Neck
Common pathologies
- Chronic neck pain
- Brachialgia
- Myelopathy – need to be moved through the service quite quickly
  - Hand function issues
  - Feel drunk
  - Positive long tract signs
    - Rombergs
    - Hoffmans
    - Plantar reflex

Subjective
- 5D’s, 3N’s – medical history important
- Dizziness – very little that we have to offer
  - Need vascular opinion. MRI will not show occlusions

Cervicogenic Headaches
- Unilateral pain starting in the neck and referring into the head, can go behind the eye
- Older population linked in with degenerative changes
- Loss of movement in neck – important in differential diagnosis with migraines
- Reproduction of headache with palpation
- Feel joints to see if one side stiffer – PPIVMS – very subjective!
- Flexion rotation test – just C1-2 can have C0-3 headaches
- Trouble can be that patients don’t come to see you for a long time after started

Objective
- ULTT - Can be useful but have to be wary of how quickly we can get changes
- Palpation – looking for pain reproduction. PPIVMS – not a lot of reliability, very subjective

Referral onwards
- Myelopathies
- Brachialgias - ?should be treated longer by physiotherapy as invasive intervention carries a lot more risk
- Chronic axial neck pain – don’t rehab enough – get into the gym lifting weights

SIJ
- Synovial joint – produces pain – so can be a source. Poor reliability on movement tests, there are provocation test – Laslett
- Difficult to differentiate
  - Area of pain doesn’t go above L5 level
- Treatment and management doesn’t really change. Could use provocation tests as mobilisations then rehab muscles

Inflammatory
- Age, male, alternating buttock pain, morning stiffness, other conditions – tendon issues, enthesitis
- If in doubt get it checked out. Refer back to gp and ask for rheumatology review, blood tests
Questions for the Achilles podcast:

1. What indicates Plantaris involvement and helps you differentiate from mid portion Achilles Tendinopathy
2. Where do patients have pain with Plantaris tendinopathy
3. What history do patients with Plantaris involvement or tendinopathy present with
4. Objective tests and findings for Plantaris tendinopathy and involvement
5. Biomechanics contributing to Plantaris tendinopathy
6. Is treatment successful for Plantaris
7. How to treat Plantaris tendinopathy and involvement in midportion Achilles
8. How to perform a loading program
9. Running adjustments
10. Discuss taping and manual therapy

Thoracic Spine

- Don’t see as many and Lsp and Csp
- Often it is mechanical, muscular pain that hasn’t resolved
- It is part of red flags – in isolation it isn’t – but be aware
- Treatment must more difficult. Not keen to do injections into thoracic spine, enclosed area and operations for thoracic discs are complicated. Don’t see many. See a lot a small bulges but these are incidental.

Key Points
1. Thorough examination
2. Reassure patients
3. With ‘treatment’ push the patient on

#WHATSNEWFRIDAY- Diastasis Recti - what is it and how do we manage it?
Diastasis Recti, also known as abdominal separation, is when the abdominal muscles separate into right and left halves. It is seen in women who are pregnant or following pregnancy.

**Risk factors:**
- 2nd pregnancy
- ‘Sticky out’ bump
- Older
- Big baby
- Long 2nd stage of labour
- ?Narrow pelvis

**Assessment:**
- Palpate along the linea alba
- More commonly seen below the umbilicus
- ‘Normal’ is 1cm below, 2cm above umbilicus
- Ideally measured with tape measure

**Treatment:**
- A descriptive study by Keeler et al (2012) reported that most therapeutic exercise for diastasis recti focuses on trans abs training.
- Walton et al (2016) suggest there is little difference between a traditional exercise programme involving abdominal crunch, posterior pelvic tilt, kegels, and Russian twist and an experimental group involving plank, posterior pelvic tilt, kegels, and Russian twist.
- However, a systematic review by Benjamin et al (2014) suggests there is very little high quality evidence to suggest whether exercises can be beneficial or not for diastasis recti

**General advice from our women’s health physios:**
- Avoid anything that causes peaks/domes
- Best improvement will be 3/12 post-partum but can see improvements beyond even 18/12

For the next #WHATSNEWFRIDAY - Soleus- what exercises do we use? Why is it important? Have a look at these links for ideas- [pic.twitter.com/aV9ah35Bps](http://www.biomechanics.completesportscare.com.au/rehab/important-soleus-managing-midportion-achilles-tendinopathy-seth-oneil/#sthash.o9bLETX0.dpbs)

Any pictures, suggestions or comments to [jessica.z.miller@ahpsuffolk-cic.nhs.uk](mailto:jessica.z.miller@ahpsuffolk-cic.nhs.uk).

**NEWSOFTHEWEEK – by Joe Russell**

Some big things have happened during my week off. 2 big/important papers published.

1. **Consensus update on PFP**
   Dr Christian Barton has just published the follow up to the consensus statement on patello-femoral pain. The initial paper was published a few years ago. This was written following a meeting of experts and academics and is combination of expert opinion and current evidence base. They make 6 recommendations. In essence exercise, taping and orthotics are good practice where as electro and manual therapies 'are unlikely to lead to improvements'. This would be a good one for local journal clubs to read.
   - [2014 paper](#)  [New paper](#)  Blog: [https://t.co/r8YZRD88uP](https://t.co/r8YZRD88uP)

2. **Lumbar fusions for back pain**
   There have been multiple short to medium term studies showing little benefit to lumbar fusions for people reporting axial or non-specific back pain over physiotherapy. This Scandinavian study
followed nearly 300 people with persistent low back pain for an average of 12 years. They either had lumbar fusion or physiotherapy. Around 65% improved with surgery compared to 35% with physiotherapy on the global assessment of back pain score. A nod to our surgical colleagues then... HOWEVER the groups were statistically similar for VAS and Owestry scores as well as pain medication use and work status following either intervention long term.

These results may seem somewhat conflicting. People feel better but aren't able to demonstrate that in work or medication use... and it may not make their pain better. Is 65% success worth the risk of spinal surgery?

This would certainly be something interesting to discuss with our BANS and pain clinic colleagues.


3. ITBS review
An interesting review published just this week on ITBS; specifically looking at the role of compressions vs friction along the length of the ITB. Lots of interesting points made and a must read for anyone treating ITBS.
https://co-kinetic.com/content/iliotibial-band-syndrome-a-narrative-review

#EXERCISEOFTHEWEEK – Suzanne Godfrey

Soleus Rehab:
@tomgoom @BarrySigrist

We know that soleus exercises are often forgotten with running rehab so this week we have picked up on a few soleus exercises supported by the Running Physio.

Strength training reduces injuries reduced sports injuries by 1/3 and overuse injuries by ½ (Laurensen et al, 2013)

A high intensity approach using more than 70% of 1 Rep Max is more effective than a low intensity approach but requires a gradual introduction to heavier loads (Kristensen et al, 2012)

Hamner et al, 2010, suggests that our calf muscles are the greatest contributor to running/propulsion

Esculier et al, 2015 found that in PFP populations the longer soleus takes to activate during the running cycle increased the risk for PFP.

Research Links:
Lauersen - http://bjsm.bmj.com/content/early/2013/10/07/bjsports-2013-092538.abstract
Kristensen - http://bjsm.bmj.com/content/46/10/719.abstract
Hamner - http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2973845/#lpo=10.0000

#AHPSCLINICALWEEKLY