



Clinical Weekly - 142nd Edition

#JOURNALTUESDAY - by Abi Peck

Physical examination tests for hip dysfunction and injury

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1. How would you differentiate these conditions mentioned with subjective questioning?
2. What are the tests recommended for each of these conditions and how do you perform them?
Please practise with colleagues.
3. How useful are these tests in terms of specificity and sensitivity? What does this mean?
4. What childhood conditions should you be aware of when assessing a hip joint?
5. What were the conclusive findings of this paper?

#CLINICALSKILLSFRIDAY - by Josh Featherstone

Cranial nerve 5 – Trigeminal nerve.

General anatomy and function

The trigeminal nerve has a variety of both motor and sensory functions and both the sensory and motor nerve roots originate at the pons.

It provides sensory innervation for both pain, pressure, temperature and touch to both the face and mucous membranes of the mouth and nasal cavities.

It enables motor function of the muscle that enable you to chew!

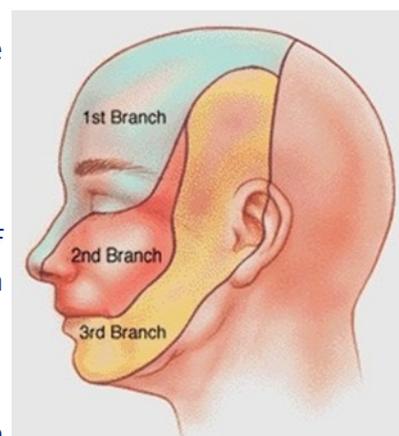
There are three regions of the face in which the trigeminal nerve innervates.

Ophthalmic region – 1st branch

Maxillary region – 2nd branch

Mandibular region – 3rd branch

The mandibular region does not innervate the corner of the jaw. If symptoms exceed over that region then this means that it is not entirely a trigeminal nerve problem as can be seen by the picture below.



Diseases of the trigeminal nerve

Trigeminal nerve neuralgia – Causes of the condition are mostly unknown however its postulated that up to 95% of cases occur due to compression of the trigeminal nerve at the brainstem.

This maybe due to an artery or vein compressing the nerve however, It's not clear why this pressure can cause painful attacks in some people but not others, as not everyone with a compressed trigeminal nerve will experience pain.





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#CLINICALSKILLSFRIDAY - by Josh Featherstone

Diseases of the trigeminal nerve

- A tumour
- A cyst
- Arteriovenous malformation – an abnormal tangle of arteries and veins
- Multiple sclerosis– a long-term condition that affects the nervous system

Trigeminal nerve testing for therapists

Terminal branches around the face can be palpated to provide an indication of the sensitivity of the trigeminal nerve however, bear in mind that a central nervous system lesion may affect all three zones as mentioned above.

1st branch – emerge at the supraorbital foramen (situated at the eyebrows)

2nd branch - infraorbital foramen (situated either side of your nose, approximately a finger width in distance, where your maxillary nasal sinuses are).

3rd branch – terminal branches around the mandibular can be palpated

Although difficult, quick tests of mastication can also enable further information for the clinician to ascertain whether the trigeminal nerve is being influenced amongst the patient's symptoms. It can be applied by asking the patient to bite whilst palpating the masseter and temporalis muscles. (No information regarding positive tests was eluded however, I can only assume that pain on action or discomfort/pain on palpation would mean a positive test result).

Testing the sensory supply. With the patients eyes closed, apply light touch to areas of the face that are innervated by the nerve. This may help detect differences in sensation if a trigeminal nerve problems is suspected.

On next weeks #ClinicalSkillsFriday we will be looking at:

- Anatomy and function of cranial nerve 6
- Diseases of cranial nerve 6
- Nerve testing for therapists for cranial nerve 6

References:

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#NEWSOFTHEWEEK - by Liz Wright

1. #BESS2017 21st – 23rd June annual meeting – Coventry

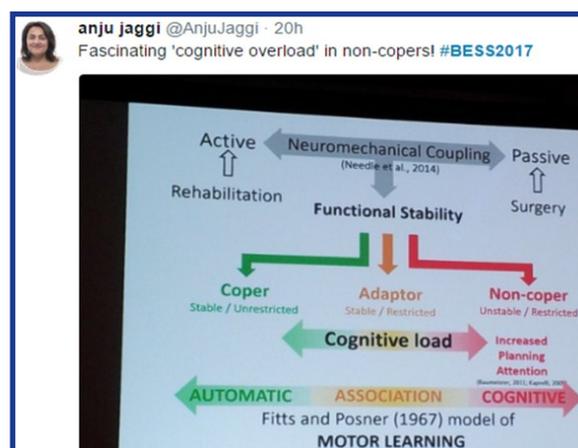
A snap-shot of key points. Search #BESS2017 for many more.

The Sports Physio @AdamMeakins · 20h
Be careful using generic reassurance with those in high risk groups of depression, distress, anxiety #BESS2017

In summary

- Consultation-based reassurance is measurable, and appears to be important.
- Generic reassurance might be risky (with those with psychological risk factors).
- The best reassurance (from the patients' point of view) are CLEAR explanations about their pain and their options for managing it.

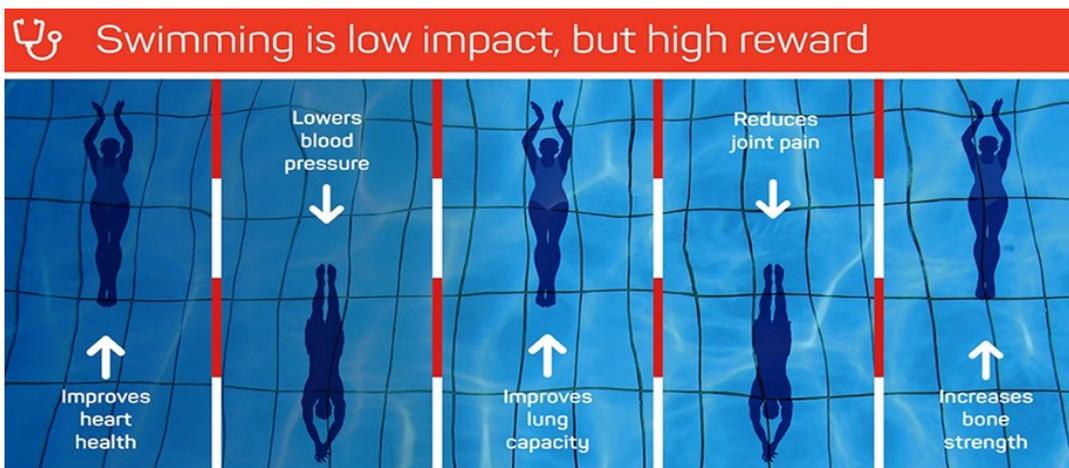
Jo Gibson @ShoulderGeek1 · 22h
@bess_org #bess2017 @EUSSEBOARD @PhysioChris time to self reflect - are clinicians the most fear avoidant 🙄



Top tip: BESS website has patient pathways for Ax and Mx of frozen shoulder, glenohumeral joint OA, Subacromial shoulder pain and traumatic shoulder instability. These pathways have been developed by BESS members who are leading treatment and research in their expert areas. There are several more due to be released, which will also be published in the BESS journal, Elbow and shoulder. <http://www.bess.org.uk/index.php/health-professionals/patient-care-pathways>

2. Benefits of swimming further revealed

Great East Swim took place Saturday 17th June – novices (myself included!) and experienced open water swimmers took to Alton Water to complete varying distances. A new study that shows the health and wellbeing benefits of swimming has been launched on 21st June 2017 by Swim England. The report shows the unique benefits of water make it the ideal place for people of all ages to exercise, particularly those with long term health conditions. The report also found evidence that swimmers live longer and children who take part in swimming lessons regularly develop physical, cognitive and social skills quicker than those who do not. Swim England commissioned the independent report and aim to use the findings to raise awareness within the health professions that swimming is a safe, viable and potentially cost-effective option to signpost patients. Who's for the Great East Swim 2018? <http://bit.ly/2rFixUS>



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#FRACTUREOFTHEWEEK BY SAM ACKERLEY

Shoulder dislocation

Most commonly dislocated joint involving the humeral head moving out of the glenoid fossa, usually occurs anteriorly.

Symptoms

Usually significant pain felt along the arm past the shoulder. Inability to move the arm from its current position, particularly in positions with the arm reaching away from the body and with the top of the arm twisted toward the back.

No palpable bone on the side of the shoulder.

Visibly displaced shoulder. Some dislocations result in the shoulder appearing unusually square.

Mechanism of injury

Nearly almost always traumatic and 95% of dislocations are anterior.



Population

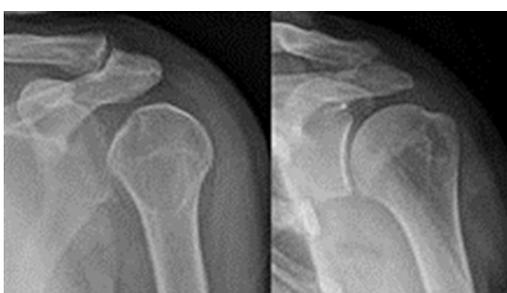
Bimodal age and sex distribution

Male : female 9:1 in younger population (20-30 years)

Anterior



Posterior



Lightbulb sign indicative of posterior shoulder dislocation shown on the left. On the right, the same shoulder after reduction.

Posterior dislocations are occasionally due to the muscle contraction from electric shock or seizure and may be caused by strength imbalance of the rotator cuff muscles. Patients typically present holding their arm internally

rotated and adducted, and exhibiting flattening of the anterior shoulder with a prominent coracoid process.

Inferior



(An inferior dislocation of the shoulder after an automobile accident. The humerus is abducted. Also present is a fracture of the greater tuberosity).

Inferior dislocation is the least likely, occurring in less than 1%. This condition is also called "luxatio erecta" because the arm appears to be permanently held upward or behind the head. It is caused by a hyper abduction of the arm that forces the humeral head against the acromion. Such injuries have a high complication rate as many vascular, neurological, tendon, and ligament injuries are likely to occur from this mechanism of injury.

Rehab/ Treatment

Reduction is where the dislocated humerus bone is put back into the joint

Following a reduction you will usually be advised to rest and immobilize the shoulder in a sling for 5-7 days, longer if there are fractures or severe soft tissue damage.

References

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<https://tinyurl.com/y7hrvajg>

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