



# Clinical Weekly - 162<sup>nd</sup> Edition

#JOURNALTUESDAY - by Abi Peck

Heavy slow resistance versus eccentric training as treatment for Achilles tendinopathy: A randomised controlled trial [Download here](#)

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. New treatment for knee OA wins NICE approval

The treatment - Autologous Chondrocyte Implantation (ACI). It is used to help patients with an articular cartilage defect/early OA in the knee –tending to affect people in their 20s and 30s, often as result of a sporting injury. However, NICE guidance stresses that surgery should only be considered once non-invasive approaches such as exercise, weight loss, physiotherapy, analgesia and corticosteroid injections have been exhausted. Evidence from the trials suggests that ACI is likely to be more successful in people who haven't had any previous knee repair surgery and who have very little damage to the knee. The ACI technique involves removing a small amount of cartilage from the knee, using it to grow cells in a laboratory and then replanting these cells back in the patient's knee, at an estimated cost of £16,000. At the moment only one hospital in the UK – the Robert Jones and Agnes Hunt Orthopaedic Hospital in Oswestry, offers the treatment, though the treatment is predicted to be offered at more hospitals. <https://www.nice.org.uk/guidance/TA477> and <http://bit.ly/2znRLY5>

## 2. New GPs guideline recommends physio over opioids for acute musculoskeletal pain

A new guideline released by the RACGP (Royal Australian College of General Practitioners) identifies the growing community concern over opioid misuse and addiction. A key recommendation is that GPs refer patients to physiotherapy early for acute msk pain. One of its recommendations to GPs is to engage a physio early in more severe acute musculoskeletal injuries, as well as look at multidisciplinary care options for their patients suffering chronic pain. Lorimer Moseley, who is Professor of Clinical Neurosciences and Chair in Physiotherapy at the University of South Australia, was involved in the guideline review process; explaining, "physiotherapists are critical in delivering evidence-based care is accepted and not surprising; modern physiotherapists are field leaders in their understanding of contemporary pain science. They have an ideal skill set to facilitate recovery and to prevent chronic pain." See the second link below for the summary of the 'the 12 point challenge to GPs' on reducing opioid prescribing in General Practice. <http://bit.ly/2hKZrtI> <http://bit.ly/2hgl8Ub>





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## #NEWSOFTHEWEEK - by Liz Wright

### 3. Physiotherapy and physical activity (PA): a cross-sectional survey exploring physical activity promotion, knowledge of physical activity guidelines and the physical activity habits of UK physiotherapists

Positive findings were identified that most respondents integrate discussions about PA into most of their patient contacts. Further investigation is needed relating to the lack of formal assessment of PA status, relatively poor knowledge of the PA guidelines and a lack of consistent signposting to further PA services/resources. Physiotherapists are ideally placed to contribute to the global efforts to reduce physical inactivity. Although 60% of physiotherapists knew that 150 min of moderate PA per week is recommended, only 16% of physiotherapists successfully answered all three questions relating to the PA guidelines (150 minutes of moderate PA, 75 minutes of vigorous PA, 2 strength sessions per week). Moreover, only 38% of physiotherapists themselves were meeting the PA recommendation of 5 x 30 mins of PA sessions per week. <http://bit.ly/2zIzWZo>

## #FRACTUREFRIDAY BY JOE RUSSELL

### Carpal bone Fracture - Phalanges Fractures

#### **Anatomy**

The phalanges of the hands are the tubular bones of the fingers and thumb. The second to fifth fingers each contain a proximal, middle and distal phalanx whereas the thumb only contains a proximal and distal phalanx. There are multiple joints in the phalanges: MCPJ, PIP, DIP.

#### **Phalanx Fracture**

Phalanx fractures are common injuries, although less common than metacarpal fractures. They have different prognosis and treatment depending on the location of the fracture. Phalanx fractures can be intra- or extra-articular and can occur at the base, neck, shaft or head of the phalanx. They often result from direct trauma to the finger (e.g. during ball sports). Crush injuries to the distal phalanx are also common, and can result in nail trauma and open fractures.



Most phalanx fractures will be managed conservatively where possible, some displaced fractures will need K-wire fixation. Open fractures will need urgent evaluation to ensure function of the digit is maintained and commonly will also need tetanus and antibiotic treatment.

<https://radiopaedia.org/articles/phalanx-fracture>





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## Jersey Finger

Jersey finger (also called Rugby finger or Sweater finger) describes a type of injury where there is avulsion of the flexor digitorum profundus (FDP) at the base of the distal interphalangeal joint (DIP).

Most commonly affects the 4th digit as the FDP insertion into the ring finger is anatomically weaker than the middle finger.

It classically occurs during certain sports resulting from sudden hyperextension of actively flexed finger (e.g., grabbing opponent's jersey during rugby or American football.)

If only partially avulsed this can be managed conservatively, however total avulsions will normally require surgical repair.

<https://radiopaedia.org/articles/jersey-finger>



## Mallet Finger

Mallet finger describes a type of injury where there is disruption of the extensor mechanism of the finger at the distal interphalangeal joint (DIP). It is the most prevalent finger tendon injury in sport. The term includes both bony avulsion injury and tendinous injury without avulsion.

The injury classically occurs in sports where the DIP undergoes sudden flexion (extended finger is struck at the tip by an object, e.g. baseball or basketball) or a crush injury (slamming a door towards the distal interphalangeal joint) in the extensor direction.

Normally this is managed conservatively with splinting in hyperextension.

<https://radiopaedia.org/articles/mallet-finger>

