

CERVICAL ARTERIAL DYSFUNCTION: WHAT SHOULD WE BE DOING?

Mr ROGER KERRY (NOTTINGHAM UK)

Cervical arterial dysfunction (CAD) relates to a wide range of pathologies affecting the blood vessels in the cervical spine region. The pathologies are numerous and include, for example, vertebrobasilar insufficiency (VBI). For decades manual therapists have been concerned with such conditions as potential adverse effects of cervical therapy intervention. The most common link reported is that between VBI and cervical manipulation. Within both manual therapy literature and clinical practice, there is an apparent large degree of contention related to all aspects of these neurovascular responses including the nature of vascular pathologies, signs and symptoms, screening and assessment procedures etc. There is a significant lack of agreement with regards to most of these aspects. This lecture sets out to present the evidence relating to CAD and its relevance to manual therapy. It will be proposed that our present understanding of VBI is incomplete and misleading. Furthermore, it will also be proposed that our present approach to pre-treatment screening restricts our clinical reasoning and our ability to identify those people who are most likely to have a serious neurovascular adverse response.

The lecture will proceed to suggest clinical assessment methods and clinical reasoning skills which incorporate the best of current practice, but which also consider contemporaneous thought and evidence with regarding to the assessment of cervical pain syndromes. Clinical case-studies and medico-legal examples will be used to demonstrate reasonable and effective practice. The focus of our clinical question will be shifted from one of pre-manipulative screening to a more holistic attempt at differentiating pain of patho-vascular origin. Delegates will be invited to contribute to this colourful discussion.

INJECTIONS IN MANAGING MUSCULOSKELETAL DISORDERS: THE PROS AND THE CONS

Dr Keith Bush (London UK)

This presentation addresses the risk/benefit ratio of performing injections. Whilst serious side effects including death may arise from for example, anaphylactic reactions, these are extremely rare provided that adequate precautions are taken and fastidious technique is adhered to.

In the context of evidence base, including research, experience and society's tolerance, various injections will be considered. These will include simple procedures such as peripheral joint and soft tissue injections, but with particular focus on the spine.

Peripheral injection techniques are relatively simple and safe but one still needs to be prepared to deal with an anaphylactic reaction. Anapen, a pre-loaded adrenalin syringe, for swift intra-muscular injection is an ideal precaution.

Thus, injecting, for example the common extensor origin with steroid and local anaesthetic is likely to be safe but it might produce a painful post-injection reaction and only result in prolonged relief in less than 50% of cases.

There is still controversy over the efficacy of epidural steroid injections but we have demonstrated their efficacy in managing sciatica which is generally a self-resolving condition due to herniated discs regressing over time. Efficacy and safety can be improved with imaging control particularly in the cervical spine. However, although success rates in managing cervical radiculopathies are even better than with sciatica, the risks associated with injecting the cervical spine are far higher. Therefore, injections in the cervical spine have to be performed with extreme care and precision.

The evidence base for facet joint injections is limited. Nevertheless, scintigraphy has helped to identify a number of patients with unilateral axial neck pain who respond to specific injections under image guidance. This scenario is far less common in the lumbar spine. On the other hand, the risks associated with performing these procedures is less than with epidural steroid injections. Sclerotherapy for spinal instability syndromes also has a limited evidence base but there is a considerable amount of positive anecdotal evidence.

Most of these procedures have endured for over half a century and are thus clearly accepted by society. There is a limitless list that could be discussed but at the end of the day, carrying out a specific injection to relieve a musculoskeletal pain is akin to oiling a door hinge to stop it squeaking. There is no harm in oiling the wrong hinge other than the door will continue to squeak. However, care needs to be taken not to spill oil on the carpet!

PATHOLOGY AND CAUSES OF TENDINOPATHY

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MANAGEMENT OF TENDINOPATHY ART OR SCIENCE?

MR NICOLA MAFFULLI (STOKE ON TRENT UK)

The Achilles tendon is the strongest tendon in the human body, but Achilles tendon ruptures are common, and their incidence is increasing. The evidence for best management is controversial, and, in selected patients, conservative management and early mobilization achieves excellent results. Surgery is associated with an increased risk of superficial skin breakdown. However, modern techniques of percutaneous repair that are performed under local anesthesia and followed by early functional rehabilitation are becoming increasingly common, and should be considered when managing such patients. The number of publications reporting Achilles tendon ruptures is increasing, the scientific quality of the studies is increasing, and the trend for the number of reported complications is decreasing. There is a trend toward earlier mobilization. Surgical repair (either open or percutaneous) and early mobilization give the best functional recovery and an acceptable complication rate. In any case, it should be stressed that surgery for these ailments carries significant risks, and rerupture, disordered scarring with potential keloid formation, nerve damage (especially the sural nerve), poor healing, infection, bleeding and haematoma formation, wound dehiscence, deep vein thrombosis (DVT), and loss of function have all been reported. Although histopathologic studies have shown that ruptured Achilles tendons have clear degenerative changes before the rupture, many Achilles tendon ruptures take place suddenly without any preceding signs or symptoms

WHY MANIPULATE AT ALL?

Prof Laurie Hartman (Cockfosters UK)

I was asked to be controversial and I hope that this is going to lead to some good questions. To start I consider the results of treatment by medical practitioners and osteopaths and to see why General Practitioners have poorer results than osteopaths. There is recent French research that shows medical practitioners have a much higher ratio of trauma in treatment than do other manual practitioners.

I then go on to explain the approach to some of the manipulations we use and try to conclude on the reasons why we use some approaches and not others to free joints.

Using the "tennis elbow" as an example I will specifically consider the osteopathic thinking behind the approach to patients with this problem.

When we use manipulation, we emphasise the use of comprehension as to the cause of the problem, the good use of handling, the efficient use of operator posture and effective technique. Therefore, a considerable amount of emphasis is placed on this is training and this will be expounded upon.

Comprehension uses current thinking of the cause of the problem being due to nervous irritability, to mechanical locking, or to hydraulic build up of pressure in tissues. The cause of the dysfunction determines the treatment approach and this will be explained

The importance of good patient handling will be identified as much practice is needed to acquire this skill which is extremely important in patient co-operation.

The reasons behind the importance of good operator posture for maximum efficiency and minimum effort will be considered.

To achieve effectiveness all the above points have to be practised relentlessly, let alone each individual technique! It takes several years to be really effective and specific, thereby causing least trauma to the tissues and maximum effect for the patient.

Osteopaths use several types of palpation to be really effective and constantly work to improve their palpation skills to a point that is really fast, effective, consistent and with the least amount of tissue change during the process, thereby ensuring a true picture of problems.

In osteopathic education, hours are spent on technique to be good. But we spend years on technique to be excellent!

In summary, we use correct posture to be effective with minimum effort. We use the correct stance to minimise operator fatigue. We use compression, compression and more compression to focus the forces. We then repeat the force 4 or 5 times in mini thrusts to build up the tissue tension and then only a minimum thrust is needed to free the specific joint.