



Clinical Weekly - 183rd 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?

Yes – to investigate the effect of brief daily exercises on the acute and longitudinal changes in occupational EMG activity of the neck muscles (scalene and trapezius) in female office workers with neck and shoulder pain.

2. Was the assignment of patients to treatments randomised?

Yes – more details given in reference 28

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

Yes 30 recruited, 2 dropped out due to lack of time

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

Patients were not blinded. Testers only interacted with participant's during the initiation and termination periods to minimise the risk of the Hawthorn effect.

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

Yes – female, office workers with chronic neck or shoulder pain.

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

Yes

7. How large was the treatment effect?

EMG main outcome: improvement in recordings in the intervention group compared to the control. Pain scores decreased in the intervention group were as the control groups increased. Results were statistically significant but not clinically significant. Isometric muscle contraction slightly increased in the intervention group but reduced in the control group.

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

Confidence intervals weren't discussed in the paper. Results show small differences.

9. Can the results be applied in your context?

Yes – normally people with neck/shoulder pain are desk based, many of them female.

10. Were all the clinically important outcomes considered?

Yes – pain, strength and muscle function.

11. Are the benefits worth the harms and costs?

No reported harms to the experiment. Only drop outs were caused by lack of time by participants.





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#NEWSOFTHEWEEK - by Liz Wright

1. Does a neuroscience based approach adequately explain the experience of pain and acknowledge the person experiencing it?

This blog ponders the question- if structural anatomy, and the damage to it, does not adequately explain pain, does neuroanatomy and physiology? Pain is an experience not just a sensation. Pain affects our well-being and emotional state (remember this is normal!). We form our individual experience and addressing these aspects for some people could be the key for their recovery (e.g the meaning that someone associates with pain, the feelings, the change of behaviours, beliefs). The way we think and feel will directly affect recovery. Human beings are very complex

and much more than anatomy that becomes damaged or even sensitised. Remember education is something we do with people rather than something which is done to people. Part of this education may include neuroscience, though how much of this needs to be part of the patients educational experience? The most important thing is to create a positive experience for the patient, trying to describe pain as a positive part of the human experience (you would not live without it!).

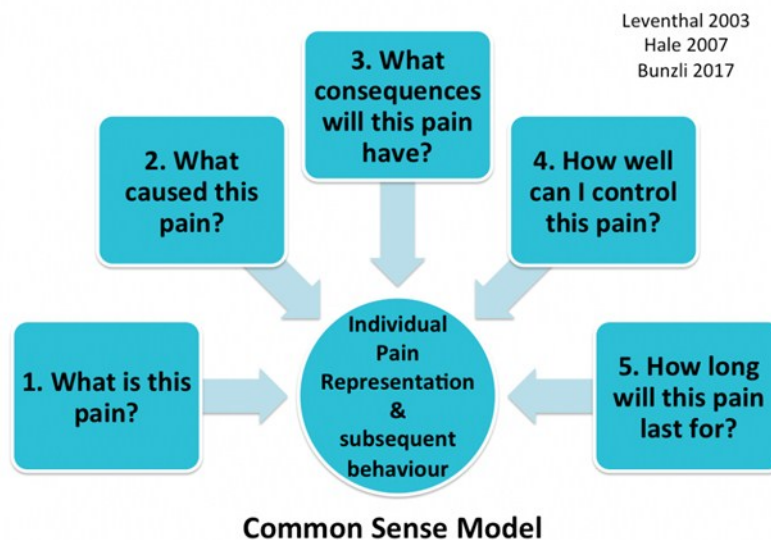
<https://cor-kinetic.com/pain-education-much-neuroscience-really-need/>

2. Love activity? Hate exercise? – CSP campaign

Designed by CSP members and patients to emphasize the unique role of physiotherapy. It is all based on research from people with long-term conditions, who explained their emotional and physical barriers to becoming more active. The title, 'Love activity, hate exercise?' reflects the conflicting feelings about exercise many people experience. The research confirmed that patients see physios as reassurers, referrers, advisors and pain relievers. What they haven't always been associated with is physical activity. Physiotherapists have explained how it was often from their patients talking about their love of these activities, such as dancing or walking, they realised that their patients did not actually hate exercise, what they hated was the pain and fatigue they feel and feared as well as concern about how they might be viewed by others if taking part in exercise.

It will be launched to members on 17th May and to the public in early July. In mid-May, the CSP will be contacting members with an invitation to register with the campaign.

<http://www.csp.org.uk/frontline/article/csp-campaign-love-activity-hate-exercise>



IPQ – R. Illness perception questionnaire





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#FRACTUREFRIDAY BY SCOTT ROWBOTHAM

Maisonneuve fracture

Maisonneuve fracture is a fracture only seen in the paediatric population and considered rare. This is due to the addition of a spiral fracture of the proximal fibula to an unstable ankle injury.

The ankle may have damage to the distal tibiofibular syndesmosis causing widening of the ankle joint, a tear to the deltoid ligament, or fracture of the medial malleolus.

Imaging

A distal x-ray will show rupture of the syndesmosis, deltoid ligament and fracture of the medial malleolus.

When this is seen it is clinically indicated to order further imaging of the entire fibula to assess for any accompanying proximal fibular shaft fracture.

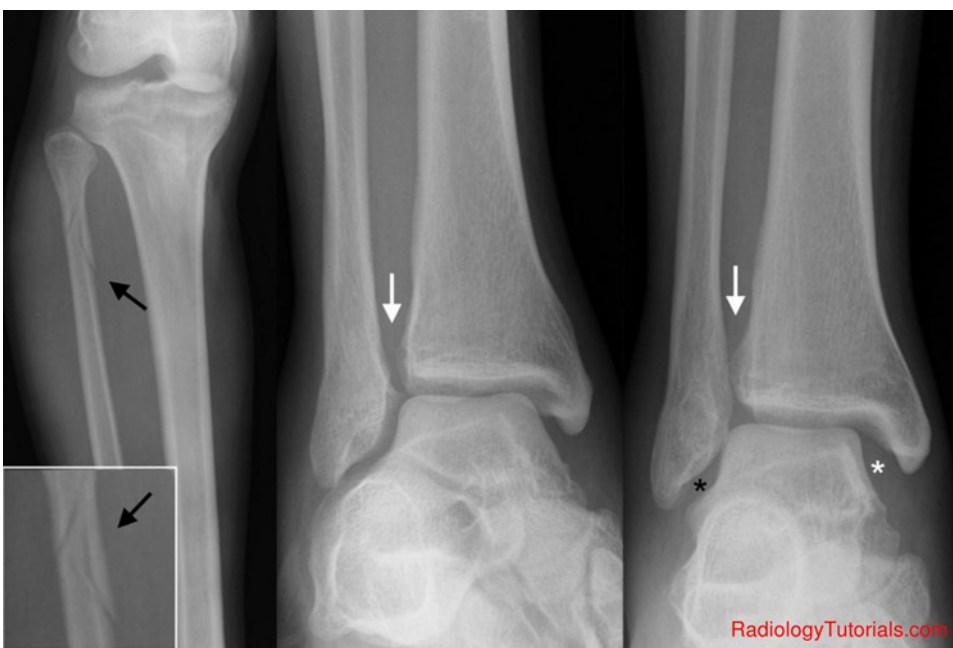
Mechanism of Injury

It is caused by a pronation external-rotation mechanism.

Rehabilitation

It will require surgical intervention to ensure union and ensure no growth plate arrest.

Physiotherapy will likely involve months of rehabilitation including hydrotherapy, gait re-education and proprioception.



<http://www.radiologytutorials.com>

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

