#PODCASTTUESDAY By Em and Em
W/C 9.5.16  Proximal hamstring tendinopathy with Tom Goom

Glenohumeral kinematics with RTC Tears Part 2.

Picking up from where we left off:
- 11 of patients had chronic tears >90 days
- Could mean there set up to be copers
- Shoulder pain could be nothing to do with rotator cuff tear
  - Could have tweaked something and be sensitive now
- Control group young mean age of 30 compared to 60 in tested group
  - Could inferior translation be normal at that age
- These findings could lead to development of new models of thinking, we mustn’t assume
- Authors thought on why hypothesis was disproven:
  - Patients primarily had isolated tears to supraspinatus muscle. Yanagawa et al (2008) theorised that supraspinatus acted primarily as a joint stabiliser and applied all its force to compressing humeral head into the glenoid. They reported that net force was directed superiorly from 15-105 degrees abduction with supraspinatus contributing this superior force whilst infraspinatus and subscapularis applied inferiorly directed forces.
  - All were ‘copers’ and had maintained movement. A tear of supraspinatus muscle does not necessarily mean glenohumeral instability.

#PODQUESTIONS for Tom Goom, Proximal Hamstring Tendinopathy
1. What kind of symptoms do people report initially?
2. What kind of activities tend to load the tendon and lead to the problem developing?
3. Discuss the differential diagnoses.
4. What is the research around PHT?
5. What should the objective assessment include?
6. What could one look at to determine what may be contributing to excessive hamstring load?
7. What kind of language can we use to educate a patient in a way that will not create fear and reluctance?
8. Discuss the progression of rehabilitation from the early phase back to pain free activity.

#WHATSNEWFRIDAY- Lhermitte’s Sign by Jessica Miller
On flexion of cervical spine:

- Sudden sensation of electric shocks passing down back of neck and back
- Can radiate into arms and legs

**Lhermitte’s sign** is thought to be caused by a miscommunication between demyelinated nerves. When the cervical spine is flexed, the hyper excitable demyelinated dorsal column of the spinal cord is stretched which leads to the electric shock sensations.

Lhermitte’s sign can be seen in many different conditions. Most commonly, it is seen in people with Multiple Sclerosis. This table [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4445188/table/T1/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4445188/table/T1/) from the paper ‘Lhermitte’s Sign: The Current Status’ (Khare and Seth, 2015) shows the other possible causes of Lhermitte’s Sign.

Beckman Y et al (2015) report 16 in every 100 MS patients present with Lhermittes sign (Likelihood of which did not correspond to age/gender/disability/length since diagnosis)

**Sensitivity:** ranges from 3-17%

**Specificity:** 97% for non-compressive myelopathy

(Khare and Seth, 2015) [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4445188/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4445188/)

For the next #WHATSNEWFRIDAY- Triple hop distance test.
[http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2267326/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2267326/)

Any pictures, suggestions or comments to Jessica.z.miller@ahpsuffolk-cic.nhs.uk.

#NEWSOFTHEWEEK – By Joe Russell

Summer is on its way! (well I hope so anyway) I saw the following infogram on Twitter about hydration, applicable for athletes but may have clinical cross over. @YLMsportsscience
1. ACLR – early or late?
John and I attended some interesting lectures last week at the UEA given by one of the NNUH surgeons. He was very keen to operate on seemingly anyone with knee pain. He spent a significant amount of time highlighting the importance and cost effectiveness of early intervention using Scandinavian registry studies. Some of the references were somewhat dated and I wondered if more recent work had been done. BJSM published an article on this very subject this month.

This new study suggests that ACL rehab alone is €13650 cheaper than early ACLR. Early ACLR was not significantly less costly that delayed and had no significant impact on QALYs. They conclude that cases should be reviewed individually as there is a risk in overtreatment in the acute phase. http://bjsm.bmj.com/content/50/9/558.full.pdf+html?sid=c33ccd9a-76a1-4bd7-9d64-8b458c614058&hwoasp=authn%3A1462371460%3A4073209%3A1367788166%3A0%3A0%3AmHPeNDMBh74ZKYckllhyg%3D%3D

2. How do we explain pain?
Ok I know this is something we have discussed at length and as much as I want to joke about bloggers writing blogs on other bloggers blogs this is worth a look. There is a nice summary of words to include and avoid when discussing pain with our patients. http://clairepatella.com/how-should-we-explain-patellofemoral-pain-to-patients/

