Clinical Weekly - 165th Edition

#JournalTuesday - by Abi Peck

Sham surgery versus labral repair or biceps tenodesis for type 2 SLAP lesions of the shoulder: a three-armed randomised clinical trial. Download here

1. Did the trial address a clearly focussed issue?

-Yes, is there a difference between Sham surgery vs labral repair or bicep tenodesis for type 2 SLAP lesions.

-39, 39, 40 people in each group. Strict inclusion/exclusion criteria.

-6 + 24 months: Rowe score (3 point question for function, stability and motion) + WOSI (21 point score for pain, psychology and function etc.)

2. Was the assignment of patients to treatments randomised?

Yes, sealed opaque envelopes were used by an independent statistician to allocate patients to intervention groups.

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

Yes, excluded due to criteria or drop out by 4 people – not explained why patients dropped out.

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

Patients, treating physiotherapists and people collecting/ analysing data were all blinded. The author was the only one not blinded, but was not involved in the collecting of information.

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

Yes, strict inclusion and exclusion criteria. All patients were similar at the start of experiment. Age ranges 18-64 – good ability to generalise.

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

Yes, same follow up procedure. Same time in theatre. Same introduction, consent gained and exercises given post op.

7. How large was the treatment effect?

Significant improvement from baseline to 6 and 24 months following all three treatment interventions. No difference between groups.

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

P=0.76 biceps vs labral repair

P=0.64 biceps vs sham

P=0.86 labral vs sham

No significant differences between groups. Significant improvement in all groups for both outcome measures: Rowe <0.001 + WOS1 P<0.002

9. Can the results be applied in your context?

Yes for patients with SLAP type 2 lesions.

10. Were all the clinically important outcomes considered?

Yes but all measures were subjective. Could have looked at objective measures i.e. strength and ROM.

11. Are the benefits worth the harms and costs?

-Benefits – shows that people without surgery improved just the same as people with surgery. Cut future costs of surgery?

-Harms – No adverse risks with study: 10 patients had post-operative stiffness (adhesive capsulitis) – 5 labral repair,4 biceps repair + 1 sham surgery

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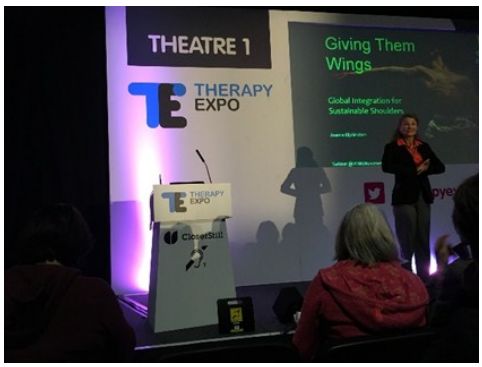
Therapy Expo 2017– Abi, Jess and Liz

Feedback from Liz Wright

Infrapatellar fat pad 'the good, the bad and the ugly'

Excellent presentation by Sanjay Anand, a consultant knee surgeon, on the extent of fat pad involvement in knee pain. The fat pad is an incredibly specialised soft tissue structure, highly innervated (often considered the most sensitive structures within the knee), richly vascular and vital in load distribution, especially in the flexed knee, helping to reduce the load in the knee and patella femoral joint. The anterior interval refers to the angle from the tibia to the line of the patella – the fat pad sits within this anterior interval. When the knee is extended the angle is larger. When the knee is flexed the angle is smaller. The fat pad is prone to contracture in many scenarios, such as post TKR, post surgery scarring and chronic fixed flexion deformity. In these circumstances early physiotherapy and patella mobilisations to encourage gliding are vital to prevent worsening fat pad contracture, which is often resistant to conservative treatment.

'Give them wings'



Joanne Elphinston, director of JEMS (Joanne Elphinston movement systems) presented the fascinating topic of functional force management in the rehabilitation of shoulders.

As clinicians on assessments we needing to be asking ourselves:

-Are forces being shared or focused on a specific area?

-Are forces being transmitted?

-Does the body support the shoulders?

-Force production - do we need to teach the patient to use their legs to spare their shoulder? Or how to rotate? E.g. watch a tennis player- force is generated from the legs, transferring through the rotating pelvis, continuing through the rotating trunk and funnelled through the arm. The shoulder is the end of the movement – not the beginning.

Joanne Elphinston emphasised that the use of orthopaedic, neurological and proprioceptive tests have their role, however we need to keep in mind the emotional, global and functional context which may be contributing to the development and continuation of the problem.

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Therapy Expo 2017– Abi, Jess and Liz

Feedback from Jess Miller

Injuries in the sporting hand by Mike Hayton

A fascinating presentation taking us through a number of different injuries which may or may not require surgery. We have covered a lot of them in our #FractureFriday session in previous newsletters.

One of the points that was emphasised was regarding scaphoid/scapholunate fractures:
-If the patient cannot extend fully after one week post-injury and they have radial wrist pain and swelling, REFER ON.
-X-rays do not always show fractures of these sites whereas an MRI scan will be positive within a few hours.
-Pressure into the anatomical snuff box will be painful on examination
-All proximal pole fractures need replacing as they have a poor blood supply
-Rehabilitation: load it! This can lead to faster healing.

Attending the Therapy Expo was a brilliant experience and I would definitely recommend it to anyone as an invaluable CPD opportunity.

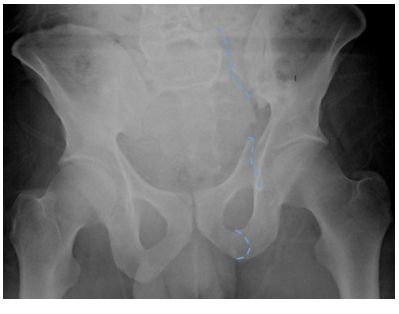
#FractureFriday by Joe Russell

Pelvic Fracture - Other pelvic fractures

Duverney fractures
Duverney fractures are a type of pelvic fracture most commonly occurring in the setting of a direct blow to the ilium, with a resultant isolated iliac wing fracture. It is regarded as a stable injury but may be operated on in the event of severe comminution.

Reference: https://radiopaedia.org/articles/duverney-fracture

Malgaigne fracture
Malgaigne fracture is an unstable type of pelvic fracture, which involves one hemipelvis, and results from vertical shear energy vectors. One of the clinical features is shortening of the leg on the affected side. Most commonly there is disruption of the ipsilateral superior and inferior pubic rami and sacroiliac joint. Common variants involve the ilium or sacral wing rather than the sacroiliac joint. This results in an unstable lateral fragment, which contains the acetabulum.



Reference: https://radiopaedia.org/articles/malgaigne-fracture