Clinical Weekly - 168th Edition

#JournalTuesday - by Abi Peck

Self-managed loaded exercise versus usual Physiotherapy treatment for rotator cuff tendinopathy: a pilot randomised controlled trial

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1. Did the trial address a clearly focussed issue?
2. Was the assignment of patients to treatments randomised?
3. Were all of the patients who entered the trial properly accounted for at its conclusion?
4. Were patients, health workers and study personnel 'blind' to treatment?
5. Were the groups similar at the start of the trial?
6. Aside from the experimental intervention, were the groups treated equally?
7. How large was the treatment effect?
8. How precise was the estimate of the treatment effect?
9. Can the results be applied in your context?
10. Were all the clinically important outcomes considered?
11. Are the benefits worth the harms and costs?

#NewsOfTheWeek - by Liz Wright

1. Karen Middleton explains as a society we must desperately change the narrative on back pain .

Some of you may be aware of the latest 'cure' for back-pain in the front pages at the start of December 2017. Amazingly scientists from Rome revealed findings of their new radiofrequency treatment that claimed to eliminate back pain in 10 minutes. WOW...Despite being one small study with no control group, media were quick to broadcast this nonsense. Too frequently we talk about the issue, focusing on a 'fix', concentrating on making a person 'feel better'. We have been 'conditioned' over time to believe our backs are fragile and pain=damage. An over-powering industry has arisen, providing endless 'snake oil' . The industry often plays on people's fears and desperation to seek that 'cure'. Daily in clinic we hear patients' describe their goal 'to fix my back' - this is all too common.

As physiotherapists we see people who avoid socialising, playing sport, spending time with their family, avoiding work, retiring early, overall losing their sense of self-worth, well-being and independence. This is a poor state of affairs, especially considering this is an entirely avoidable tragedy. Who is to blame? Media? Myths? Commercial world? Send me your thoughts: elizabeth.wright1@nhs.net

http://bit.ly/2oJlTJx

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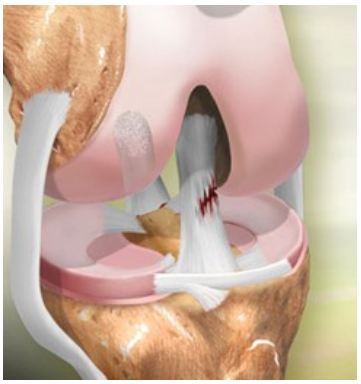
#NewsOfTheWeek - by Liz Wright

2. Exercise in the management of knee and hip OA

The review focuses on studies published between July 2001 and August 2017 which concentrate on the influence of exercise as an intervention for hip and knee OA patients. Current literature appears more focused on the knee than the hip joint. Both traditional (strength, aerobic, flexibility) and more non-traditional (yoga, Tai Chi, aquatic-based) training modes improve patient outcomes (joint symptoms, mobility, QOL, psychological health, MSK properties, body composition, fatigue and sleep). Adequately dosed and progressive exercise demonstrated greatest improvements in outcomes. Future research needs to focus on factors influencing patient non-adherence for exercise management of OA to aid the lessening of the lifelong burden of OA.
http://bit.ly/2kQxcL1

3. Mick Hughes: Return to sport 'cut-offs' after ACL reconstruction in young athletes

Two recent articles – Grindem et al (2016) and Krytsis et al (2016), both showed a reduction of ACL re-injury risk in elite adult athletes who waited a minimum of 9 months, passed a battery of strength and functional tests prior to being cleared for RTS. This current blog explores some concerning trends in the literature which suggest a longer wait before the RTS in the athlete aged > 20. Tim Hewett and Kate Webster at the SMA conference this year, highlighted findings that 30% of young people (mean age 17) who RTS post ACL reconstruction will sustain at ACL injury within the 2 years (females were 5 x more likely to do so). Research suggests it can take up to 2 years full maturation of the graft, restoration of proprioception, neuromuscular control and knee strength.



Key points to consider for your ACL patients:
-Up to 30% aged <20 sustain a 2nd ACL injury within 2 years upon RTS.
-Surgery only restores mechanical/anatomical stability of the knee. Functional deficits of the knee are not addressed – i.e. dynamic knee valgus, poor trunk control, abnormal quad to hamstring ratio.
-Better quality rehab (regular jump, landing & agility training), will encourage better post-op functional outcomes and reduce chances of re-injury on RTS.
-Decision for RTS should be based on orthopaedic opinion, time (at least 9 months) and a battery of strength and functional tests (quads, hamstrings, hop tests, agility tests, achievement of at least 90% symmetry between limbs on all tests).
-Rehab drills performed unilaterally due to high rates of contra-lateral injuries.
-For non-professional athletes a supervised training plan for at least 12 months is needed prior to RTS.
-For the remaining of their sporting carer, athletes should continue at least 2x per week ACL injury prevention drills.

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#FractureFriday by Joe Russell

Femoral shaft fractures

Anatomy & Epidemiology

The femur is the longest and strongest bone in the body. It has an anterior bow with a supporting strut (linea aspera) on the posterior surface which is common muscular attachment. The femoral shaft can be fractured in low energy trauma in osteoporotic patients, in high energy trauma at any age and as a result of malignancy of the bone. The musculature surrounding and attaching to the femur acts as a deforming force following fracture meaning that fixation is typically required.

Winquist and Hansen Classification of femoral shaft fractures

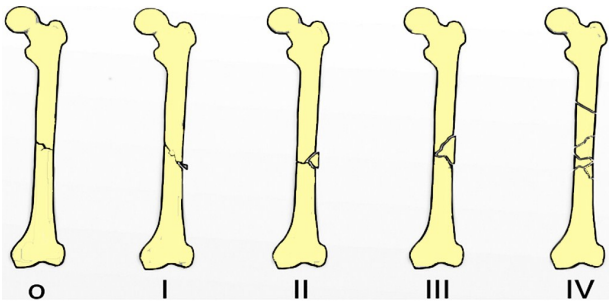
Type 0:
No comminution or a small butterfly fragment less than 25 % of the bone.

Type I:
Small butterfly fragment less than 25 % of the bone.

Type II:
Butterfly fragment 50 % or less of the width of the bone

Type III:
Comminuted with a large butterfly fragment greater than 50 % of the width

Type IV:
Severe comminution of an entire segment of bone (segmental comminution)



Winquist Classification of Femoral Shaft Fractures.

Treatment

Normally fixation is required. This can take many forms depending on patient characteristics and concomitant injuries. IM nailing or plated ORIF is common. External fixation can be used if very fragmented or there is multiple trauma.

References:
http://bit.ly/2BRPN1k
http://bit.ly/2kHybho