



Clinical Weekly - 166th Edition

#JOURNALTUESDAY - by Abi Peck

Should exercises be painful in the management of chronic musculoskeletal pain?
A systematic review and meta-analysis. [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. Group exercises groups for non-specific shoulder pain

A case series observed changes in shoulder pain, disability, and thoracic kyphosis, in 2 groups of patients after 2 different types of exercise classes. Classes were attended as 6 week blocks, containing either shoulder exercises alone or a mix of shoulder and thoracic based exercises. Outcome measures (The Disabilities of the Arm, Shoulder and Hand questionnaire for disability and the Numeric Rating Scale for pain) were measured at baseline, 6 weeks and 6 months. Thoracic kyphosis was measured at baseline and 6 weeks using the manual inclinometer. Significant improvements in Numeric Rating Scale and Disabilities of the Arm, Shoulder and Hand were demonstrated in both groups at 6 week and 6 month follow-up. Surprise, surprise resting thoracic kyphosis did not change after either exercise intervention.

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





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#NEWSOFTHEWEEK - by Liz Wright

2. Inappropriate claims from non-equivalent medications in osteoarthritis

Glucosamine and chondroitin are biologically active molecules that are substrates for proteoglycan, a vital component of the cartilage matrix. Evidence supports the use of glucosamine and chondroitin as symptomatic slow-acting drugs for OA (SYSADOAs) with impact on OA symptoms and disease-modifying effects in the long term. Glucosamine and chondroitin are available, both as prescription-grade products and nutritional supplements. However, while all preparations may claim to deliver a therapeutic level of glucosamine or chondroitin not all are supported by clinical evidence. Only patented crystalline glucosamine sulphate (pCGS) is shown to deliver consistently high glucosamine bioavailability and plasma concentration in humans, which corresponds to demonstrated clinical efficacy. Similarly, clinical evidence supports only the pharmaceutical-grade chondroitin sulphate. The European Society for Clinical and Economic Aspects of Osteoporosis, Osteoarthritis and Musculoskeletal Diseases (ESCEO) advocates careful and informed selection of glucosamine and chondroitin formulation. This is essential to optimize treatment effect. Therefore the ESCEO guidelines specifically recommend only prescription-grade glucosamine or chondroitin sulphate to maximize clinical outcomes, while claims of equivalence from other formulations may be considered as inappropriate. <http://bit.ly/ziXyOWe>

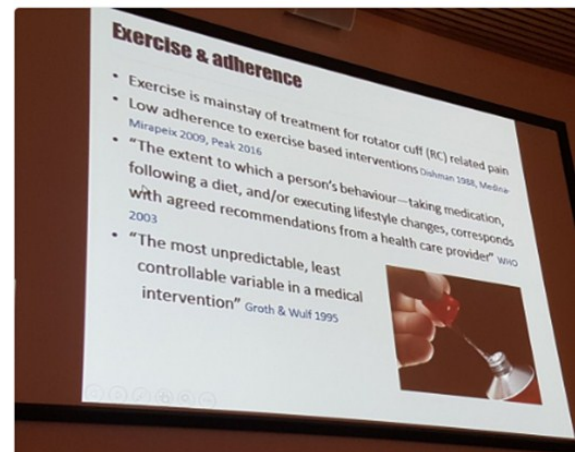
3. Shoulder rehabilitation conference #HopeSR17 (27/11/2017-28/11/2017)

The first shoulder rehabilitation conference to be held at Liverpool Hope University. The theme? 'New discoveries and future directions'. An outstanding line up of speakers combined scientific content and clinical expertise to share the current advances in the field of upper limb rehabilitation. 2018 could not come soon enough! Here's my pick of the favourite tweets I have come across, follow #HopeSR2017 for many more.



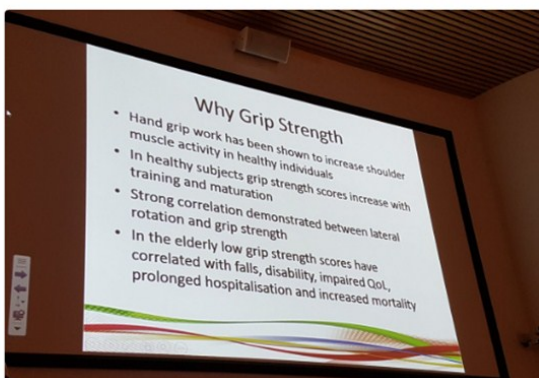
anju jaggi @AnjuJaggi · Nov 27

Exercise adherence is a fascinating & should be growing area of research. #HopeSR17



anju jaggi @AnjuJaggi · Nov 27

The importance of grip strength. #HopeSR17



Sheffield Shoulder
@AndrewVCuff

Following

Progressive exercise required for up to 12/52 if your first episode of shoulder pain.

Progressive exercise required for up to 6/12 if your second episode of shoulder pain.

#HopeSR17



Find us @AHPsuffolk



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#FRACTUREFRIDAY BY JOE RUSSELL

Intracapsular femoral fractures

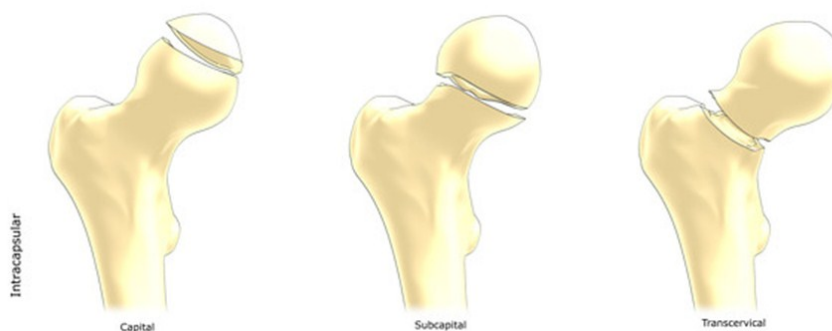
Anatomy

The hip is comprised of the femoral head and acetabulum, with the femoral neck joining the trochanteric region and femoral shaft. Blood supply for the femoral head is derived from vessels within the hip capsule. When a fracture of the femoral neck occurs, disruption to these blood vessels can occur result in devascularisation of the femoral head and resulting avascular necrosis.

Proximal fractures of the femur at classified on location either intracapsular or extracapsular.

Epidemiology

They tend to occur in older patients, and in those who have osteoporosis. In this group of patients, fracture is usually the result of low-impact trauma although, in younger patients they are usually victims of high-impact trauma, usually during a car accident.



Classification

Neck of femur fractures are considered intracapsular fractures (also called proximal femoral fractures).

Intracapsular fractures include:

Subcapital: femoral head/neck junction

Transcervical: midportion of femoral neck

Basicervical: base of femoral neck

Treatment

It is important for the correct treatment to be selected in intracapsular femoral fractures as there is a high risk of avascular necrosis. As a general rule, internal fixation is recommended for young, otherwise, fit patients with small risk for AVN. While prosthetic replacement is reserved for fractures with a high risk of AVN and the elderly.

The risk of AVN depends on the type of fracture. The Delbet classification correlates with the risk of AVN:

Type 1 (transphyseal): ~90% risk of AVN

Type 2 (subcapital): ~50% risk of AVN

Type 3 (basicervical/transcervical): ~25% risk of AVN

Resources: <http://bit.ly/2qLeHoi>

