

#JOURNALTUESDAY - by Abi Peck

High-load strength training improves outcome in patients with plantar fasciitis: A randomized controlled trial with 12-month follow-up. Rathleff et al. Scand J Med Sci Sports 2014

[Download Here](#)

- 1) What is plantar fasciitis?
 - Damage/ inflammation and/or thickening to plantar fascia (tough fibrous band) on the sole of the foot.

- 2) What are the common types of advice given for treatment?
 - Avoid aggs/ overloading area
 - Ice bottle
 - Stretches (calf, sole of foot)
 - Exercises (heel raises with towel under toes)
 - Insoles/ Tuli heel cups or fitted shoes.

- 3) When would be the best time to load the plantar fascia?
 - Dysrepair / degenerative stages – similar to that of tendons
 - Reactive PF may not respond well to being overloaded.

- 4) What does the article suggest is the best treatment for plantar fasciitis?
 - Loading PF by doing heel raises with big toes over a towel – increase load by increasing weight in backpack.

- 5) What condition/ risks can predispose someone to developing plantar fasciitis?
 - Active (running, reduce recovery periods, overloading)
 - Sedentary lifestyle / overweight
 - Occupation (lots of walking/ standing)
 - Inflammatory conditions e.g. RA.

#CLINICALSKILLSFRIDAY by Jess Miller- Schöbers test

Schöbers test is used to measure the ability of a patient to flex the lower back. It is commonly used in conditions such as ankylosing spondylitis.

There are a few different methods that have been reported:

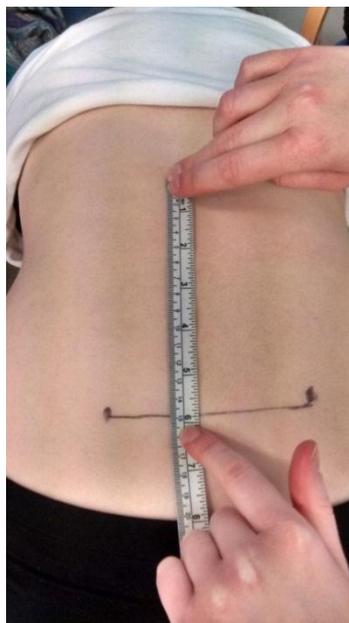
Original Schöber Test

-Patient stands facing away from clinician

- Clinician marks one horizontal line at the lumbosacral junction and another 10cm above the first line
- The difference between the distances in an upright position compared to a flexed position are recorded

Modified Schöber Test

- Patient stands facing away from clinician
- The lumbosacral junction is identified using the PSIS and a horizontal line is drawn between them. Two further lines are drawn 10cm above and 5cm below the first line and the differences in distance between the superior and inferior lines is measured in upright and flexed positions



Less than 5cm increase in distance in both tests is considered as a positive test to show restricted range of movement.

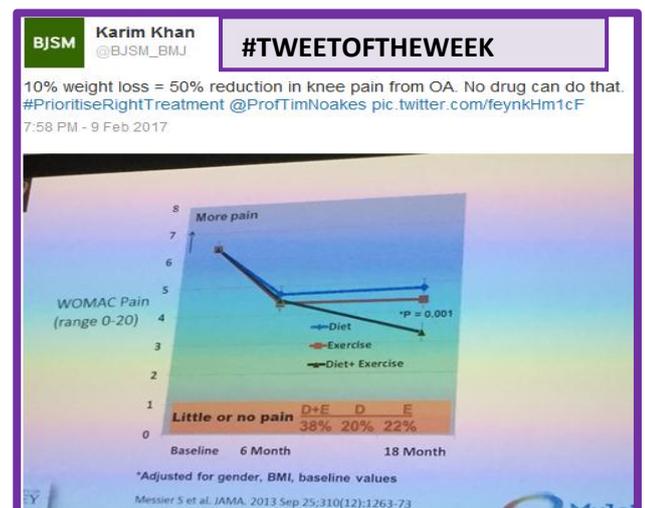
For the next **#CLINICALSKILLSFRIDAY**- Pittsburgh Decision Rules

Any pictures, suggestions or comments to Jessica.z.miller@ahpsuffolk-cic.nhs.uk

#NEWSOFTHEWEEK by Liz Wright

1. Imaging and tendinopathy

Infographic to summarise 8 reasons when imaging would/would not be indicated. As pain and pathology are poorly correlated, imaging is not recommended to confirm tendon pain. Doppler signal and neurovascular ingrowth are unlikely to be



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key factors in tendon pain. Imaging can be useful in confirming a differential diagnosis that is suspected clinically. Ultrasound tissue characterization has been put forward as a modality to identify early and subtle tendon pathology changes, appearing to play a role in the identification of plantaris involvement in Achilles tendinopathy.