3. In, out, in, out, stretch it all about!
Patients with frozen shoulder get different treatments, which is often (in my own experience) based on the clinician they see. Yoon et al investigated whether intra-articular, subacromial or hydrodilitation provided better outcomes. The study included 54 patients split over the 3 groups. Hydrodilitation provided better outcome scores at 1 and 3 months but by 6 months all groups were statistically the same. All received physiotherapist at the same time. No control group however we know that often these injections have been shown to be no better than physio.

http://www.jshoulderelbow.org/article/S1058-2746(15)00623-0/abstract?elsca1=etoc&amp;elsca2=email&amp;elsca3=1058-2746_201603_25_3_&amp;elsca4=Orthopaedics

4. Don’t discount inflammatory signs
Tom Goom being featured again today. An interesting blog from a clinician on being a patient that has potentially overlooked some of his own symptoms. This really highlights how much overlap there are in symptoms between conditions. It also shows we should not dismiss things too soon, although escalating too quickly also isn’t advisable. http://www.running-physio.com/pht-psa/
Headache and the Cervical Spine

Classification

- **Primary**
  - Headache without apparent identifiable cause e.g. migraine, tension type headache, chronic daily headache, medication overuse headache (more than 15 days a month)

- **Secondary**
  - Headache associated with secondary pathology, stroke, TMJ, cervical spine (What we are interested in)

- Cranial neuropathies
  Most common headache in primary care

- **Migraine without aura, tension type headache, cervicogenic headache, medication overuse headache**

Cervicogenic headaches

- Occur where upper 3 cervical nerve roots meet trigeminal nerves
- Can be trigeminal sensitisation causing neck pain and stiffness (muscles hyperactive)

- Important to consider because:
  - Systematic reviews and RCT’s of manual therapy for different headache forms indicate that only people with cervicogenic headaches and tension type headaches gain sustained long term benefit
  - 100% of subjects with cervicogenic headache were mis-diagnosed as migraine, un-responsive to migraine treatment but responded to cervicogenic headache treatment

- **Potential causes:**
  - Psychosocial co-morbidities – depression, anxiety etc.
  - Joints C0-4 – sub-chondral bone, ligaments, capsules, intra and extraarticular soft tissue
  - Muscles – upper traps, semispinalis, splenius, longissimus capitis, SCM, levator scapulae
  - Neural strucutres – cervical dura, spinal nerves C1-3, greater occipital nerve and others
  - Vascular structures
  - TMJ

- Difficult to diagnose as symptoms of different headache forms overlap (50% incorrect diagnosis) and neck pain does not indicate cervical cause (70% have neck pain associated with migraine attack)

Signs and symptoms of Cervicogenic Headaches

- **Precipitation of headache by:**
  - Neck movement
  - Posture
  - Pressure over upper cervical / occipital region

- **Restriction of neck range of movement**
- **Ipsilateral neck, shoulder or vague arm pain**
- **Side dominant without side shift**
- **Head pain is mod to severe, non throbbing, no clustering. Starts in neck and spreads to head. Varying duration and has long term fluctuation pattern.**
- **Exmaination, 3 factors identified as important:**
Cervical range of movement – extension mainly
Craniocervical flexion test muscle control
Pain on palpation C0-4

*100% sensitivity and 94% specificity in isolating cervicogenic headaches from control, migraine and tension type headaches* (Jull, 2007)

Treatment / Management
- Good evidence for manual therapy for cervicogenic headaches (Jull et al, 2002; Castien et al, 2011) (Check out the papers and see last edition for techniques!)

#CONFERENCEOFTHEWEEK – Basketball Sports Medicine Conference 2016
I was fortunate to attend the basketball Sports medicine conference and it didn’t disappoint. Some great speakers, if you love your rehab check out the stuff Dr Ben Rosenblatt was discussing, some really interesting points. For everyone, check out Seth O’Neills talk! Some really interesting points and my favourite slide of the day showing that using the opposite non-symptomatic leg is not reliable for comparing return to strength against healthy matched individuals!! #BSMC16
https://springfieldphysio.com/2016/04/30/basketball-sports-medicine-conference-2016-bsmc16/

#EXERCISEOFTHEWEEK – Suzanne Godfrey
Constrained VS unconstrained Finger Exercises post-surgery (Miller et al, 2016)
Interesting paper found that there are similar effects of constrained and unconstrained exercises post open reduction/internal fixation of proximal phalangeal fracture.
- RCT over 6 weeks
- 66 participants within 1 week of ORIF
- Comparing constrained and unconstrained exercises
- No significant difference with AROM, strength, pain and dexterity at 6/12 week

Result: safe to introduce constrained exercises within 1 week post op.

Check out the article below, also on the CSP page!
Research Link: