



Clinical Weekly - 161st Edition

#JOURNALTUESDAY - by Abi Peck

High load strength training improves outcome in patients with plantar fasciitis: A randomised controlled trial with 12-month follow up [Download here](#)

1. Did the trial address a clearly focussed issue?

Yes

-Method: stretch vs high load

-Outcomes: Foot function index + plantar fascia thickness with ultrasound + foot pain first steps in the morning

-48 patients

2. Was the assignment of patients to treatments randomised?

Yes. Block randomised = computer generalised system

3. Were all of the patients who entered the trial properly accounted for at its conclusion?

No

-24 patients in each group were analysed

-Table showing dropout rate – no explanation given as to why

4. Were patients, health workers and study personnel 'blind' to treatment?

No blinding was used

5. Were the groups similar at the start of the trial?

Group similarities – age and gender

6. Aside from the experimental intervention, were the groups treated equally?

Yes

-Same follow up period

-Same information given – leaflet

-Heel inserts given to both groups

-Same procedure – other than high loading or stretching interventions

Stretching x10, x10 secs, x3 a day / High load started 12x3, every 2 days for 3 months – 8x5, after 4 weeks

7. How large was the treatment effect?

Treatment effect: significant difference in stretch to high load at 3 months. High load reduced by 29 points on the foot function index score.

8. How precise was the estimate of the treatment effect?

P=0.016 – 95% confident

9. Can the results be applied in your context?

Yes

10. Were all the clinically important outcomes considered?

Yes

-They looked at pain and function

-Could have looked at compliance of exercises + strength

11. Are the benefits worth the harms and costs?

Yes- Cheap

Drop out rate? – injuries?





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#NEWSOFTHEWEEK - by Liz Wright

1. Can gait re-training reduce risk of running injury?

The emerging research is promising and highlights that gait re-training may have a role in modifying tissue load, reducing injury risk and improving performance but we need to recognise that further research is required in each of these fields. Specifically, studies demonstrating long term improvement in pain or performance following gait re-training interventions are needed. Follow the link to gain a useful video summary of current research produced by Tom Goom on this topic.

<http://bit.ly/2lCvTD5>

2. Making sense of fear in people with low back pain

Useful blog from pain-ed.com; Dr. Samantha Bunzli outlines the difficulty dealing with patients' fear in clinical practice. The fear avoidance model has been proposed to help us understand how interpreting the LBP experience as threatening can lead to pain-related fear and kinesiophobia. However, approximately 50 % of people seeking care for LBP will present with high fear and associated avoidance behaviours; suggesting that rather than being a 'phobic' response, it may be more useful to think of fear avoidance as a normal, culturally endorsed response to a threatening pain experience. In a recent publication in JOSPT, a 'common sense' perspective of fear avoidance is proposed, explaining how when we experience a symptom of pain in the back, we attempt to make sense of it. We ask ourselves: what is this pain? (Identity beliefs); what caused this pain? (Causal beliefs); what might be the consequences of this pain? How can I control this pain? How long will this pain last? This 'representation' will then influence what we do about the pain. Fear avoidance behaviour can be considered a common-sense problem solving response to avoid a pain experience. As long as the outcome of avoidance is expected (i.e. no increase in pain) then the representation is perceived to be useful and avoidance behaviour will be maintained. If avoidance is maintained long-term it can interfere with social and occupational roles; eventually driving people to seek help from a healthcare professional with expectations of a linear pathway from diagnosis of an underlying pathology, to treatment, removal of the abnormality, to a cure and return to 'normal'. However, this expectation is rarely fulfilled, leaving patients with an experience that doesn't make sense to them. For us as health professionals, the implications of a common sense perspective is that we may reduce fear and avoidance by helping patients to make sense of their pain. Consider the common sense approach to sense-making. The approach involves:

Behavioural experimentation is considered essential so patients can disconfirm beliefs about the negative consequences of performing movements associated with threat or pain.

Guiding patients through the provision of new information (e.g. 'sensitisation' of the spinal structures are linked to factors such as poor sleep, stress, protective guarding and movement avoidance that in turn cause more pain and strategies to address these factors such as relaxation and engaging in movement will facilitate a return to valued activities)

Encouraging patients to share their beliefs about their LBP along the 5 belief dimensions comprising the representation





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Once patients have an explanation that helps them make sense of their LBP, combined with strategies to effectively control pain and enable a return to valued activities, the threat of LBP is reduced, facilitating fear reduction.

#FRACTUREFRIDAY BY JOE RUSSELL

Carpal bone Fracture - 5th Metacarpal Fractures

Anatomy

The 5th metacarpal joins the ulnar aspect of the carpals to the phalanges of the little finger.

Boxer Fracture

Boxer fractures are minimally comminuted, transverse fractures of the 5th metacarpal and are the most common type of metacarpal fracture. They typically occur (as the name suggests) when punching and are a common sight in all emergency departments on Friday nights.

Reverse Bennett Fracture

A reverse Bennett fracture-dislocation is a fracture-dislocation of the base of the 5th metacarpal bone. It is pathologically and radiographically analogous to the Bennett's fracture of the thumb. It is quite unstable due to unopposed extensor carpi ulnaris force on the fracture fragment, which causes migration and subluxation of the fragment.

This will need K-Wire fixation due to its instability

<https://radiopaedia.org/articles/reverse-bennett-fracture-dislocation-2>



MOVEMBER

It's that time of year again!

Please support our physios Matt, Pete and Joe in their quest for beautiful 'taches and raising awareness for men's health!

<https://uk.movember.com/team/2245549>