<http://www.tendinopathyrehab.com/blog/tendinopathy-updates/how-useful-is-imaging-in-tendinopathy-infographic>

2. Running retraining infographic

For those of you who have been on Tom Goom's running repairs course, you will have no doubt found it useful to your clinical practice. Recently the course has also been run in Australia and consequently there has been an influx of resources via clinical edge including this useful infographic.

<https://tinyurl.com/gsygm4w>

3-

4. Is ice useful for acute injuries?

Does ice application reduce swelling? The main effect of ice is to decrease nerve conduction velocity, reducing pain from surface tissues, allowing patients to perform exercises= secondary effect of reducing swelling.

Recommendations for RUNNING RETRAINING
Based on Physio Edge podcast 049 with Dr Rich Willy

- Cadence**
Average running cadence is 165-185, with a lot of variation.
- If you are aiming to increase cadence, have a target 7.5% higher than their current cadence.
- In runners that have high impact forces (sound loud when they are running), increasing cadence by 7.5% decreases impact forces by 18-20%.
- Give your runner a target, and allow them to develop their own strategies to increase cadence.
- If a runner has a higher baseline cadence of 192 or above, don't attempt to increase cadence.
- Crossover gait and high torsional loads may contribute to PFJ & tibial stress fractures.
- Cue a wider running base of support, or run on a track straddling 2 lanes.
- Increased cadence by 5-10% decreases PFJ loads 15-20% by reducing knee flexion, vertical oscillation and step length.
- ITB Syndrome related factors include increased hip adduction and crossover gait.
- Widen stance or increase cadence to reduce crossover gait and hip adduction.

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What is the best way to apply ice? A tissue temperature of 10 degrees is desirable. Crushed ice will achieve this goal within 5 minutes; other types of icing e.g. frozen peas do not get the skin temperature < 13 degrees.

How long should ice be applied? Using crushed ice, the skin temperature can be reduced to the goal temperature within 5 minutes- this is enough. The depth of the injured tissue and the amount of body fat are also factors in the length of time that ice is applied.

Should we use towels with ice application? Given contraindications and precautions are noted (see link below), if crushed ice (within a plastic bag) is applied directly to the skin, it is not comfortable, but very effective. If it is applied over bandages, icing is ineffective.

<https://tinyurl.com/ze8puny>

#MEDOFTHEWEEK – by Alex Courtney-Hatcher

Disease Modifying Anti-Rheumatic Drugs (DMARDs)

- Action –
 - Can affect the progression of rheumatoid arthritis and psoriatic arthritis but require 2-6/12 of treatment for full therapeutic dose
 - Exact mechanism of action unknown, believed to affect cellular production of cytokines thereby inhibiting cell mediated immunity
 - Better efficacy than NSAIDs, which are only used for symptom control
 - Early initiation of DMARDs is recommended to limit irreversible joint damage
- Conventional DMARDs –
 - Include: methotrexate, azathioprine, gold injection, hydroxychloroquine, leflunomide, sulfasalazine
 - Multiple DMARDs (usually methotrexate and 1 other) and a corticosteroid should be given in newly diagnosed cases of active RA
 - In established and stable RA, dose should be reduced to lowest clinically effective level
- Cautions –
 - Greater risk of infection due to effect on immune system – care needed in food preparation and contact with people with active infections should be avoided
 - Regular liver function tests are advised due to (low) risk of toxicity
- Side-effects –
 - Rash
 - Nausea
 - Headache
 - Dizziness

<https://www.evidence.nhs.uk/formulary/bnf/current/10-musculoskeletal-and-joint-diseases/101-drugs-used-in-rheumatic-diseases-and-gout/1013-drugs-that-suppress-the-rheumatic-disease-process>

Disclaimer: This edit is for information/education use only and does not entitle people to advise patients on medication.