warranted via internal fixation and bone grafting in cases of non-union or if significant displacement is found.

It is important to note that it is expected for the initial healing process to take longer than the expected 8 weeks when considering weight bearing rehabilitation exercises.

<https://radiopaedia.org/articles/jones-fracture-1>

