



Clinical Weekly - 182nd Edition

#JOURNALTUESDAY - by Abi Peck

Effect of Brief Daily Resistance Training on Occupational Neck/Shoulder Muscle Activity in Office Workers with Chronic Pain: Randomized 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 Manuela Aye

OA Pain: Nociceptive or Neuropathic?

This article proposes a case for individuals with OA presenting with neuropathic features. The ability to distinguish between neuropathic and chronic nociceptive pain can be useful when recommending pain relief to patients, improving patient's quality of life and treatment outcomes. NSAIDs for example may be minimally beneficial in some patients with neuropathic pain and thus recommending anti-neuropathic medication would be more appropriate.

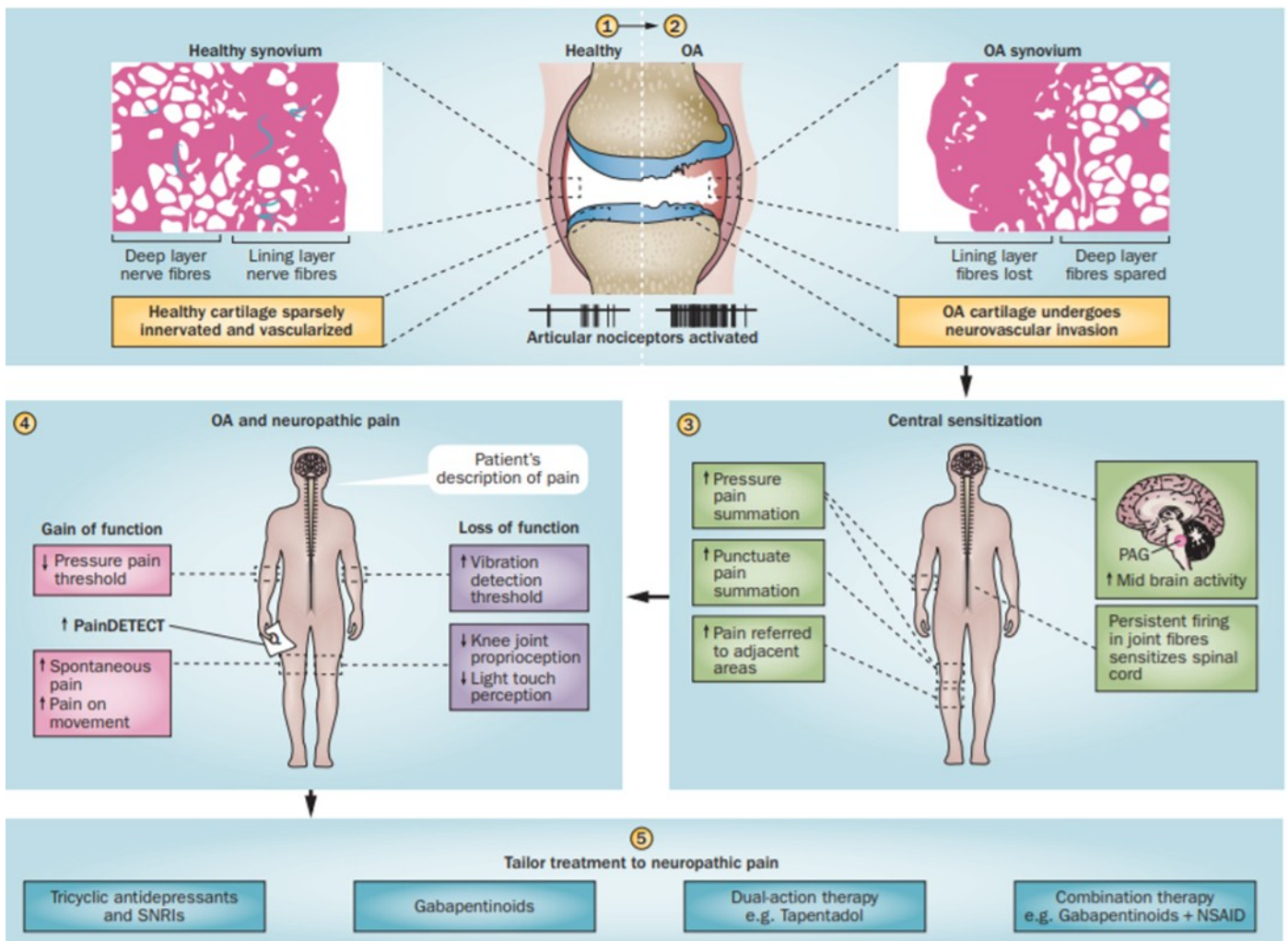
Characteristics of neuropathic OA:

1. Loss of innervation in synovial lining
2. Increased innervation of cartilage and the osteochondral junction (plasticity in intraarticular somatosensory structures).
3. Upregulation of neuronal damage marker in peripheral nerves

During OA a joint that is usually well innervated is disrupted and pain detecting afferent fibres are activated. Central sensitization of the spinal cord and Supraspinal central nervous system areas occurs. This leads to disruption of nerves and in turn neuropathic symptoms in some individuals.



Figure 1: Development of Neuropathic pain in an OA Knee



Identification of neuropathic OA

Patients should be tested for positive (enhanced sensations) and negative (reduced sensations) symptoms. Positive signs include: mechanical and thermal allodynia and pain hyperalgesia. Negative signs include: numbness, loss of vibration and pin prick sensitivity. To support a diagnosis of nociceptive or neuropathic pain, a referral for lab tests (e.g. nerve conduction studies) should also be considered.

Access article from: <https://bit.ly/2HcF2fE>



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#FRACTUREFRIDAY BY SCOTT ROWBOTHAM

Wagstaffe-Leforte fracture

This is an avulsion fracture of the anterior tibiofibular ligament as it attaches to 'Wagstaffe's tubercle' or the medial aspect of the distal fibula.

It is commonly classed as a high-ankle sprain or Lauge-Hansen SER type.

Mechanism of Injury

Normally through trauma or a sporting injury when landing with a dorsiflexed foot and the foot is forcibly supinated and externally rotated.

Patients may not report it for some months if rested and if refrained from sporting activity or sustained weight-bearing due to it being a high-ankle sprain.

Imaging

X-ray will show if avulsion is large enough and in combination with other fractures
MRI likely needed if anterior tibiofibular ligament only involved



Rehabilitation

Associated structures and injury will dictate management but assuming there is no displacement there will be a period of immobilisation followed by physiotherapy.

Resources

<https://www.orthopaedicsone.com/display/Review/Ankle+Fractures>

<https://www2.aofoundation.org/>

