

#JOURNALTUESDAY - by Abi Peck

**CASP tool – Heavy slow resistance versus eccentric training as treatment for Achilles tendinopathy: A randomised controlled trial**

[Download here](#)

1. Did the trial address a clearly focused issue?
2. Was the assignment of patients to treatments randomised?
3. Were patients, health workers and study personnel blinded?
4. Were the groups similar at the start of the trial?
5. Aside from the experimental intervention, were the groups treated equally?
6. Were all of the patients who entered the trial properly accounted for at its conclusion?
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 clinically important outcomes considered?
11. Are the benefits worth the harms and costs?

#CLINICALSKILLSFRIDAY by Jess Miller - Ottawa knee rules

The Ottawa knee rules were developed to determine the need for radiographs to rule out fractures in people with acute knee injuries.

The rules are as follows:

A person presenting with an acute knee injury and any one of the following:

- Age >55 years
- Tenderness at head of fibula
- Isolated tenderness of patella during palpation
- Inability to flex the knee to 90 degrees
- Inability to weight bear immediately and at emergency department

Pooled sensitivity: 98.5%

Pooled specificity: 48.6%

*(Bachmann et al, 2004)*

A study by Cheung et al (2013) compared the Pittsburgh knee decision rule (PDR) to the Ottawa knee rules (OKR) and found that the PDR was more specific than the OKR but the sensitivity was equal.

For the next #CLINICALSKILLSFRIDAY- Well's criteria for DVT

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

**#NEWSOFTHEWEEK by Liz Wright**

**1) Incidence of Spontaneous Resorption of Lumbar Disc Herniation (LDH): A Meta-Analysis**

LHD is common, often treated conservatively, frequently resulting in spontaneous resorption. The above analysis aimed to determine the incidence of resorption post conservative treatment using methods such as MRI. Results pooled from 11 cohort studies found the overall incidence of resorption to be 66.66%. However, there were no randomized controlled trials that met the inclusion criteria, presenting limitations of this analysis. It was concluded conservative management may be viewed as the first instance of treatment. Future studies which are large-scale, randomized controlled trials are required.

<http://www.painphysicianjournal.com/current/pdf?article=NDAwNA%3D%3D&journal=101>

**2) New report launched 9.3.2017 'Providing physical activity interventions for people with musculoskeletal conditions'**

The report has been produced in partnership with the Department of Health, Public Health England and NHS England and is also endorsed by the Royal College of General Practitioners, Local Government Association and Chartered Society of Physiotherapists. It's intended for organisations responsible for commissioning and providing local services, as well as musculoskeletal and physical activity organisations. Highlighted is the importance of providing physical activity interventions for people with MSK conditions, providing details of the resources that local authorities can use to support people to be physically active. A 'one-size-fits-all' approach isn't appropriate for people with differing levels of mobility and activity. Depending on an individual's needs, physical activity can involve a spectrum of approaches prescribed by a health professional. The report aims to ensure these approaches are at the centre of commissioners' plans. Follow the link to download the full report. <http://bit.ly/2m193od>

**3) Hot topic of hip precautions – on-going**

The British Hip Society (allied to the British Orthopaedic Association) ran its annual meeting from 1<sup>st</sup> March – 3rd in London. Topics under focus included 'the patient pathway' and of course the review of the current hip precautions. As you may have remembered previously the topic was heavily debated at the ATOCP conference in November 2016 regarding the potential abolishment of the hip precautions (see link below for CSP article). There is also a video link to the full debate.



## AHPS CLINICAL WEEKLY

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This picture shows an audience of health care professions at the ATOCP conference, specialising in elective orthopaedics; they were asked, show green if you agree with this abolishment and red if you disagree. Say no more!  
<http://bit.ly/2mK4pYM>  
<https://www.youtube.com/watch?v=l5pqrEde1Zo>



### #TWEETOFTHEWEEK



**anju jaggi** @AnjuJaggi · Mar 11

Love a quote from our course today: 'An exercise a day keeps the surgeon away!'

### #VITAMINOFTHEWEEK – by Sam Ackerley

#### RIBOFLAVIN (vitamin B<sub>2</sub>)

Riboflavin is a water-soluble vitamin which functions as a coenzyme, required for enzymes to perform normal physiological actions. The active forms of riboflavin are flavin mononucleotide (FMN) and flavin adenine dinucleotide (FAD) which function as cofactors for a variety of flavoproteine enzyme reactions.

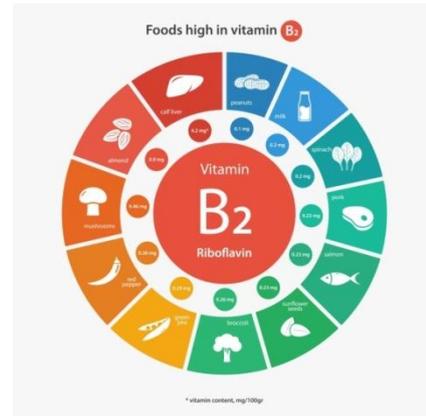
#### **Functions:**

- Riboflavin is required by the body for cellular respiration therefore essential for energy metabolism. It also helps metabolize fats and proteins.
- As one of the B complex vitamins it is necessary for a healthy liver, skin, hair, and eyes.
- Riboflavin also acts as an antioxidant which neutralises free radicles which can damage cells and DNA, contributing to the aging process, as well as the development of a number of health conditions, such as heart disease and cancer.
- Riboflavin supplements are used as part of the phototherapy treatment of neonatal jaundice, as the light used to irradiate the infants breaks down riboflavin, as well as jaundice causing toxin bilirubin.

- High-doses of riboflavin have been shown in some clinical trials to effectively prevent of migraines (however this is variable between studies.) It can be used alone or with other supplementation (beta-blockers, magnesium citrate 500 mg and coenzyme Q10.)

**Top 10 sources: (Per 100 grams)**

1. Cheese (Gjetost) - 1.38mg (81%)
2. Almonds - 1.10mg (60%)
3. Beef & Lamb (Lean Steak) - 0.86mg (51%)
4. Oily Fish (Mackerel) - 0.58mg (34%)
5. Egg (Hard Boiled) - 0.51mg (30%)
6. Pork (Sirloin) - 0.51mg (30%)
7. Mushrooms (Raw Brown Italian) - 0.49mg (29%)
8. Sesame Seeds - 0.47mg (27%)
9. Seafood (Squid) - 0.46mg (27%)
10. Spinach 0.24mg (14%)



**Deficiency – Ariboflavinosis**

-Rare in developed countries.

Riboflavin deficiency results in stomatitis (inflammation of the mouth and lip) including painful red tongue with sore throat, chapped and fissured lips and inflammation of the corners of the mouth (angular stomatitis).



The eyes can become itchy, watery, bloodshot and sensitive to light.

Due to interference with iron absorption, even mild to moderate riboflavin deficiency results in an anaemia.

Deficiency of riboflavin during pregnancy can result in birth defects including congenital heart defects and limb deformities.

Other symptoms include: Fatigue, slowed growth, digestive problems, eye fatigue, swelling and soreness of the throat and sensitivity to light.

**Resources:**

- <https://en.wikipedia.org/wiki/Riboflavin>
- [http://www.health.harvard.edu/staying-healthy/listing\\_of\\_vitamins](http://www.health.harvard.edu/staying-healthy/listing_of_vitamins)
- <https://www.healthaliciousness.com/articles/foods-high-in-riboflavin-vitamin-B2.php>
- <http://umm.edu/health/medical/altmed/supplement/vitamin-b2-riboflavin>

**Images:**

- [Vitamin wheel] <https://appreciategoods.com/vitamin-b2-riboflavin/>
- [Mouth image] <http://doctor-uncle.blogspot.co.uk/2013/02/riboflavin-deficiency.html>