



Clinical Weekly - 174th Edition

#JOURNALTUESDAY - by Abi Peck

Stem cell injections in knee osteoarthritis: a systematic review of the literature

[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. Should we consider cultural-religious factors in the management of CLBP?

This is the first study to provide a cross-cultural exploration of CLBP beliefs and experiences of English speaking Punjabi and white British people with CLBP. In the UK, HCPs encounter people from different cultures and ethnic backgrounds, with South Asian Indians (including Punjabis) forming the largest ethnic minority group. This qualitative study used semi structured interviews in a NHS physiotherapy department. Participants from both groups held negative biomechanical beliefs (e.g 'the spine is weak'). Specific findings to Punjabi participants included a) disruption to cultural-religious well-being, b) a perceived lack of understanding and empathy from the Punjabi community c) initially using passive coping strategies, though transitioning towards active coping mechanisms. These findings may help improve mx of CLBP. However a small sample size of only 10 participants and selected from only one geographical region, which may limit transferability of the findings.

<http://bit.ly/2EF0t2a>





Clinical Weekly - 174th Edition

#NEWSOFTHEWEEK - by Liz Wright

2. What happens to patients who are treated conservatively with full thickness rotator cuff tears? 5 year QOL index outcomes f/u.

Approximately 75% of patients remained successfully treated with non-operative treatment at 5 years and reported a mean QOL index score of 83/100. Those in the non-operative group who remained symptomatic who then underwent rotator cuff surgical repair surgery had a mean QOL index of 89/100. The operative and non-operative groups at 5 year f/u were not significantly different in the QOL index measure.

<http://bit.ly/2HwhtLx>

3. Strength Stretching – blog my Adam Meakins

-Reduce injury? Unless you are stretching for sports which involve EROM routinely (e.g. gymnastics or martial arts), stretching does not significantly improve performance or reduce risk of injury.

-Detrimental effects? Unlikely to be, for those who stretch routinely before an activity, positive psychological benefits/familiarity may produce positive expectations – no harm in this? For those with certain tendinopathies in the acute painful stage, stretching is not necessarily recommended.

-Long, lean muscles? The forces produced in the soft tissues during stretching are often too low and too short to create significant adaptive changes.

-External load? This is the easiest way to increase forces into a muscle/other soft tissue (e.g. resistance training). Heavy eccentric forces appear to signal the addition of sarcomeres.

-How heavy are the eccentrics? How much depends on the patient and their pain levels, but usually heavy enough so they cannot do the concentric phase of the movement. Usually 5-8 reps at the slowest pace possible, performing 3-5 sets. Soreness may last for a few days and this should be settled before beginning another session.

Which will it be for you static or strength-stretching or ideally both?

<http://bit.ly/2swLOpK>

#TWEETOFTHWEEK



Ben Cormack
@CorKinetic

Following

One of the best prognostic factors for LBP appears to be the level of self efficacy someone has.

How often do people come away from a therapist with a list of things NOT to do rather than things TO do.

This has to stop.

Foster independence not dependence.





Clinical Weekly - 174th Edition

#FRACTUREFRIDAY BY SCOTT ROWBOTHAM

Biceps Femoris Avulsion Fracture

An avulsion fracture that most commonly occurs where the long head attaches to the ischial tuberosity in the buttocks but can also occur at the attachment to the fibula.

Mechanism of injury

Normally occurs during a rapid or violent movement involving hip flexion and knee extension

Attachments

Origin - The long head arises from the ischial tuberosity
 - The short head arises from the linea aspera

Insertion - fibula head. Can blend with the lateral collateral ligament

Innervation - The short head of the biceps femoris is innervated by common fibular branch of the sciatic nerve

-The long head is innervated by the tibial branch of the sciatic nerve

Blood supply

The perforating branches of the profunda femoris artery, the inferior gluteal artery and the popliteal artery all supply the biceps femoris.

Imaging

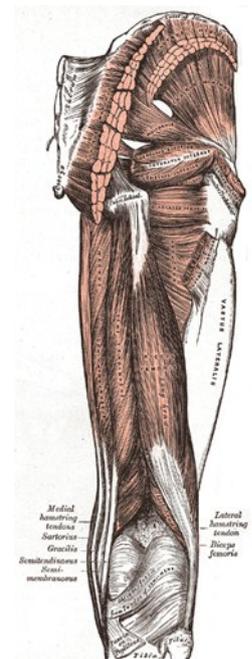
CT and MRI are more appropriate than plain X-ray to consider surrounding tissues particularly at knee

Clinical signs

Prominent swelling around the posterior aspect of the knee localised to the fibula head, pain and weakness on knee flexion.

Rehab

Depending on severity of the avulsion options are conservative management including progressive strengthening, immobilisation of the knee at a 90 degree angle (if distal avulsion) or surgical management.



<http://bit.ly/2CeKdcb>

<http://bit.ly/2sIDYcU>

