Clinical Weekly - 156th Edition

#JournalTuesday - by Abi Peck

Isometric exercise induces analgesia and reduces inhibition in patella tendinopathy

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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. One in 12 deaths could be prevented with 30 minutes of exercise five days a week

People who exercise 5 a week for 30 minutes significantly reduce their risk of dying early and of developing heart disease, according to a new international study, published in the Lancet medical journal. Tracking 130,000 people in 17 countries, both rich and poor, the study found that whether it's going to the gym, walking to work, or household chores, being physically active extends life and reduces illness. The researchers, led by Scott Lear, a heart specialist at St Paul's Hospital in Canada, also found a so-called dose response: The more people exercise, the greater the reductions are in their risks of getting heart disease or dying early. The study found "no ceiling effect", the researchers said, and "no risks associated with extremely high levels of physical activity," defined as more than 2,500 minutes, or more than 41 hours, per week.
http://bit.ly/2wRHmUt

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#NewsOfTheWeek - by Liz Wright

2. Pain education: what might make it more effective?

Ben Cormack presents this blog which sympathises with the difficulty of implementing pain education, offering practical tips in improving delivery.

Listening: pain education should start with this, the desire to be listened to appears to be valued from a patient perspective, helping build therapeutic alliance.

Validation: If symptoms cannot be 'medically' explained or solved by traditional interventions, then patients may feel that they are being seen to 'make it up' their experience. All pain is real and although it can often be hard to describe it is also exactly the way that someone says it is. It cannot be anything else.

Individualisation: By weaving it into their story and using their painful examples to tie in some of the key concepts, is this more likely to get some elements of comprehension? Without listening we cannot place the information in the context of the patients narrative.

Asking: "Do you want to know more about pain?"

It is not a passive exchange: It is not simply a teacher pupil relationship. Patients lived experiences are also important.

Pain science is not an intervention it is a way of thinking: The concepts and ideas should affect the way we reason, interact, explain and apply the treatment provided.

Experiences are as powerful as talking without the actual doing we cannot 'prove' the point. Beliefs about the body are a good example of this. Without seeing or feeling a positive outcome to that expected, a belief may remain in place.

Find out how your education has been interpreted: Simply ask.

Reflective questioning: E.g. someone has a negative belief regarding their back because of a 'slipped disk' a number of years ago. We could suggest that structure and symptoms don't always display a consistent relationship, and follow up by asking if their symptoms come and go (as long term back pain generally does) and would this be a sole cause if the 'slipped' disc remained a constant.

http://bit.ly/2yD7Wh3

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#NewsOfTheWeek - by Liz Wright

3. Effects of anti-inflammatory (NSAID) treatment on human tendinopathic tissue

Little is known regarding effects of NSAIDs on human tendinopathic tendon. This study investigated effects of ibuprofen on human tendinopathic tendon. Gene expression was the primary outcome, and tendon pain, function and blood flow were secondary outcomes. 26 adults diagnosed with chronic Achilles tendinopathy were randomized to one-week treatment with ibuprofen (600mgx3/day) or placebo (double-blinded). There was no indication that short-term ibuprofen treatment affects gene expression in human chronic tendinopathic tendon or leads to any clear changes in tendon pain or function. http://bit.ly/2xxufVm

#FractureFriday by Joe Russell

Carpal bone fractures– Capitate

Anatomy
The capitate sits in the centre of the distal row of the carpal bones of the wrist, of which it is the largest. It's larger size is to support the strength and stress placed on the middle fingers of the hand.

Epidemiology
Capitate fractures account for around only 2% of all wrist fractures. They often occur in conjunction with a scaphoid fracture. Normally caused by a fall onto an outstretched hand, patients often report pain on the dorsal aspect of the wrist which is exacerbated on movement.

Management
The majority of capitate fractures will be managed conservatively. The capitate also suffers a tenuous blood supply so care should be taken to ensure union is occurring.

Resources
http://www.physioroom.com/injuries/hand_and_wrist/broken_wrist_full.php
http://wikem.org/wiki/Capitate_fracture